St. Peter's Health

COMMUNITY HEALTH IMPLEMENTATION STRATEGY

FISCAL YEARS 2025- 2027

UPDATED: 3/18/2025

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ABOUT ST. PETER'S HEALTH

St. Peter's Health (SPH), based in Helena, Montana, is a not-for-profit, 99-bed hospital serving a 5 county area (Lewis & Clark, Broadwater, Jefferson, Meagher and Powell Counties), with a combined area over 11,000 square miles. With over 1,700 employees, St. Peter's Health provides services to an estimated population over 95,000. St. Peter's Health is accredited by DNV.

MISSION

To improve the health, wellness and quality of life of the people and communities we serve.

VISION

Together, we will serve every patient, every person, every time with exceptional hospitality, compassionate care and high-quality clinical outcomes.

VALUES

We will:

- Treat every person with dignity, respect and loving-kindness
- Keep colleagues and patients safe, in every sense of the word
- Empower and invest in our people to help them grow and thrive
- Inspire collaboration to cultivate joy, pride and a sense of belonging
- Drive excellence through learning, innovation and continuous improvement
- Steward our resources wisely so we can fulfill our mission

ST. PETER'S HEALTH SERVICES:

- Inpatient care
- Outpatient Primary Care
- Outpatient Specialty Care
- Emergency Care
- Surgical Services
- Pharmacy Services
- Obstetrics
- Inpatient and Outpatient Behavioral Health
- Urgent care
- Dialysis
- Endoscopy Services
- Home Health & Hospice Services
- Mobile Crisis Response
- Childcare Services

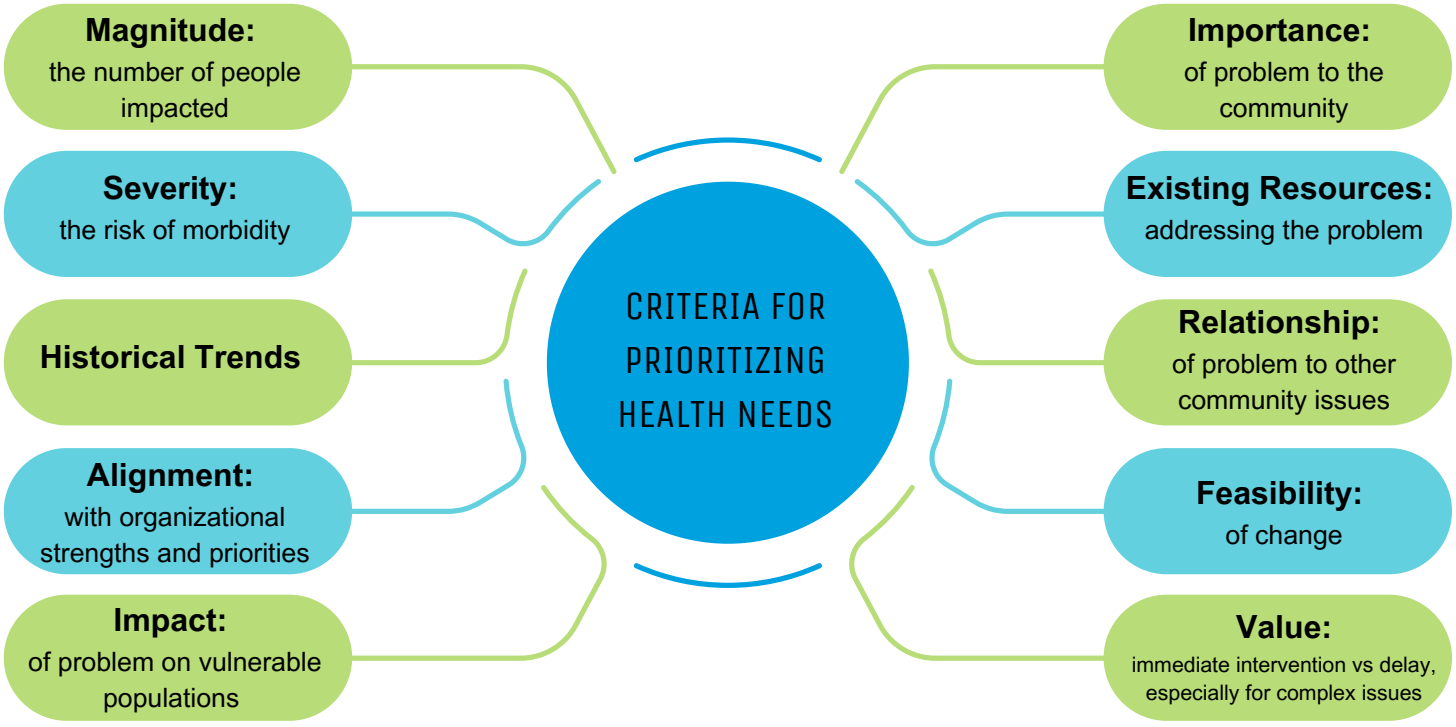
INTRODUCTION

THE COMMUNITY HEALTH NEEDS ASSESSMENT:

Our Community Health Needs Assessment (CHNA) is a data-driven process that evaluates the health status, behaviors, and needs of residents in St. Peter's Health service area. This comprehensive analysis provides valuable insights to inform decision-making and improve the overall health and well-being of our community. By identifying areas of greatest concern, we can strategically allocate resources, maximizing our impact on community health. The IRS requires that each identified need is either addressed with specific actions or justified as not a focal point.

HEALTH NEEDS PRIORITIZATION PROCESS:

The Population Health Department collaborates with the Population Health Advisory Council and Community stakeholders to prioritize health needs for the next 3 years of Community Health Implementation Strategies and community benefit programming. The figure below illustrates the criteria used to review the CHNA data determine the final priority health areas and their order.



INTRODUCTION (CONTINUED)

THE COMMUNITY HEALTH IMPLEMENTATION STRATEGY:

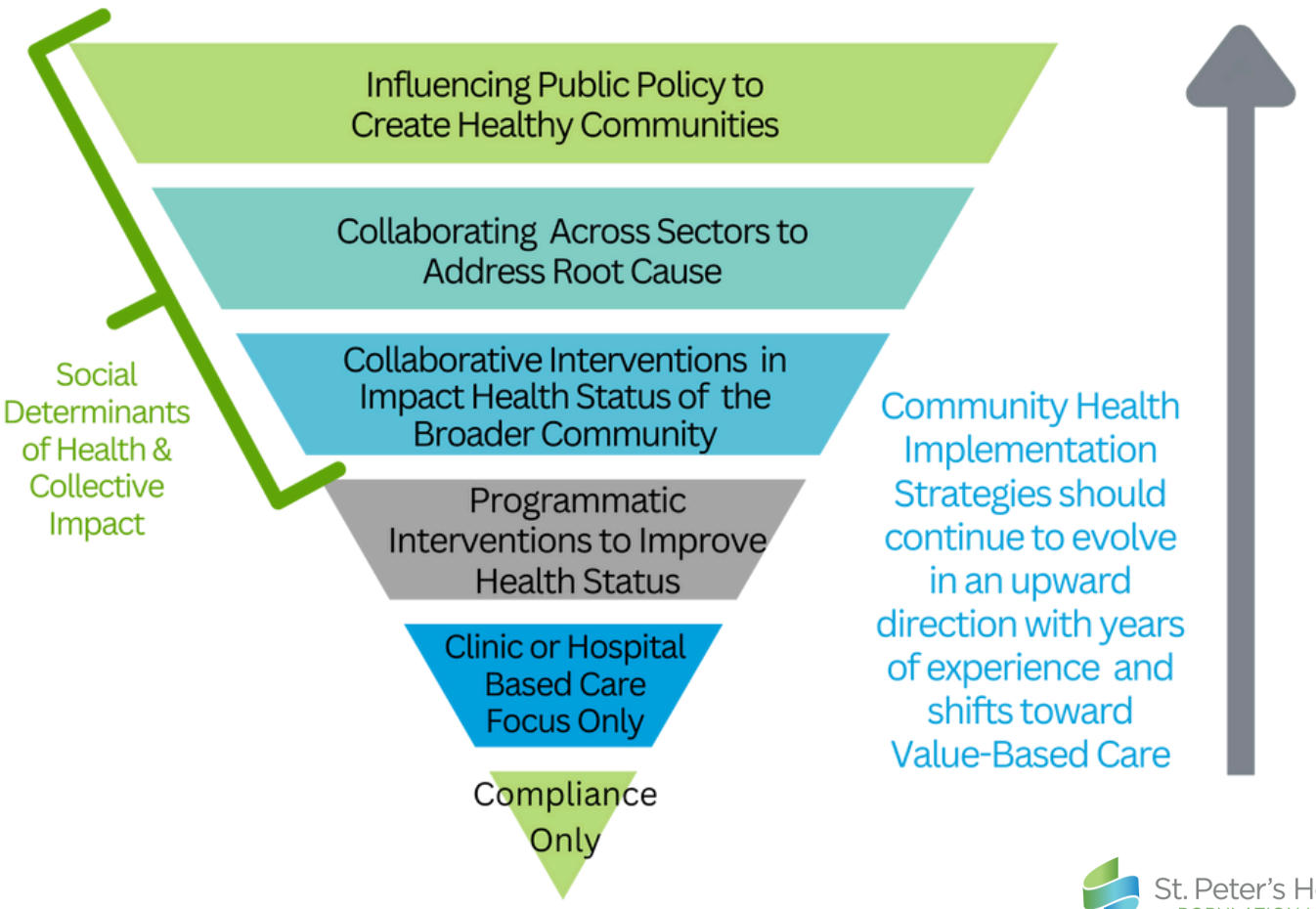
The Community Health Implementation Strategy goes beyond traditional or typical healthcare.

It adopts a holistic view by aligning CHNA recommendations and focusing on community strengths. By promoting coalition building, community systems alignment, partnerships and a collaborative approach for addressing complex health and social challenges. Informed by CDC guidance, it emphasizes a 'balanced portfolio of interventions' across key areas:

- Clinical Care
- Health Behaviors
- Socioeconomic Factors
- Physical Environment

Our approach intentionally spans all four action areas, with a gradual increase in socioeconomic investments over time. St. Peter's Health is dedicated to progressively enhancing investments in socioeconomic areas to achieve lasting community health outcomes and enhancing overall community well-being.

COMMUNITY HEALTH IMPLEMENTATION STRATEGY PROGRESSION:



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2024 CHNA HEALTH FINDINGS

The 2024 Community Health Assessment (CHA) was led by the Healthy Together Steering Committee, a collaboration of community partners, with SPH Population Health as a key contributor. This comprehensive, community-driven process engaged hundreds of residents, health professionals, and key stakeholders across multiple sectors to identify top health priorities and inform future initiatives. The CHA utilized community surveys, key informant input, and secondary data analysis to assess health needs, ensuring a data-driven approach to resource allocation and program development. Findings from this assessment will guide the collaborative Community Health Improvement Plan (CHIP) as well as this St. Peter's Health specific Implementation Plan and shape health strategies for the next three years.

2024 HEALTH NEEDS, LISTED IN PRIORITY ORDER:

1 Access to Healthcare Services

2 Behavioral Health

3 Chronic Disease

4 Housing

NOTE:

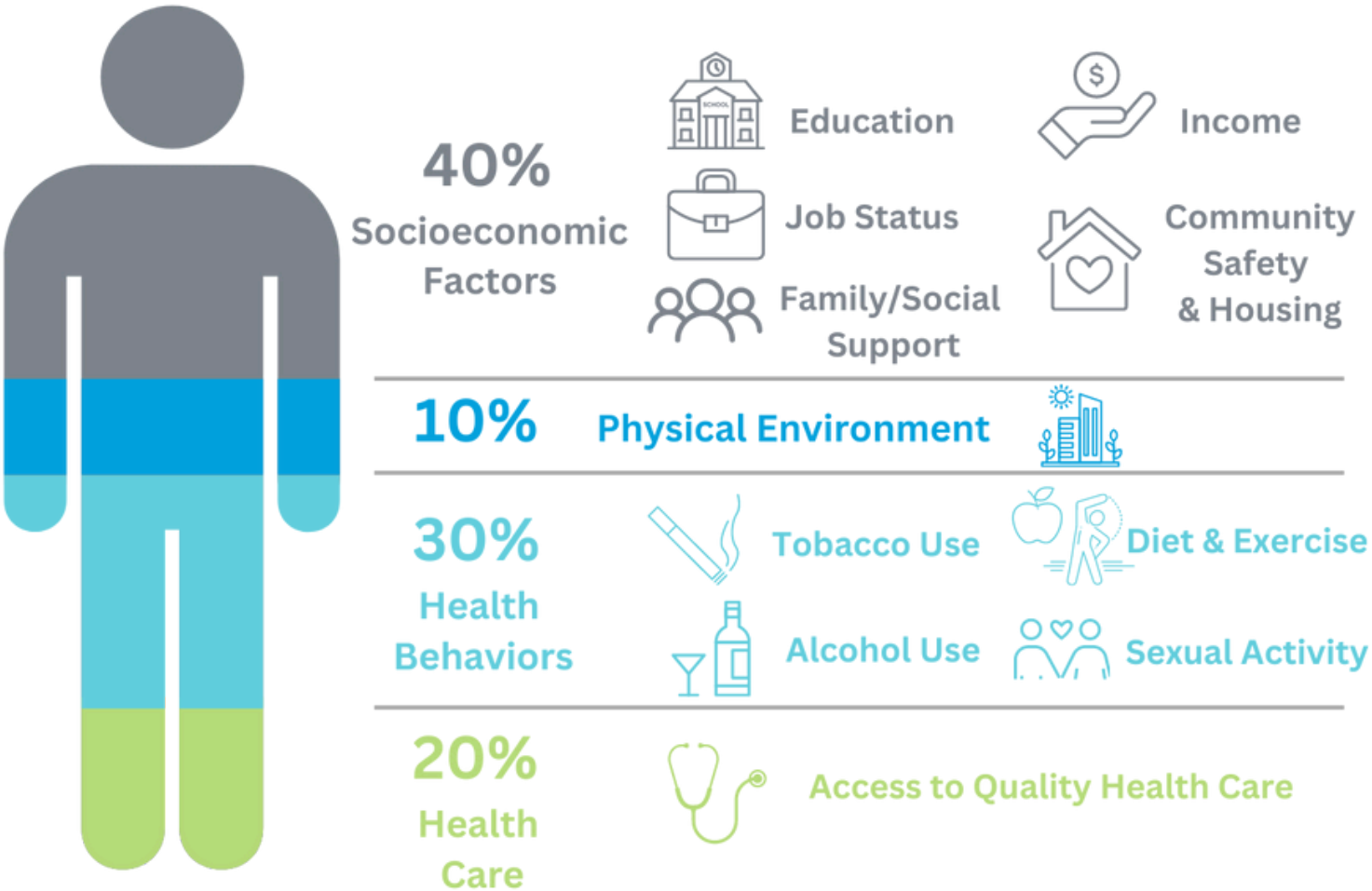
Together, these data sources shape the Community Health Improvement Plan (CHIP), which transforms assessment findings into targeted strategies and measurable goals. This ongoing cycle of evaluation and action allows the community to track progress, adapt to emerging issues, and refine strategies over time.

UNDERSTANDING WHAT IMPACTS HEALTH

Health outcomes are shaped by factors like access to healthcare, socio-economic status, lifestyle choices, and community support systems. Improving community health requires a comprehensive approach, focusing on prevention, education, and equitable access to healthcare resources.

These factors, known as social determinants of health, include conditions where people live, work, learn, and age, significantly influencing health, risks, and quality of life. They encompass social, economic, environmental conditions, and health behaviors, collectively influencing about **80%** of health outcomes in the United States. Refer to the visual diagram below for a clearer view

VISUALIZING WHAT IMPACTS OUR HEALTH OUTCOMES:



Source: Hood, CM, Gennuso, KP, Swain, GR, & Catlin, BB. (2015). County health ranking: Relationships between determinant factors and health outcomes. *American Journal of Preventive Medicine.*

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ADDRESSING HEALTH EQUITY

At. St. Peter's Health, we're committed to actively improving how we serve our community's most vulnerable populations. This includes those who have been historically marginalized or oppressed, and members of groups that commonly face disparities when accessing health care and disparities in health outcomes.

HEALTH EQUALITY

HEALTH EQUITY

We strive to ensure the care that we provide is culturally competent and appropriate for members of minority and underrepresented groups. We also work to help provide effective follow-up care, by optimizing our referral and communication pathways with other health care and community organizations.

Our goal is to continually assess, identify, and put structures in place to address the health disparities and concerns of the populations we serve.

	HEALTH EQUALITY	HEALTH EQUITY
Ensures access to healthcare	✓	✓
Removes discrimination in healthcare	✗	✓
Acknowledges different cultures, access to resources, and socioeconomic status	✗	✓
Considers the impact of social determinants of health and strategies for addressing them	✗	✓
Ensures a good quality of life and health even if it requires giving some people more support and resources	✗	✓

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UNIFIED APPROACH: STRATEGY & COMMUNITY COMMITMENT

St. Peter's Health extends its reach beyond its doors, collaborating with community partners to address healthcare needs and reach vulnerable sectors. The goal is twofold: empower citizens for healthier life choices and actively participate in setting up systems where making the healthy choice is the easy choice, reducing the onus on individuals. This aims to improve overall community health status.

SPH, governed by a community-led Board, reinvests its profits into its mission and community. Each year, SPH gives back over $20 million to the community through health education, complimentary community health services, and free or reduced-cost health care to ensure that financial limitations do not prevent individuals from seeking or receiving care.

This Implementation Strategy is part of a broader collection of projects, programs, and partnerships that SPH is developing to address health needs within its CBSA. The action items outlined in the following pages specifically address health needs identified in the 2024 CHNA.

COMMUNITY HEALTH NEEDS ASSESSMENT & IMPLEMENTATION STRATEGY PROCESS*

*SPH follows the American Hospital Association CNHA process

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OUR STRATEGIC IMPLEMENTATION APPROACH

All SPH community benefit investments and programs are built on a framework that promotes health equity and is framed by the community benefit overarching goal to enhance community health and wellness around the CHNA priority needs in the SPH service area. To achieve these goals, SPH executes its interventions, services and or programs through the following approach and methods:

HOW WE ORGANIZE OUR EFFORTS

UPSTREAM:

Focuses on preventing diseases, injuries, or harmful conditions from occurring in the first place. These strategies target the general population or high-risk groups before any signs of illness appear.

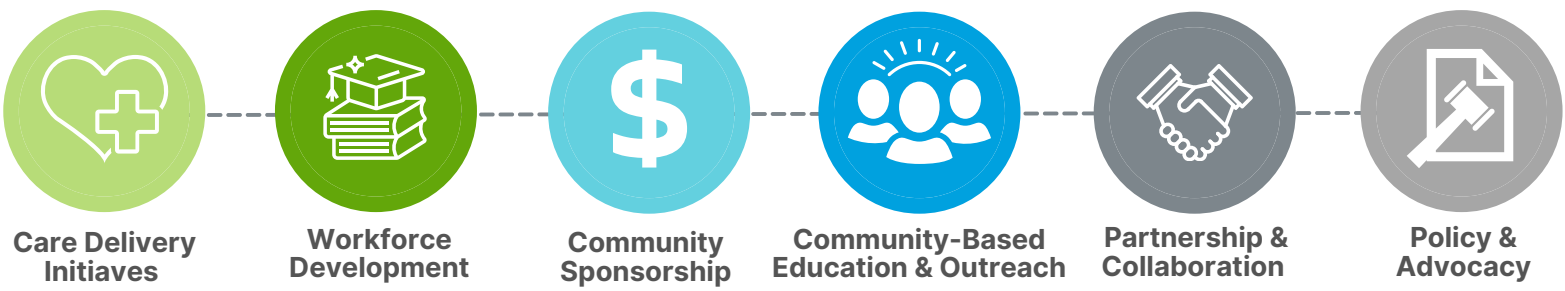
MIDSTREAM:

Focuses on early identification and intervention to detect conditions at an early stage and prevent them from progressing into more serious diseases.

DOWNSTREAM:

Focuses on managing long-term health conditions, reducing complications, and improving quality of life for individuals who already have an illness or injury.

METHODS



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SUMMARIZED COMMUNITY HEALTH IMPLEMENTATION STATEGIES

Details surrounding specific strategies and initiatives corresponding to each of the selected health priority areas are outlined in the following pages. See **Appendix** for details.

Number of Initiatives	Strategy to Address Health Need
31	**Priority Area Access to Health Care Services** **To improve access to quality healthcare services for all individuals within our community, ensuring equitable and timely access to quality medical care**
17	**Upstream: Health Care Access**
2	Community based Organization Partnerships and Engagement
5	Community Coalitions Engagement
4	Community Education & Engagement
6	Workforce & System Level Change
-	Data Driven decision making & Sustainability
-	Community Sponsorships
3	**Midstream: Health Care Access**
-	Community Classes & Support Groups
-	Evidence-Based Education
3	Risk Reduction
11	**Downstream: Health Care Access**
3	High Intensity Support Services
3	Long term Management & Recovery Support
2	Evidence-based Treatment
3	Acute Intervention

SUMMARIZED COMMUNITY HEALTH IMPLEMENTATION STATEGIES (CONTINUED)

Details surrounding specific strategies and initiatives corresponding to each of the selected health priority areas are outlined in the following pages. See **Appendix** for details.

Number of Initiatives	Strategy to Address Health Need
61	**Priority Area Behavioral Health** **Provide an inclusive mental health system that enhances well-being, ensures accessible care, and reduces mental health disorders, bolstering community-wide mental health.**
24	Upstream: Behavioral Health
1	Community based Organization Partnerships and Engagement
9	Community Coalitions Engagement
3	Community Education & Engagement
9	Workforce & System Level Change
1	Data Driven decision making & Sustainability
1	Community Sponsorships
19	Midstream: Behavioral Health
5	Community Classes & Support Groups
1	Evidence-Based Education
7	Risk Reduction
6	Evidence-based Universal Screening
18	Downstream: Behavioral Health
4	High Intensity Support Services
7	Long term Management & Recovery Support
5	Evidence-based Treatment
2	Acute Intervention

SUMMARIZED COMMUNITY HEALTH IMPLEMENTATION STATEGIES (CONTINUED)

Details surrounding specific strategies and initiatives corresponding to each of the selected health priority areas are outlined in the following pages. See **Appendix** for details.

Number of Initiatives	Strategy to Address Health Need
80	**Priority Area Chronic Disease** **Improve the overall health and well-being of our community through chronic disease prevention, early detection, treatment, and support services**
47	Upstream: Chronic Disease
17	Community Based Organization Partnerships & Engagement
5	Community Coalition Engagement
11	Community Education & Engagement
4	Community Sponsorships
3	Workforce & System Level Change
7	Data Driven Decision Making & Sustainability
18	Mid Stream: Chronic Disease
4	Community Classes & Support Groups
4	Evidence-Based Education
10	Risk Reduction
-	Evidence-based Universal Screening
15	Downstream: Chronic Disease
4	High Intensity Support Services
4	Long term Management & Recovery Support
5	Evidence-based Treatment
2	Acute Intervention

SUMMARIZED COMMUNITY HEALTH IMPLEMENTATION STATEGIES (CONTINUED)

Details surrounding specific strategies and initiatives corresponding to each of the selected health priority areas are outlined in the following pages. See **Appendix** for details.

Number of Initiatives	Strategy to Address Health Need
18	**Priority Area Housing** **Access to safe and stable housing for essential workers, older adults, and medically complex individuals, leading to improved health outcomes, reduced system strain, and a stronger, more resilient community.**
11	Upstream: Housing
1	Community based Organization Partnerships and Engagement
3	Community Coalitions Engagement
2	Community Education & Engagement
1	Workforce & System Level Change
3	Data Driven decision making & Sustainability
1	Community Sponsorships
4	Midstream: Housing
-	Community Classes & Support Groups
1	Evidence-Based Education
3	Risk Reduction
3	Downstream: Housing
2	High Intensity Support Services
1	Long term Management & Recovery Support
-	Evidence-based Treatment
-	Acute Intervention

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APPENDIX

IMPLEMENTATION STRATEGIES DETAILED REPORT

Number of Initiatives	Strategy to Address Health Need	Targeted Year	Anticipated Outcome	Evaluation Measure	Current Impact	Collaborators (Internal & External)
31	**Priority Area Access to Health Care Services**	2025-2027	To improve access to quality healthcare services for all individuals within our community, ensuring equitable and timely access to quality medical care	See Specific Strategy Information	▲	See Specific Strategy Information
17	**Upstream: Health Care Access**				▲	
2	**Community based Organization Partnerships and Engagement**					
	Provide Wellness on-site client services for SPH Employees and Other Community organizations	Ongoing	1. improved employee health and well-being, reduced healthcare costs, and a healthier community overall through increased access to wellness programs and support services.	1. # of Community Wellness Clients 1. # of individuals Screened	▲	1. SPH People Health & Wellness 2. Helena School District
	Actively engage with APS Monthly Meeting	Ongoing	1. improving the safety and well-being of vulnerable adults is the potential for more effective collaboration and coordinated support, leading to enhanced protection and improved quality of life for vulnerable individuals.	1. SPH representatives regularly attending meetings	▲	1. SPH Outpatient Care Management 2. SPH Inpatient Care Management 3. Adult Protective Services
5	**Community Coalitions Engagement**					
	Capital Transit Advisory Council	Ongoing	improved public transportation systems and services through informed decision-making, better alignment with community needs, and enhanced collaboration between transit providers and the community	1. SPH representatives regularly attending meetings	▲	1. SPH Population Health 2. Capital Transit Advisory Council Memebers
	Aging Well Workgroup	Ongoing	1. Improved coordination of services that support healthy aging. 2. Increased community awareness of aging-related resources and programs. 3. Enhanced quality of life and independence for older adults.	1. SPH representatives regularly attending meetings	▲	1. SPH Population Health Department 2. Aging Well Workgroup Members
	Helena Village Collective	Ongoing	1. Improved access to perinatal resources and support for families. 2. Stronger community connections and care networks for new and expecting parents. 3. Enhanced collaboration and knowledge-sharing among perinatal professionals.	1. SPH representatives regularly attending meetings	▲	1. SPH Population Health 2. Helena Village Collective Members
	Helena Community SDOH Leadership Team	Ongoing	1. Improved cross-sector coordination to address social determinants of health (SDOH). 2. Development of shared goals and strategies to reduce health disparities. 3. Increased alignment of community resources to better meet population needs.	1. SPH representatives regularly attending meetings	▲	1. SPH Population Health 2. Lewis & Clark DPHHS
	Helena Resource Advocates	Ongoing	Improved referral processes, increased access to essential services, and more efficient support for individuals in need, ultimately enhancing the well-being of the community.	1. SPH representatives regularly attending meetings	▲	1. SPH Outpatient Care Management 2. SPH Inpatient Care Management 3. United Way
4	**Community Education & Engagement**					
	Provide Education at Our Place on appropriate health care utilization and how to access health care	2025	1. Help community members understand when and where to seek care—primary care, urgent care, or the emergency room	TBD	TBD	TBD
	Stop The Bleed Education	Ongoing	1. Increased ability of community members to respond effectively to severe bleeding incidents, leading to reduced fatalities and improved emergency preparedness	1. # of classes	▬	1. SPH Emergency Department
	My Chart Education	TBD	1. increased patient engagement, better utilization of online healthcare resources, and enhanced access to care, ultimately leading to improved patient outcomes and satisfaction.	1. # of patients active in EPIC My Chart	TBD	1. SPH PR & Marketing
	Implementing Navigating the Health System	TBD	TBD	TBD	TBD	TBD
6	**Workforce & System Level Change**					
	Pete's Place Early Learning Center	Ongoing	Increased number of children and families with access to high quality childcare and early learning within the 0-5 age range. Overall, integrating early childhood learning with health service access fosters a healthier, more resilient community by supporting both healthcare workers and patients alike.	1. Number of Children served in SPH funded Early Learning Facilities 2. Stars to Quality Rating	▲	1. SPH Pete's Place Department 2. Headwater Foundation 3. Early Childhood Collaborative of the Greater Helena Area 4. Helena School District
	Offer student intern opportunities within mental health services including (outreach, caring contact, MCRT, IBH, etc.)	2025	1. development of a more well-rounded and empathetic mental health workforce, which can enhance the quality of care and support provided to individuals in need. 2. Increase the workforce pipeline of mental health professionals into SPH	1. # of internship opportunities at SPH within Mental Health Areas of care 2. # of completed internships within a given year	TBD	TBD
	Provide SDOH education to clinical areas to understand SDOH can impact access to health care services	2025	increased awareness and consideration of social determinants of health in patient care, leading to more effective and tailored healthcare services that address patients' unique needs and challenges.	1. # of Care Team members trained for SDOH	▬	TBD
	Workforce Development Educational Opportunities	TBD	TBD	TBD	TBD	TBD
	New west side clinic for access to care - Pharmacy, PT, Primary Care, etc.	2026	1. Improved access to primary and supportive care services for west side residents. 2. Increased care continuity through co-located services like pharmacy and physical therapy. 3. Reduced travel and wait times for patients seeking routine and preventive care.	1. Number of patients served at west side clinic 2. Appointment availability and wait times 3. Utilization rates of co-located services (e.g., pharmacy, PT)	▲	1. SPH Primary Care 2. SPH Population Health 3. SPH Administration 4. Carroll College 5. SPH Lifestyle Medicine 6. SPH Pharmacy 7. SPH Physical Therapy
	Create a comprehensive plan and approach to broaden the clinical rotations, Internships, and licensure candidates into mental health areas of care	TBD	Increased pool of skilled mental health professionals, helping to address workforce shortages and improve the accessibility and quality of mental health services in the community.	1. Documented plan	TBD	TBD
-	**Data Driven decision making & Sustainability**					
-	**Community Sponsorships**					
3	**Midstream: Health Care Access**				▲	
-	**Community Classes & Support Groups**					
-	**Evidence-Based Education**					
3	**Risk Reduction**					
	Establish a streamlined process to reconnect postpartum patients with primary care for ongoing health and wellness support	2025	1. Improved continuity of care during the postpartum period. 2. Earlier identification and management of postpartum health concerns. 3. Increased engagement in long-term preventive and primary care.	1. Postpartum primary care visit completion rate	TBD	TBD
	Proactive outreach for Annual Wellness Visits (AWVs) and preventive visits	New in 2024	1. Increased completion rates of AWVs and preventive screenings. 2. Earlier identification and management of health risks. 3. Improved patient engagement in routine, preventive care.	1. AWV and preventive visit completion rates 2. Number of patients contacted through outreach 3. Preventive screening rates (e.g., cancer, cholesterol)	▲	1. SPH Population Health 2. PR & Marketing 3. Data Analytics 4. SPH Primary Care 5. SPH Quality Committee
	Support the development and sustainability of a Universal Home Visiting Program in Lewis & Clark County to promote early childhood and family well-being	New in 2024	1. Improved maternal and child health outcomes through early support and education. 2. Increased connection to community resources for families. 3. Enhanced parent confidence and early childhood development.	1. Embedded Home Visiting Nurse on WAC 2. Number of families enrolled in the program	▲	1. SPH Population Health 2. SPH WAC Unit 3. Lewis & Clark DPHHS 4. SPH Primary Care
11	**Downstream: Health Care Access**				▲	

Number of Initiatives	Strategy to Address Health Need	Targeted Year	Anticipated Outcome	Evaluation Measure	Current Impact	Collaborators (Internal & External)
3	**High Intensity Support Services**					
	Frequent Users Systems Engagement (FUSE) - Community Health Workers	Ongoing	1. Reduced emergency department visits and hospitalizations among high-utilizers. 2. Increased housing stability and connection to supportive services. 3. Improved care coordination across health, housing, and justice systems.	1. ED visits and hospitalizations pre/post enrollment 2. Housing placement and retention rates 3. Number of individuals connected to supportive services	▲	1. SPH Primary Care 2. SPH Population Health 3. United Way 4. SPH Foundation 5. Good Samaritan 6. PureView Health Center 7. SPH Emergency Department
	Community Paramedic Program	Ongoing	improved community health outcomes, reduced emergency department visits, and better access to preventive care and support for individuals with complex medical needs, ultimately enhancing the overall well-being of the community.	1.# of patient referrals 2. # of visits completed	▲	1. SPH Primary Care 2. SPH Community Paramedic 3. AHEC 4. SPH Foundation 5. SPH Outpatient Care Management
	Strengthen collaboration between FUSE, EMS, MCRT, and law enforcement to support early engagement and reduce unnecessary arrests or transports through de-escalation.	TBD	TBD	TBD	TBD	TBD
3	**Long term Management & Recovery Support**					
	Pilot Primary Care Community Health Worker Role	2025	1. Improved patient connection to resources and preventive care. 2. Enhanced care team support for addressing social determinants of health. 3. Increased patient engagement and follow-through with care plans.	1. Number of patients engaged by CHW 2. Referrals made to community resources 3. Patient follow-through and care plan completion rates	TBD	1. SPH Outpatient Care Managers 2. SPH Outpatient Social Services 3. SPH Primary Care
	RN Care Management - Longitudinal Chronic Care Management	New in 2024	1. Improved chronic disease outcomes through ongoing care coordination. 2. Increased patient adherence to treatment and self-management goals. 3. Reduced hospitalizations and emergency department visits.	1. Number of patients enrolled in care management 2. Clinical outcomes (e.g., A1c, BP control) 3. Hospital and ED utilization rates	▬	1. SPH Outpatient Care Managers 2. SPH Outpatient Clinical Pharmacists 3. SPH Outpatient Social Services 4. SPH Primary Care
	Offer Post Acute & Long Term Care (PALTEC) Program	New in 2024	1. Improved continuity of care for patients transitioning from hospital to skilled nursing or long-term care. 2. Reduced hospital readmissions and avoidable ED visits. 3. Enhanced quality of life and care coordination for medically complex patients.	1. Number of patients enrolled in PALTEC 2. Hospital readmission and ED visit rates 3. Patient and facility satisfaction scores	▲	1. SPH PALTEC 2. SPH Hospitalists 3. Cooney Rehab 4. Elkhorn Rehab 5. Big Sky Care Center
2	**Evidence-based Treatment**					
	Offer virtual care with SPH providers.	Ongoing	1. increased patient access to timely medical advice and consultations, promoting quicker healthcare interventions, reducing healthcare disparities, and enhancing overall patient satisfaction with the healthcare system.	1. # of Virtual visits completed	▲	1. SPH Primary Care 2. SPH Specialty Care 3. SPH IT Department
	Offer Home dialysis services.	Ongoing	1. Improved patient satisfaction, increased flexibility in treatment options, and potentially better health outcomes for individuals with kidney disease who can receive dialysis at home.	1. # of patient served through the home dialysis program	▲	1. SPH Dialysis
3	**Acute Intervention**					
	Care Management - Hospital Follow up	Ongoing	1. Improved care transitions and reduced gaps post-discharge. 2. Decreased hospital readmissions and avoidable ED visits. 3. Increased patient understanding of discharge plans and medications 4. Increased Transition of Care Visits with PCP and/or Specialist	1. Follow-up contact completion rate 2. 30-day readmission rate	▲	1. SPH Outpatient Care Managers 2. SPH Behavioral Health Navigator 3. SPH Outpatient Social Services 4. SPH Primary Care
	Care Management - ED Follow up	Ongoing	1. Improved care transitions and reduced gaps post-discharge. 2. Decreased hospital readmissions and avoidable ED visits. 3. Increased patient understanding of discharge plans and medications 4. Increased Transition of Care Visits with PCP and/or Specialist	1. Follow-up contact completion rate 2. 30-day readmission rate	▬	1. SPH Outpatient Care Managers 2. SPH Behavioral Health Navigator 3. SPH Outpatient Social Services 4. SPH Primary Care
	Implement Forensic Nurse Program	Ongoing	1. Improved care and support for sexual assault survivors, including sensitive medical examinations and evidence collection, which can enhance both the survivor's well-being and the effectiveness of legal proceedings.	1. # of patients served by the SANE program	▲	1. SPH Emergency Department
61	**Priority Area Behavioral Health**	2025-2027	Provide an inclusive mental health system that enhances well-being, ensures accessible care, and reduces mental health disorders, bolstering community-wide mental health.	See Specific Strategy Information	▲	See Specific Strategy Information
24	**Upstream: Behavioral Health**				▲	
1	**Community based Organization Partnerships and Engagement**					
	Ensure Taking Care of You Program engagement with community partners	Ongoing	1. Increased access to mental health resources through early intervention and reduced stigma. 2. Stronger community collaboration to improve referrals and coordinated support.	1. Number of active community partner organizations 2. Frequency and quality of partner meetings or joint initiatives 3. Partner satisfaction or feedback surveys	▲	1. Maternal Mental Health Task Force 2. Early Childhood Coalition 3. Department of Child & Family Services 4. Montana Health Care Foundation 5. National Council for Wellbeing 6. SPH Primary Care Department 7. SPH Women's & Children's Unit 8. SPH Psychiatry Department 9. SPH Population Health Department
9	**Community Coalitions Engagement**					
	Actively engage with Suicide Prevention Coalition	Ongoing	Increasing access to community education about suicide & to support interventions and policies	1. SPH representatives regularly attending meetings	▲	1. SPH Population Health Department 2. ER Department 3. Suicide Prevention Coalition Members
	Actively engage with LOSS (Local Outreach for Suicide Survivors) Team	Ongoing	Significant reduction in the time individuals newly bereaved by suicide wait to access vital support and resources, potentially preventing intergenerational suicides and mitigating the development of complicated grief.	1. SPH representatives regularly attending meetings	▲	1. SPH Population Health Department 2. LOSS Team Members
	Actively engage with Behavioral Health Local Advisory Council	Ongoing	Improve awareness, access and coordination of behavioral health services for the community	1. SPH representatives regularly attending meetings	▲	1. SPH Population Health Department 2. SPH Behavioral Health Unit 3. Local Advisory Council Members
	Actively engage with Behavioral Health Community Data	Ongoing	Group meeting to improve on the tracking of local behavioral health services utilization and impact of services/interventions provided	1. SPH representatives regularly attending meetings 2. Community Behavioral Health Dashboard	▲	1. SPH Population Health Department 2. SPH Data Analytics Department
	Actively engage with Elevate Montana Helena Affiliate Community Coalition	Ongoing	1. Improved overall well-being, reduced long-term health issues, and enhanced mental resilience in individuals who have experienced trauma or adversity in their childhoods.	1. SPH representatives regularly attending meetings	▲	1. SPH Population Health 2. Elevate Montana Coaltion Members

Number of Initiatives	Strategy to Address Health Need	Targeted Year	Anticipated Outcome	Evaluation Measure	Current Impact	Collaborators (Internal & External)
	Actively engage with Safer Communities Montana General & Leadership	Ongoing	1. Improve awareness, access and coordination of behavioral health services for the community through reduction of access to lethal means by people at risk.	1. SPH representatives regularly attending meetings	▲	1. SPH Population Health Department 2. ER Department 3. Safer Communities Montana Members
	Actively engage and participate in Healthy Together Steering Committee	Ongoing	1. Strengthened cross-sector collaboration to align efforts and share resources across health, social services, and community organizations. 2. Improved coordination of community health initiatives through joint planning and shared priority-setting. 3. Increased impact of CHNA strategies by ensuring alignment with broader community goals and leveraging collective expertise.	1. SPH representatives regularly attending meetings	▲	1. SPH Population Health Department 2. Healthy Together Committee Members
	Actively engage with Behavioral health Systems Leadership Improvement Team	Ongoing	TBD	1. SPH representatives regularly attending meetings	▲	TBD
	Join and participate in the Rural Addiction Implementation Network (RAIN)	Ongoing	1. Establishment of stronger networks and partnerships with other organizations and experts focused on rural addiction issues, leading to more effective and comprehensive solutions for addressing addiction challenges in rural areas.	1. SPH representatives regularly attending meetings	▲	1. SPH Population Health 2. SPH Quality Department 3. SPH Addiction Medicine Services 4. RAIN with the U of U
3	**Community Education & Engagement**					
	Annually hosts "We Speak Mental Health Week" with community activities, education, and training for National Suicide Prevention Month	Annually	1. Increased community awareness and preparedness for suicide prevention, leading to a potentially reduced rate of suicide attempts and improved mental health support.	1. # of Community/Employee Educational opportunities/activities 2. # of employees attending and/or involved in educational opportunities/activities	▲	1. SPH PR & Marketing Team 2. SPH Population Health Community Education 3. Lewis & Clark Suicide Prevention Coordinator 4. Safer Communities Montana
	Provide SPH resources as expert speakers on recovery and substance use to community groups	Ongoing	1. Community members become more informed about recovery and substance use, leading to increased awareness, reduced stigma, and improved access to resources for those in need of assistance.	1. # of community education events	▲	1. SPH Addiction Medicine 2. SPH Population Health 3. Our Place 4. Lewis & Clark Criminal Justice Services
	Offer childbirth classes that include education on postpartum depression as part of comprehensive parental support	Ongoing	1. Increased awareness and understanding among expectant parents about postpartum depression, leading to earlier recognition and support-seeking if symptoms arise.	1. Updated Class material 2. # of parents completing the class 3. Feeback from parents completing class	▲	1. SPH Team-Based Care 2. SPH Population Health Community Education 3. SPH WAC Unit
9	**Workforce & System Level Change**					
	Participation in the legislative process related to mental health and substance use disorder through advocacy, policy engagement, and stakeholder collaboration	Ongoing	1. Informed policy decisions that reflect community needs, driven by active advocacy, stakeholder collaboration, and engagement in the legislative process.	1. # of SPH Employees Completing QPR NEO Training	▲	1. SPH Medical Group Providers 2. SPH Population Health 3. SPH PR
	Train all staff on suicide prevention and response - QPR Training (Zero Suicide Framework)	Ongoing	1. SPH employees is a more prepared and vigilant workforce that can potentially prevent suicide by recognizing warning signs and taking appropriate actions when needed.	1. # of SPH Employees Completing QPR NEO Training 2. % of SPH Employees trained annually on QPR or more indepth training	▲	1. SPH People Services Team 2. SPH Population Health Community Education 3. Lewis & Clark Suicide Prevention Coordinator
	Advance integration through the Cross-Continuum SPH Behavioral Health Service Line Workgroup	Ongoing	1. Developed SPH Behavioral Health Strategic Plan whcih will result in more cohesive and patient-centered care, resulting in improved mental health outcomes and a smoother patient experience as they navigate different levels of behavioral health services	1. Group Meeting on a regular basis 2. Defined strategic plan to address mental health needs across the continuum of care at SPH	▲	1. SPH Primary Care 2. SPH Psychiatry Department 3. SPH Integrated Behavioral Health 4. SPH Population Health 5. SAMHSA 6. MCRT Department 7. SPH BHU Department 8. SPH ER Department
	Integrate suicide prevention into organizational policies (Zero Suicide Framework)	Ongoing	1. Reduction in Suicide Rates: Significantly lower suicide rates among individuals receiving healthcare services due to improved prevention and intervention efforts. 2. Enhanced Screening and Assessment: Better identification of individuals at risk through comprehensive screening and assessment, leading to timely interventions. 3. Coordinated and Effective Care: Improved coordination of care across healthcare settings using evidence-based treatment and support. 4. Increased Access to Care: Reduced barriers to mental health and crisis services, ensuring individuals in crisis have timely access to the care they need.	1. Suicide Rate Reduction 2. Screening and Assessment Rates: PHQ-9, SI Risk Assessments, Safety Plans 3. % of patients identified as at risk of suicide who receive timely and appropriate follow-up care. 4. Care Team & Provider Training Rates 5. Patient and Family Satisfaction scores/feedback	–	1. SPH Primary Care 2. SPH Psychiatry Department 3. SPH Integrated Behavioral Health 4. SPH Population Health 5. SAMHSA 6. MCRT Department 7. SPH BHU Department 8. SPH ER Department
	Simulation training to practice and refine the Zero Suicide model processes	2025	1. Increased community capacity to recognize and respond to suicide risk, potentially leading to a reduction in suicide rates and improved mental health outcomes for individuals at risk.	1. Zero Suicide Grant Metrics	TBD	1. SPH Primary Care 2. SPH Psychiatry Department 3. SPH Integrated Behavioral Health 4. SPH Population Health 5. SAMHSA 6. MCRT Department 7. SPH BHU Department 8. SPH ER Department 9. SIMS Montana
	Conduct annual Zero Suicide organizational assessment and identify areas for improvement (Zero Suicide Framework)	Annually	1. Improved identification of system gaps in suicide prevention practices. 2. Data-driven quality improvement initiatives implemented to enhance patient safety. 3. Increased staff readiness and competence in suicide prevention through targeted training and support.	1. Completion of annual Zero Suicide assessment 2. Number of improvement actions implemented	▲	1. SPH All Departments 2. SAMHSA
	Recovery Friendly Workplace Designation	2025	1. Enhanced workplace culture that supports employees in recovery, leading to increased retention, reduced stigma, and improved employee well-being.	TBD	TBD	1. SPH People Services Team 2. SPH Population Health Department 3. United Way
	Comprehensive Substance Use Disorder (SUD) policy that supports standardized screening, intervention, and referral to treatment across all patient care settings	TBD	1. Consistent identification and response to SUD across all care settings. 2. Improved referral and connection to treatment services. 3. Reduced variation in SUD care practices organization-wide.	TBD	TBD	TBD
	Establish and maintain a protocol for providing educational opportunities to SPH employees pursuing Licensed Addiction Counselor (LAC) certification.	TBD	1. Increased workforce for LAC position and empowered SPH employees to expand their skill set and career prospects by offering a path towards LAC certification	TBD	TBD	TBD
1	**Data Driven decision making & Sustainability**					
	Zero Suicide Dashboard	Ongoing	1. Ability to track and measure the effectiveness of mental health initiatives more accurately, leading to data-driven improvements and better-informed resource allocation for the benefit of the community's mental well-being.	1. Completed Dashboard	TBD	1. SPH Primary Care 2. SPH Psychiatry Department 3. SPH Integrated Behavioral Health 4. Montana Health Care Foundation 5. SAMHSA 6. MCRT Department 7. SPH Population Health
1	**Community Sponsorships**					
	Sponorship for Perinatal Mental Health Confrence - HMHB	Ongoing	Improved community health through increased access to resources, services, and programs that target specific health issues, ultimately fostering a healthier and more resilient local population.	Not Applicable	–	1. SPH PR & Marketing Team
19	**Midstream: Behavioral Health**				▲	

Number of Initiatives	Strategy to Address Health Need	Targeted Year	Anticipated Outcome	Evaluation Measure	Current Impact	Collaborators (Internal & External)
5	**Community Classes & Support Groups**					
	Grief Support Group	Ongoing	1. A reduction in the feelings of isolation and despair among participants, leading to increased emotional resilience ultimately contributing to improved mental well-being.	Not Applicable	▲	1. SPH PR & Marketing Team 2. SPH Population Health Community Education 3. SPH Home Health & Hospice
	Suicide Support Group	Ongoing	1. A reduction in the feelings of isolation and despair among participants, leading to increased emotional resilience and a lower risk of self-harm or suicide, ultimately contributing to improved mental well-being.	Not Applicable	▲	1. SPH PR & Marketing Team 2. SPH Population Health Community Education 3. Helena Indian Alliance
	SPH Perinatal Loss Group Work	New in 2024	1. Increased emotional support and connection for individuals experiencing perinatal loss. 2. Improved coping and grief processing through facilitated group sessions. 3. Reduced feelings of isolation among participants.	1. Group attendance numbers 2. Participant satisfaction surveys 3. # of Community Events	▲	1. SPH PR & Marketing Team 2. SPH Population Health 3. Headwaters Foundation 4. SPH WAC Unit
	Provide tobacco and substance use cessation classes	Ongoing	1. Increased likelihood of successful tobacco cessation among program participants	1. # of patient referrals 2. # of patients completed the class annually 3. Rate of tobacco cessation	▲	1. SPH Population Health 2. Lewis & Clark DPHHS
	Offer Invitation to Change groups to support individuals and build skills for navigating a loved one's SUD.	New in 2024	1. Increased caregiver confidence and skills in supporting loved ones with SUD. 2. Improved family communication and relationships. 3. Reduced caregiver stress and burnout.	1. Attendance and participation rates 2. Pre/post caregiver confidence and stress scores 3. Participant feedback or satisfaction surveys	▲	1. SPH Population Health 2. SPH Addiction Medicine 3. SPH PR & Marketing Team
1	**Evidence-Based Education**					
	Care Team Training Universal suicide risk screening in all patient encounters (e.g., PHQ-9, Columbia Suicide Severity Rating Scale in primary care, ED, and specialty settings) (Zero Suicide Model)	New in 2024	1. Increased staff knowledge and confidence in conducting suicide risk screenings. 2. Improved screening accuracy and consistency across care settings. 3. Greater adherence to Zero Suicide best practices.	1. # of SPH employees completed the training	▲	1. SPH Population Health 2. Safer Communities Montana 3. SAMHSA 4. SPH ER & MCRT Team 5. SPH Primary Care 6. SPH BHU
7	**Risk Reduction**					
	Launch firearm safety program involving education and gun lock distribution	Ongoing	1. Reduction in both accidental firearm-related injuries and suicides within the community, as responsible firearm ownership practices and suicide prevention measures are promoted and implemented. 2. Care Team members have the tools and education to help patient promote and practice safe firearm storage	1. # of SPH employees educated 2. # of gunlocks provided	▲	1. SPH Population Health 2. Safer Communities Montana Coalition
	Narcan training & availability within St. Peter's Health	Ongoing	1. Enhanced preparedness to respond to opioid overdoses, potentially saving lives within the St. Peter's Health community.	TBD	TBD	TBD
	Safe Medication Disposal for the Community	Ongoing	1. Safe and convenient disposal of unused medications through the Medication drop-off site and Deterra Drug Deactivation Systems, promoting responsible medication management and reducing the risk of drug misuse or environmental contamination.	1. # of Prescriptions returned to the medication drop off site	▲	1. SPH Addiction Medicine 2. SPH Population Health 3. Lewis & Clark DPHHS 4. Safer Communities Montana 5. SPH Pharmacy Department
	Implement Deterra Drug Deactivation systems throughout ambulatory clinics.	Ongoing	1. Improved medication disposal practices in ambulatory clinics, reducing the risk of medication misuse and environmental harm.	1. # of Deterra systems provided annually	▲	1. Safer Communities Montana 2. SPH Population Health 3. SPH Primary Care
	Implement system approach to Controlled Substance Use Contracts - for safe prescribing and patient use	2025	Improved patient safety and responsible use of controlled substances	TBD	TBD	TBD
	SPH to be an authorized Narcan Distribution location	TBD	increased availability of Narcan in the community, leading to more timely interventions and potentially saving lives in opioid overdose situations.	TBD	TBD	TBD
	Actively engage with Lewis & Clark Public Health on availability Fentanyl Test strips	TBD	TBD	TBD	TBD	1. Lewis & Clark County Public Health 2. SPH Population Health 3. SPH Addiction Medicine Service
6	**Evidence-based Universal Screening**					
	Implement universal tobacco screening throughout SPH clinics	Ongoing	Improved ability to identify tobacco users among patients, leading to more timely and effective smoking cessation interventions, ultimately contributing to better health outcomes and reduced tobacco-related diseases within the community	1. # of patients Screened 2. Rates of Tobacco Users and Non-Tobacco Users over time	▬	1. SPH Primary Care Teams 2. SPH Population Health Team 3. SPH Outpatient Specialty Care Teams
	Screen Perinatal Substance Use through the Taking Care of You Program	Ongoing	1. Increased early identification and intervention through routine screening 2. Defined and seamless care pathway in the perinatal substance use 3. Reduction in adverse outcome related perinatal substance use	1. # women screened for postpartum depression 2. Outreach Percentage	▲	1. SPH Population Health 2. SPH Primary Care 3. Montana Health Care Foundation 4. SPH IBH Team
	Implement annual substance use education to include evidenced-based practices, resources available, screening, brief intervention, referral to treatment (SBIRT) and follow-up.	TBD	1. Enhanced provider and care team knowledge and support for substance use issues through annual education initiatives.	TBD	TBD	TBD
	Universal suicide risk screening in all patient encounters (e.g., PHQ-9, Columbia Suicide Severity Rating Scale in primary care, ED, and specialty settings) (Zero Suicide Model)	New in 2024	1. Increased early identification of individuals at risk for suicide. 2. Improved consistency and standardization of suicide risk assessment. 3. Enhanced linkage to appropriate behavioral health interventions.	1. # of SPH employees completed the training	▲	1. SPH Population Health 2. Safer Communities Montana 3. SAMHSA 4. SPH ER & MCRT Team 5. SPH Primary Care 6. SPH BHU
	Zero Suicide Standardized Screening in Primary Care for Suicidal ideation with development of clear workflows for managing positive screens	New in 2024	1. Early and consistent identification of suicide risk in primary care. 2. Improved care pathways and follow-up for patients with positive screens. 3. Enhanced provider confidence through clear, actionable workflows.	1. Screening completion rate in primary care 2. Number of positive screens with documented follow-up 3. Provider adherence to workflow steps	▲	1. SPH Population Health 2. Safer Communities Montana 3. SAMHSA 4. SPH ER & MCRT Team 5. SPH Primary Care 6. SPH BHU
	Standardized Screening in Primary Care for depression with development of clear workflows for managing positive screens	TBD	1. Improved early detection and diagnosis of depression. 2. Consistent follow-up and treatment through clear workflows. 3. Enhanced care team confidence in managing depression.	1. Depression screening completion rate 2. Number of positive screens with documented follow-up 3. Adherence to depression management workflows	TBD	1. SPH Population Health 2. SPH Primary Care 3. SPH Psychiatry
18	**Downstream: Behavioral Health**				▲	
4	**High Intensity Support Services**					
	Actively engage with Department of Child and Family Services	Ongoing	improved maternal and infant health outcomes, as well as enhanced coordination of care that ensures mothers receive the necessary support and treatment to address their substance use during pregnancy, ultimately promoting healthier births and family well-being.	1. SPH representatives regularly attending meetings	▲	1. SPH Team Care 2. Department of Child and Family Services 3. Montana Health Care Foundation
	Actively engage with Drug Treatment Court partnership	Ongoing	Anticipated outcomes include improved access to addiction treatment for individuals in the criminal justice system and reduced recidivism rates through better coordination with Drug Treatment Courts.	1. SPH representative regularly attending Drug Treatment Court 2. # of patients connected to SPH Addiction Medicine Services through Drug Treatment Court	▲	1. Lewis & Clark County Public Health 2. SPH Population Health 3. SPH Addiction Medicine Service
	Implement Peer Support opportunities	2025	TBD	TBD	TBD	TBD

Number of Initiatives	Strategy to Address Health Need	Targeted Year	Anticipated Outcome	Evaluation Measure	Current Impact	Collaborators (Internal & External)
	Offer Behavioral Health Navigator to Increase Continuity of Care	New in 2024	This approach aims to improve patient outcomes by reducing treatment gaps, facilitating access to appropriate services, and providing valuable support throughout the care journey.	1. # of patients who are connected to appropriate mental health services or resources 2. # of caring contacts generated 3. Rate of patients with follow-up visit with PCP after ER, MCRT, or Inpatient stay related to Behavioral Health	▲	1. Montana Health Care Foundation 2. SPH Team-Care Department 3. SPH Population Health Department 4. SPH Primary Care 5. SAMHSA
7	**Long term Management & Recovery Support**					
	Address Perinatal Substance Use & Mental Health through the Taking Care of You Program	Ongoing	1. Increased early identification and intervention through routine screening 2. Defined and seamless care pathway in the perinatal substance use 3. Reduction in adverse outcome related perinatal substance use	- # women screened for postpartum depression - Outreach Percentange	▲	1. SPH Population Health 2. SPH Primary Care 3. Montana Health Care Foundation 4. SPH IBH Team
	Implement Pathway To Care - a structured follow-up for at-risk individuals (e.g., rapid referral pathways to behavioral health, follow-up calls post-discharge, caring contacts, etc.) (Zero Suicide Framework)	2025	1. Reduced suicide risk, improved mental health, and enhanced feelings of support and connection among at-risk individuals.	1. % of patients with SI receiving Caring Contacts 2. # of Caring Contacts	TBD	1. SPH Primary Care 2. SPH Psychiatry Department 3. SPH Integrated Behavioral Health
	Maintain and evaluate opportunities Integrated Behavioral Health (IBH) - Behaviorist Model within Ambulatory Setting	Ongoing	1. Improved access to behavioral health support within primary care. 2. Enhanced whole-person care through team-based interventions. 3. Early identification and management of behavioral health conditions.	1. Number of patients seen by behavioral health providers 2. Screening and referral rates for behavioral health needs 3. Sustainability: Billing revenue vs. cost of IBH services	▬	1. SPH Primary Care 2. SPH Psychiatry Department 3. SPH Integrated Behavioral Health
	Explore Group Therapy as standard offering at SPH	2025	TBD	TBD	TBD	TBD
	Maintain and evaluate opportunities for enhancing and expanding the Addiction Medicine service line	Ongoing	1. access to high-quality addiction treatment services, leading to improved outcomes, reduced substance use disorders, and better overall health and well-being for individuals seeking help with addiction issues.	1. # of patient with Addiction medicine visits	▲	1. SPH Addiction Medicine 2. SPH Clinical Admin Support
	Integrate Licensed Addiction Counselor into team-based care	New in 2024	1. Enhanced patient support and more effective treatment for individuals with substance use disorders through the integration of Licensed Addiction Counselors into healthcare teams, leading to improved recovery outcomes.	1. # of patients referred 2. # of patient with LAC Viisits	▲	1. SPH Population Health 2. Montana Health Care Foundation 3. SPH Addiction Medicine Services 4. RAIN with the U of U
	Expand Taking Care of You Program to provide Inpatient Coverage	TBD	TBD	TBD	TBD	TBD
5	**Evidence-based Treatment**					
	Offer Transcranial Magnetic Stimulation	New in 2024	1. Reduced symptoms of treatment-resistant depression. 2. Improved quality of life for patients receiving TMS. 3. Increased access to non-pharmacologic mental health treatment options.	1. Number of patients receiving TMS 2. Pre/post depression severity scores (e.g., PHQ-9) 3. Patient-reported outcomes and satisfaction	▲	1. SPH Psychiatry Department 2. SPH Foundation
	Maintain and assess opportunities for enhancing and expanding the Collaborative Care Program	Ongoing	1.Improved Access to Mental Health Services by integrating mental health care into primary care settings 2.Early Detection and Intervention through routine mental health screenings. 3.Enhanced Coordination of Care with a team approach for care 4.Improved Treatment Outcomes for mental health conditions 5.Patients have an improved quality of life	1. PHQ-9 Scores - Change over time 2. GAD-7 Scores - Change over time	▲	1. Montana Health Care Foundation 2. National Council for Wellbeing 3. SPH Primary Care Department 4. SPH Psychiatry Department 5. SPH Population Health Department 6. SPH Data Analytics Department
	Offer evidence-based Spravato treatment as a strategy for addressing depression	Ongoing	Anticipated measurable outcomes for implementing Spravato in a clinic include improved depression symptom reduction rates, enhanced patient quality of life, increased treatment adherence, and a decrease in the frequency and severity of depressive episodes.	1. Patient Outcomes - Depression change over time 2. # of patients served	▲	1. SPH Psychiatry Department
	Provide Inpatient Behavioral Health Services	Ongoing	1. Stabilization of individuals experiencing acute mental health crises. 2. Improved continuity of care through discharge planning and follow-up. 3, Reduced psychiatric hospital readmissions.	1. Inpatient admission and discharge data 2. Readmission rates within 30 days	▲	1. SPH BHU
	Explore opportunities for Substance Use Inpatient Unit	TBD	TBD	TBD	TBD	TBD
2	**Acute Intervention**					
	Train and certify additional master's-level behavioral health clinicians (e.g., LCSWs, LCPCs) to conduct ASAM assessments	2026	1. Increased access to timely chemical dependency evaluations. 2. Reduced wait times for SUD treatment placement. 3. Improved care coordination through standardized assessment practices.	1. Number of clinicians trained and certified 2. Number of ASAM assessments completed 3. Average wait time for chemical dependency evaluations	TBD	TBD
	Mobile Crisis Response	Ongoing	1. Reduce suicides rates within SPH Service area 2. Reduce ED visits and incarceration rates for patients in mental health crisis. 3. Build upon our community behavioral health crisis system. 4. Decrease total cost of care (TCOC).	1. # of ER visits related to SI 2. # of MCRT visits 3. Suicide Rate Reduction 4. Total Cost of Care	▲	1. Lewis & Clark County Public Health 2. PureView FQHC 3. Lewis and Clark County Sherriff's Office 4. SPH Emergency Department 5. SPH Ambulance Department 6. SPH Behavioral Health Unit
80	**Priority Area Chronic Disease**	2025-2027	Improve the overall health and well-being of our community through chronic disease prevention, early detection, treatment, and support services	See Specific Strategy Information	▲	See Specific Strategy Information
47	**Upstream: Chronic Disease**				▲	
17	**Community Based Organization Partnerships & Engagement**					
	University of Utah Clinical Kidney Transplant Partnership	Ongoing	1. Increased availability and accessibility of high-quality kidney transplant services for patients, leading to improved health and enhanced outcomes for those in need of kidney transplants.	1. # of Patients receiving Kidney Transplants	▲	1. SPH Dialysis 2. SPH Nephrology 3. University of Utah
	SPH Cancer Center Affiliate with Huntsman Cancer Institute	Ongoing	1. Elevated cancer care standards, access to advanced treatments, and enhanced support for cancer patients, ultimately leading to improved outcomes and a higher quality of care within the community.	1. Maintaining Affiliation	▲	1. Huntsman Cancer Institute 2. University of Utah 3. SPH Cancer Center
	SPH Community Supported Agriculture (CSA) Drop Off Location	Ongoing	establishment of a partnership with Western Montana Growers Cooperative, allowing 25 St. Peter's Health employees and their family to access to health foods, promoting healthy eating and supporting local agriculture.	1. continuation of CSA drop off location 2. # of CSA Shares	▲	1. SPH People Health & Wellness 2. Western Montana Growers Cooperative
	Active SPH presence in the Helena Community Gardens	Ongoing	Enhanced community partnership and increased access to fresh produce for vulnerable individuals, potentially leading to improved nutrition, reduced food insecurity, and better overall community health.	1. # lbs of food grown and donated to the community	▲	1. SPH Population Health 2. Helena Food Share 3. Carroll College

Number of Initiatives	Strategy to Address Health Need	Targeted Year	Anticipated Outcome	Evaluation Measure	Current Impact	Collaborators (Internal & External)
	Helena Health Fair Fun Fest	Annually	1. Increased community awareness of health and wellness resources. 2. Improved health literacy through interactive education and screenings. 3. Strengthened community engagement and trust in local health organizations.	1. Event attendance numbers 2. Number of health screenings or services provided 3. Participant feedback or satisfaction surveys	▲	1. SPH Population Health 2. SPH PR & Marketing 3. SPH Foundation 4. MANY Community Organizations
	Bicycle Rodeo	Annually	1. Increased knowledge of bike safety and road rules among participants. 2. Reduced risk of bike-related injuries in the community.	1. Event attendance numbers 2. Number of health screenings or services provided 3. Participant feedback or satisfaction surveys	▲	1. SPH Emergency Department 2. SPH PR & Marketing
	Offer Harvest of the Month to all Helena School District Elementary Schools	Ongoing	Improved student nutrition and a greater appreciation for locally sourced, seasonal produce, which can contribute to healthier eating habits and better overall student well-being.	1. # of Schools with active program 2. # of Community Events completed 3. # students served 4. Program Outcomes	▲	1. Helena School District 2. SPH Population Health 3. Kid Nutrition Coalition 4. No Kid Hungry Montana 4. Carroll College
	SPH to serve as a donor breast milk distribution and collection site	New in 2024	1. Improved infant nutrition and health outcomes. 2. Increased access to safe donor milk for families in need. 3. Enhanced community participation through milk donation.	1. Volume of donor milk distributed and collected 2. Number of infants receiving donor milk 3. Number of active milk donors	▲	1. SPH Population Health 2. SPH WAC 3. SPH PR & Marketing 4. Northwest Mother's Milk Bank
	Week of the Young Child	Annually	1. Increased community awareness of early childhood development and education. 2. Strengthened engagement between families, educators, and community organizations. Enhanced support for young children's learning through fun, developmentally appropriate activities.	1. Number of events held 2. Event attendance or participation rates 3. Parent and educator feedback	▲	1. SPH Population Health 2. SPH PR & Marketing 3. Early Childhood Coalition 4. MANY Community Organizations
	Support Garden Space at HOM Schools	2025	1. Increased student engagement with healthy eating and nutrition education. 2. Enhanced hands-on learning through gardening activities tied to HOM curriculum. 3. Improved access to fresh produce for school and community use.	1.Number of participating schools with garden space 2.Student participation in garden activities 3.Amount or variety of produce grown	TBD	1. Helena School District 2. SPH Population Health 3. Kid Nutrition Coalition 4. No Kid Hungry Montana 4. Carroll College 5. USDA Grant
	Early Childhood Collaborative	Ongoing				
	Educate patients on choosing the right level of care—primary care, urgent care, or emergency services—to improve health outcomes and reduce unnecessary ER visits (FUSE)	2025	TBD	TBD	TBD	TBD
	Support Infrastructure for healthy & quality School meals	TBD	TBD	TBD	TBD	TBD
	Expand Harvest of the Month to SPH Service Area	TBD	TBD	TBD	TBD	TBD
	Explore opportunities to offer parent group classes focused on education, support, and skill-building	TBD	TBD	TBD	TBD	TBD
	Offer Whole Food cooking Classes	TBD	TBD	TBD	TBD	TBD
	Offer Grocery Store Tours	TBD	TBD	TBD	TBD	TBD
5	**Community Coalition Engagement**					
	Actively Engage with Helena School District Wellness Committee	Ongoing	Improved health and wellness among students and employees within the Helena School District	1. SPH representatives regularly attending meetings	▲	1. SPH Population Health 2. SPH People Health & Wellness 3. Helena School District
	Actively Engage with Helena Healthy Communities Coalition	Ongoing	Utilize data to drive improvement in screening for and addressing SDOH. Utilize CMS data to explore cost and utilization to further identify gaps in services/care. Improve care transitions between healthcare providers and referrals to community-based programs and services. Develop systematic tools and processes to engage patients with chronic disease to decrease complications and maintain quality of life.	1. SPH representatives regularly attending meetings	▲	1. SPH Population Health 2. SPH People Health & Wellness
	Actively Engage with community SDOH Leadership Team	Ongoing	A more comprehensive and effective approach to addressing social determinants of health, leading to improved health equity and overall well-being within the community.	1. SPH representatives regularly attending meetings	▲	1. SPH Population Health
	Actively Engage with Community Kid Nutrition Coalition	Ongoing	Improved child nutrition programs and better-nourished children within the community, as a result of active engagement with the Community Kid Nutrition Coalition and collaborative efforts to enhance nutrition initiatives.	1. SPH representatives regularly attending meetings	▲	1. SPH Population Health
	Actively Engage with the Montana Cancer Coalition	Ongoing	increased awareness, knowledge, and community involvement in cancer-related issues, ultimately leading to improved cancer prevention, early detection, and support within the community.	1. SPH representatives regularly attending meetings	▬	1. Huntsman Cancer Institute 2. University of Utah 3. SPH Cancer Center 4. DPHHS Montana 4. Population Health Department
11	**Community Education & Engagement**					
	Offer Breast Feeding & Breast Pump Education	Ongoing	1. Increased breastfeeding initiation and duration rates. 2. Improved parent confidence in breastfeeding and pump use. 3. Enhanced infant health through improved nutrition and bonding.	1. Number of participants in education sessions 2. Pre/post knowledge or confidence scores 3. Breastfeeding initiation and continuation rates	▲	1. SPH Population Health 3. SPH WAC Unit 2. SPH PR & Marketing
	Offer student intern opportunities with proactive outreach related to Chronic Disease gaps in clinical care	Ongoing	1. Increased awareness and proactive management of chronic diseases in clinical care	1. # of student interns 2. # of Patients outreach completed	▬	1. SPH Population Health 2. Innovaccer
	Stepping On Fall Prevention	Ongoing	1. Reduction in fall-related injuries among older adults, improved balance and confidence, and an overall enhancement of the well-being of participants in the Stepping On Fall Prevention program.	1. # of Classes offered on an annual basis 2. # of patients who attend the class	▲	1. SPH Population Health 2. SPH PR & Marketing
	Relaunch proactive outreach and education Campaigns for Respiratory Diseases that can avoided and/or lessen disease impact through preventative vaccines (Influenza, COVID-, Pneumonia)	2025	1. Increased vaccination rates and improved understanding of the importance of immunization, leading to reduced cases and severity of Influenza, COVID-19, and Pneumonia within the community.	1. # of Community education campaigns Annually 2. # of patients who received a proactive outreach	TBD	1. SPH Population Health 2. PR & Marketing 3. Data Analytics 4. SPH Primary Care 5. SPH Quality Committee
	SPH to have an active presence at Helena's Farmer's Market	Ongoing	1. Increased community awareness of health-related topics and practices, as well as improved access to health education and resources, ultimately contributing to a healthier and more informed community.	1. # of Helena's Farmer's Market SPH is Present	▲	1. SPH Population Health 2. SPH PR & Marketing
	Walk with a Doc	Ongoing	1. Increased physical activity levels and improved community health as individuals engage in regular walks and health discussions with healthcare professionals, ultimately contributing to a culture of wellness.	1. # of individuals signed up for the event 2. # of events offered within the year	▲	1. SPH People Health & Wellness 2. SPH PR & Marketing
	Offer SPH Employees & SPH Service Area Annual Step Challenge	Annually	1. Improved physical fitness and overall well-being among participants, contributing to a healthier workforce and community.	1. # of individuals signed up for the challenge 2. # of individuals completed the challenge	▲	1. SPH People Health & Wellness 2. SPH PR & Marketing 3. BCBS of Montana

Number of Initiatives	Strategy to Address Health Need	Targeted Year	Anticipated Outcome	Evaluation Measure	Current Impact	Collaborators (Internal & External)
	Offer SPH Employees & SPH Service Area Annual Sugar Challenge	Annually	1. Increased awareness of and reduced sugar consumption, which can contribute to improved overall health and a decreased risk of diet-related health issues among participants in the workforce and the community.	1. # of individuals signed up for the challenge 2. # of individuals completed the challenge	▲	1. SPH People Health & Wellness 2. SPH PR & Marketing
	Annually Offer SPH Employees & SPH Service Area Whole Foods Challenge	Annually	1. Increased awareness and adoption of healthier eating habits, leading to improved nutritional choices and better overall health for participants within SPH and the surrounding community.	1. # of individuals signed up for the challenge 2. # of individuals completed the challenge	▲	1. SPH People Health & Wellness 2. SPH PR & Marketing
	Work with School district to provide nutrition education to students in elementary schools	2026	TBD	TBD	TBD	TBD
	Integrate health literacy education into existing programs (e.g., chronic disease management, preventive screenings).	TBD	TBD	TBD	TBD	TBD
	Attend Community education & engagement events	Ongoing	improved community knowledge, increased awareness of Chronic disease and cancer-related issues, and greater community involvement in initiatives aimed at preventing Chronic disease and cancer, detecting it early, and providing support to those affected.	1. # of Community education events SPH is present	–	PRN
4	**Community Sponsorships**					
	Assess Community Sponsorship needs/asks within 2025	2025	Improved community health through increased access to resources, services, and programs that target specific health issues, ultimately fostering a healthier and more resilient local population.	Not Applicable	–	1. SPH PR & Marketing
	Provide free community space for the Helena Ostomy Support Group	Ongoing	Improved support, education, and community for individuals with ostomies, leading to enhanced well-being and a better quality of life for those affected.	1. # of Group sessions or total time space available	–	1. Wound Care Clinic 2. United Ostomy Association of America 3. PR & Marketing
	Healthy Food Options Sponorship to Helena Food Share	Annually	Helena Food Share is an increased availability of nutritious food for community members in need, helping to improved dietary choices and better overall health among recipients.	Not Applicable	▲	1. SPH PR & Marketing 2. SPH Population Health 3. Helena Food Share
	Provide free community space for the Helena Bariatric Support Group	Ongoing	Enhanced support and resources for individuals on their weight loss and bariatric surgery journey, contributing to better health outcomes and community well-being.	1. # of Group sessions or total time space available	–	1. SPH PR & Marketing 2. SPH Population Health
	Youth Sports and Physical Activity Sponsorships (see Partners List)	Ongoing	Improved community health through increased access to resources, services, and programs that target specific health issues, ultimately fostering a healthier and more resilient local population.	Not Applicable	▲	1. MT Southwest Dolphins Swimming 2. Jefferson High Booster Club 3. MT Southwest Dolphins Swimming 4. Premiere Dance Company 5. Girls Thrive 6. Helena Public Schools Activities Department 7. Carroll College 8. Rotary Club of Townsend 9. Cohesion Dance 10. East Helena School District 11. Northwest Wild Cheer and Dance 12. Helena American Legion Baseball 13. Helena Christian School 14. Prickly Pear Land Trust 15. Treasure State Runners 16. Helena High Bengalettes 17. Helena Bearcats Wrestling Club 18. Helena Figure Skating Club 19.Last Chance Lacrosse Club
3	**Workforce & System Level Change**					
	SPH Provides Free Gym Membership to Employees and Family Members	Ongoing	Improved employee health and well-being, increased physical activity, and a positive impact on the overall wellness of SPH staff and their families through access to free gym memberships.	1. # of individuals utilizing Health Club Membership	▲	1. SPH People Health & Wellness 2. SPH PR & Marketing 3. SPH Finance Department 4. Capital City Health Club
	Offer student intern opportunities to co-lead community education classes with Harvest of the Month	Ongoing	Increased nutrition knowledge and healthier eating practices within the community, leading to improved overall well-being among participants.	1. # of Student Interns Annually 2. # of classes taught by Student Interns	▲	1. SPH Population Health 2. Carroll College 3. Helena High
	Explore Launching a Gym Challenge for Employees and Family Members	TBD	The anticipated outcome is increased employee and family member engagement in physical fitness activities, enhanced camaraderie, and healthier lifestyles as a result of participating in the gym challenge.	TBD	TBD	1. SPH People Health & Wellness 2. SPH PR & Marketing 3. SPH Finance Department 4. Capital City Health Club
7	**Data Driven Decision Making & Sustainability**					
	Build and deploy Hypertension Registries to Understand opportunities for outcome improvement	2025	more data-driven and targeted approach to disease management, enabling healthcare providers to identify opportunities for improving patient outcomes, reducing complications, and enhancing the overall quality of care for individuals with these conditions.	1. Creation of Diabetes Registry & Dashboard	–	TBD
	Build and deploy Colorectal Cancer Screening Registries to Understand opportunities for outcome prevention improvement	2025	More data-driven and targeted approach to colorectal cancer prevention, enabling healthcare providers to identify opportunities for improving screening rates, early detection, and ultimately reducing the burden of colorectal cancer in the community.	1. Creation of Registry & Dashboard	–	TBD
	Build and deploy Cervical Cancer Screening Registries to Understand opportunities for outcome prevention improvement	2025	More data-driven and targeted approach to cervical cancer prevention, enabling healthcare providers to identify opportunities for improving screening rates, early detection, and ultimately reducing the burden of cervical cancer in the community.	1. Creation of Registry & Dashboard	–	TBD
	Build and deploy Breast Cancer Screening Registries to Understand opportunities for outcome prevention improvement	2025	More data-driven and targeted approach to breast cancer prevention, enabling healthcare providers to identify opportunities for improving screening rates, early detection, and ultimately reducing the burden of breast cancer in the community.	1. Creation of Registry & Dashboard	–	TBD
	Build and deploy Coronary Artery Disease and Ischemic Vascular Disease Registries to Understand opportunities for outcome improvement	2025	more data-driven and targeted approach to disease management, enabling healthcare providers to identify opportunities for improving patient outcomes, reducing complications, and enhancing the overall quality of care for individuals with these conditions.	1. Creation of Diabetes Registry & Dashboard	–	TBD
	Build and deploy Diabetes Management Registries to Understand opportunities for outcome prevention improvement	2025	A more data-driven and targeted approach to diabetes care, enabling healthcare providers to identify specific areas for improvement, tailor interventions, and ultimately enhance diabetes management, leading to better outcomes and reduced complications for individuals with diabetes.	1. Creation of Diabetes Registry & Dashboard	–	TBD
	Build and deploy Chronic Kidney Screen for patient with diabetes Registries to Understand opportunities for outcome improvement	2025	more data-driven and targeted approach to disease management, enabling healthcare providers to identify opportunities for improving patient outcomes, reducing complications, and enhancing the overall quality of care for individuals with these conditions.	1. Creation of Diabetes Registry & Dashboard	–	TBD
18	**Mid Stream: Chronic Disease**				▲	
4	**Community Classes & Support Groups**					

Number of Initiatives	Strategy to Address Health Need	Targeted Year	Anticipated Outcome	Evaluation Measure	Current Impact	Collaborators (Internal & External)
	Health Coaches for Hypertension Control	Ongoing	improved hypertension management and overall health among participants	1. # of patient referrals 2. # of patients completed the class annually 3. BP in target range with completion of class	▲	1. SPH Population Health 2. Montana State DPHHS
	Diabetes Support Group	Ongoing	Improved diabetes self-management and overall well-being among participants as they benefit from shared experiences, knowledge exchange, and emotional support within the community.	1. # of Group sessions or total time space available	▲	1. SPH Clinical Nutrition
	Arthritis Movement	Ongoing	improved joint health, reduced pain, and enhanced mobility among participants with arthritis, ultimately leading to an improved quality of life for individuals managing this condition.	1. # of Classes offered on an annual basis 2. # of patients who attend the class	▲	1. SPH Population Health 2. SPH PR & Marketing
	Expand Inch-by-Inch program access and enrollment.	Ongoing	Expanding referrals and access is the potential for a broader reach, enabling more individuals to participate in the program and reduce their risk of diabetes and heart disease through lifestyle changes.	1. # of annual referrals 2. # of individuals completed the program 3. Program outcomes	▲	1. SPH Clinical Nutrition Department 2. Montana Department of Public Health and Human Services
4	**Evidence-Based Education**					
	Offer Free Virtual Diabetes Education	Ongoing	Participants to gain essential knowledge and skills to manage their diabetes effectively, leading to improved self-care, better health, and a greater understanding of their condition.	1. # of patient attending class	▬	1. SPH Clinical Nutrition
	Offer Year Long Diabetes Education Program	Ongoing	Individuals with diabetes to acquire the knowledge and skills needed for effective self-management, leading to improved diabetes control, reduced risk of heart disease, and overall better health outcomes.	1. # of patient attending class	▬	1. SPH Clinical Nutrition
	Educate Community about Palliative Care	2025	TBD	TBD	TBD	TBD
	Implementation of Asthma Action Plan	TBD	TBD	TBD	TBD	TBD
10	**Risk Reduction**					
	Obtain Target BP designation	2025	1. Improved identification and control of high blood pressure in patients. 2. Increased use of evidence-based hypertension management practices. 3. Recognition of the health system's commitment to cardiovascular health.	1. Hypertension control rate 2. Number of patients screened and monitored for BP 3. Achievement of Target: BP recognition criteria	TBD	1. SPH Population Health 2. PR & Marketing 3. Data Analytics 4. SPH Primary Care 5. SPH Quality Committee
	Relaunch proactive outreach and education Campaigns for Colorectal Cancer Screenings	New in 2024	1. Increased participation in screenings, improved awareness of the importance of early detection, and ultimately a reduction in colorectal cancer cases and related mortality rates within the community.	1. # of Community education campaigns Annually 2. # of patients who received a proactive outreach	▲	1. SPH Population Health 2. PR & Marketing 3. Data Analytics 4. SPH Primary Care 5. SPH Quality Committee
	Relaunch proactive outreach and education Campaigns for Cervical Cancer Screenings	New in 2024	1. Increased participation in screenings, improved awareness of the importance of early detection, and ultimately a reduction in cervical cancer cases and related mortality rates within the community.	1. # of Community education campaigns Annually 2. # of patients who received a proactive outreach	▲	1. SPH Population Health 2. PR & Marketing 3. Data Analytics 4. SPH Primary Care 5. SPH Quality Committee
	Relaunch proactive outreach and education Campaigns for Breast Cancer Screenings	New in 2024	1. Increased participation in screenings, improved awareness of the importance of early detection, and ultimately a reduction in breast cancer cases and related mortality rates within the community.	1. # of Community education campaigns Annually 2. # of patients who received a proactive outreach	▲	1. SPH Population Health 2. PR & Marketing 3. Data Analytics 4. SPH Primary Care 5. SPH Quality Committee
	Implement Lung Cancer Screening within Primary Care	Ongoing	1. Earlier detection and diagnosis of lung cancer in at-risk individuals, leading to improved treatment options and ultimately better survival rates for those affected by the disease.	1. # of Patients Screened	▬	1. SPH Primary Care Teams 2. SPH Diagnostic Imaging 3. SPH Radiation & Oncology Department 4. SPH Quality Committee
	Offer Free Breast Cancer Screenings & Share DPHHS Free Mammograms via social media	Ongoing	1. Increased screening and early detection of breast cancer in individuals who may not have had access to such screenings, leading to timely treatment and improved survival rates for those affected by the disease.	1. # of Free Breast Cancer Screens Provided 2. Created social media content for free Community screenings	▲	1. SPH Diagnostic Imaging 2. Lewis & Clark Public Health Cancer Screening Program 3. PR & Marketing
	Systematic approach to population based outreach for GAPs in Care	2025	TBD	TBD	TBD	TBD
	Screen for SDOH	Ongoing	1. Improved ability to identify individuals in need and provide them with vital resources, potentially leading to reduced the enhanced well-being within the community.	1. # of Individuals Screened for SDOH Annually 2. # of Individuals screened positive 3. # of referrals to programs to lessen barriers	▬	1. SPH Population Health 2. SPH Quality Department 3. SPH Clinical Areas 4. SPH Primary Care
	Hypertension Proactive Outreach Program	New in 2024	1. Improved blood pressure control and cardiovascular health among individuals, as they receive proactive support and interventions tailored to their needs, ultimately reducing the risk of hypertension-related complications.	1. # of patient outreach completed 2. Rate of BPs in target range	▲	1. SPH Population Health 2. SPH Primary Care
	Relaunch Food RX Program	TBD	1. Improved health outcomes among individuals with chronic conditions, as they gain increased access to fresh produce and nutrition education, ultimately reducing the impact of social determinants of health (SDOH) on their well-being.	1. # of individuals referred to the Program 2. Program outcomes	TBD	1. SPH Clinical Nutrition 2. Local Grocery Store 3. SPH Population Health 4. SPH Primary Care 5 SPH Lifestyle Medicine
-	**Evidence-based Universal Screening**					
15	**Downstream: Chronic Disease**				▲	
4	**High Intensity Support Services**					
	Cancer Nurse Navigator Program	Ongoing	Improved patient experience and outcomes, as individuals receive personalized support and guidance throughout their cancer treatment, leading to better coordination of care and enhanced well-being.	1. # of patients served by the Nurse Navigator	▲	1. SPH Radiation & Oncology Department 2. SPH Diagnostic Imaging
	Integrate Clinical Pharmacists into Ambulatory Care Clinics	Ongoing	1. Improved medication management and adherence for complex patients. 2. Reduced medication-related errors and adverse events. 3. Enhanced care team efficiency and chronic disease outcomes.	1. Number of pharmacist-led patient visits 2 . Clinical outcomes (e.g., A1c, BP) in managed patients	▲	1. SPH Endocrinology 2. SPH Lifestyle Medicine 3. SPH Primary Care 4. SPH Gastroenterology 5. SPH Rheumatology 6. SPH Post Acute & Long-Term Care
	Provide Food Is Care Program - Medically tailored grocery/meal Delivery for community members in need	Ongoing	Improved health and well-being among vulnerable community members, as they gain easier access to nutritious food, better managing their chronic conditions and mitigating the impact of limited transportation and mobility issues.	1. # of referrals to the program 2. Program Outcomes	▲	1. SPH Population Health 2. Helena Food Share 3. Carroll College 4. CHS Capital High National Honors Society
	Evaluate Opportunities for a Mobile Health Team in Community	TBD	TBD	TBD	TBD	TBD
4	**Long term Management & Recovery Support**					
	Integrate Clinical Nutrition into Clinics	Ongoing	1. Improved patient health and well-being, as individuals receive personalized dietary guidance and support, leading to better nutritional choices and overall health outcomes.	1. # of patient visits with Clinical Nutrition in the Clinic Settings	▲	1. SPH Endocrinology 2. SPH Lifestyle Medicine 3. SPH Primary Care

Number of Initiatives	Strategy to Address Health Need	Targeted Year	Anticipated Outcome	Evaluation Measure	Current Impact	Collaborators (Internal & External)
	Provide inpatient and outpatient Palliative Care Program	Enhancement coming 2025	1. Improved quality of life for patients with serious illness. 2. Enhanced symptom management and goal-concordant care. 3. Reduced hospital readmissions and intensive care utilization.	1. Number of patients served (inpatient and outpatient) 2. Patient and family satisfaction scores 3. Hospital readmission rates for palliative patients	▲	1. SPH Palliative Care 2. SPH Hospitalist Team 3. SPH Primary Care 4. SPH Hospice Department
	Implement Lifestyle Medicine Program	Ongoing	1. Improved health outcomes and a reduced risk of chronic diseases through the adoption of healthier lifestyle choices, ultimately leading to a higher quality of life and lower healthcare costs.	1. # of Program Referrals 2. Additional Metrics TBD	▲	1. SPH Clinical Nutrition Department 2. SPH Lifestyle Medicine 3. SPH Primary Care
	Create Patient Specific Care Plans for Chronic Disease Management	2025	1. Improved patient engagement and self-management of chronic conditions. 2, More individualized, goal-directed care delivery. 3. Better clinical outcomes and reduced complications.	1. Number of care plans created 2. Patient adherence to care plan goals 3. Clinical outcomes (e.g., A1c, BP, hospitalizations)	TBD	TBD
5	**Evidence-based Treatment**					
	Provide Blood pressure remote monitoring Program	New in 2024	1. Increased engagement of individuals in actively tracking their blood pressure, leading to better awareness of their cardiovascular health and potentially reducing the risk of hypertension-related complications through timely interventions.	1. # of patient served through remote monitoring device	▲	1. SPH Population Health Senior Director 2. SPH Primary Care
	Explore CHF remote monitoring opportunities	2025	1. More proactive and effective management of congestive heart failure patients, leading to improved symptom control, reduced hospitalizations, and an overall better quality of life for individuals with CHF.	1. # of patient served through remote monitoring device	TBD	1. SPH Population Health Senior Director 2. SPH Primary Care 3. SPH Cardiology
	RPM for Pulmonary Conditions (COPD, Asthma)	TBD	TBD	TBD	TBD	TBD
	Offer Nurse Driven medical protocols to support HTN & CHF medication management with Remote Monitoring	New in 2024	1. Improved blood pressure and heart failure symptom control through proactive monitoring. 2. Increased access to timely care by empowering nurses to act on clinical protocols within a team-based approach. 3. Reduced hospital admissions and emergency visits through earlier intervention and coordinated chronic disease management.	1. Creation of Nurse Protocols	▲	1. Population Health Department 2. SPHMG Quality Committee 3. Primary Care Department 4. Cardiology Department 5. DPHHS
	Explore in-home diabetes care protocol including remote blood glucose monitoring	TBD	Enhanced diabetes management, leading to better blood glucose control, reduced complications, and improved overall quality of life for individuals with diabetes.	TBD	TBD	1. SPH Endocrinology 2. SPH Lifestyle Medicine 3. SPH Primary Care 4. SPH Population Health 5. SPH Team Care
2	**Acute Intervention**					
	Offer tele-stroke services in the ED.	Ongoing	1. Faster diagnosis and treatment of stroke patients, leading to improved outcomes and a higher likelihood of minimizing the long-term effects of stroke, ultimately enhancing patient well-being.	1 # of patient who were able to connect to tele-stroke services	▲	1. SPH Emergency Department 2. SPH Intensive Care Unit 3. University of Utah 4. Lewis and Clark ED Physicians
	Cardio-Pulmonary Rehabilitation Program	Ongoing	1. Improved cardiovascular and respiratory function and exercise tolerance. 2. Reduced hospital readmissions and complications. 3. Enhanced quality of life and self-management for patients with chronic heart and lung conditions.	1. Program enrollment and completion rates 2. Pre/post functional capacity (e.g., 6-minute walk test) 3. Hospital readmission rates	▲	1. SPH Rehab Department 2. SPH Cardiology 3. SPH Pulmonology 4. SPH Primary Care
18	**Priority Area Housing**	2025-2027	Access to safe and stable housing for essential workers, older adults, and medically complex individuals, leading to improved health outcomes, reduced system strain, and a stronger, more resilient community.	See Specific Strategy Information	▲	See Specific Strategy Information
11	**Upstream: Housing**				▲	
1	**Community based Organization Partnerships and Engagement**					
	Partner with Community to explore options for improved access to emergency shelters	TBD	TBD	TBD	TBD	TBD
3	**Community Coalitions Engagement**					
	SPH Represented at Helena Area Case Conferencing	Ongoing	1. Improved coordination of care and services for individuals experiencing homelessness. 2. Increased connection to housing, healthcare, and support resources. 3. More efficient use of community resources through shared accountability and action planning.	1. Number of case conferences held 2. Number of individuals connected to services or housing 3. Reduction in time from identification to service connection	▲	1. SPH Population Health Team 2. MANY Helena Service Organizations
	FUSE Leadership Team	Ongoing	1. Strengthened cross-sector collaboration to address housing and health needs. 2. Strategic oversight and guidance for FUSE program implementation and improvement. 3. Increased alignment of policies and resources to support high-utilizer populations.	1. Number of leadership team meetings held 2. Action items completed or initiatives launched 3. Cross-agency participation and engagement levels	▲	1. SPH Population Health Team 2. PureView Health Center 3. Good Samaritan 4. Carroll College 5. L&C Justice System 6. Helena Housing Authority
	SPH Represented at United Way Leads-Move the Dial (Housing Focus)	2025	TBD	TBD	TBD	TBD
2	**Community Education & Engagement**					
	Housing is Health Care Summit	Annually	1. Increased awareness of the intersection between housing and health among stakeholders. 2. Strengthened partnerships across sectors to address housing insecurity. 3. Actionable strategies developed to inform policy and community initiatives.	1. Number of attendees and sectors represented 2. Post-event survey feedback 3. Number of new partnerships or initiatives launched	▲	1. SPH Population Health Team 2. FUSE Leadership Team
	Re-Entry Simulation	New in 2024	1. Increased awareness of barriers faced by individuals re-entering the community after incarceration. 2. Enhanced empathy and understanding among service providers and stakeholders. 3. Identification of system gaps and opportunities for improved re-entry support.	1. Number of participants 2. Pre/post simulation knowledge or attitude shift 3. Participant feedback or satisfaction survey	▲	1. SPH Population Health Team 2. FUSE Leadership Team
1	**Workforce & System Level Change**					
	Evaluate Workforce Housing Opportunities	TBD	TBD	TBD	TBD	TBD
3	**Data Driven decision making & Sustainability**					
	Screening for SDOH - Housing Insecurity	Ongoing	1. Increased identification of patients experiencing housing instability. 2. Improved connection to housing resources and support services. 3. Enhanced understanding of population needs to inform care and community partnerships.	1. Number of patients screened for housing insecurity 2. Number of positive screens connected to resources 3. Documentation rate of SDOH screening in EHR	▬	1. ALL SPH Patient Care Units

Number of Initiatives	Strategy to Address Health Need	Targeted Year	Anticipated Outcome	Evaluation Measure	Current Impact	Collaborators (Internal & External)
	Housing Is Health/FUSE Care Impact Study	2025	1. Demonstrated link between housing stability and improved health outcomes. 2. Evidence of reduced healthcare utilization and costs among FUSE participants. 3. Informed policy and funding decisions through data-driven insights.	1. Completed Impact Study	▲	1. SPH Population Health Team 2. SPH Foundation 3. University of Montana
	Leverage the Homeless Management Information System (HMIS) to improve coordination of care, data-driven decision-making, and service delivery for individuals experiencing or at risk of homelessness.	Ongoing	1. Improved care coordination and service tracking for individuals experiencing or at risk of homelessness. 2. Enhanced data-driven decision-making to identify gaps and prioritize resources. 3. Increased compliance with HUD reporting requirements and strengthened partnerships within the Continuum of Care.	1. Number of clients entered into HMIS 2. Number of SPH users entering into HMIS 3. Frequency of HMIS data use in planning or reporting	–	1. SPH Population Health Team 2. United Way 3. Helena Housing Authority
1	**Community Sponsorships**					
	United Way Funding for Supportive Housing	Ongoing	Improved community health through increased access to resources, services, and programs that target specific health issues, ultimately fostering a healthier and more resilient local population.	Not Applicable	▲	1. SPH PR & Marketing Team
4	**Midstream: Housing**				▲	
-	**Community Classes & Support Groups**					
1	**Evidence-Based Education**					
	Provider Hoarder Training	TBD	1. Increased provider awareness and understanding of hoarding disorder. 2. Improved ability to identify and respond to hoarding situations. 3. Enhanced coordination with behavioral health and housing services.	1. Number of participants trained 2. Pre/post knowledge assessment 3. Participant satisfaction or confidence scores	TBD	TBD
3	**Risk Reduction**					
	Habitat for Humanity Home repairs for Complex Care Primary Care Patients	New in 2024	1. Improved safety, accessibility, and living conditions for medically complex patients. 2. Reduced health risks associated with substandard housing. 3. Enhanced ability for patients to manage health conditions at home.	1. Number of homes repaired for eligible patients 2. Patient-reported improvements in home safety or health 3. Reduction in avoidable ED visits or hospitalizations	–	1. SPH Population Health Team 2. SPH Foundation 3. Helena Habitat for Humanity
	Explore Opportunity to invest in Aging Community Housing	TBD	TBD	TBD	TBD	TBD
	Screen Door Agency at SPH	Ongoing	1. Increased identification and engagement of individuals experiencing homelessness. 2. Improved access to the HMIS system and timely connection to Front Door Agencies. 3. Streamlined entry into housing and support services from the healthcare setting.	1. Number of individuals screened and added to HMIS 2. Number of referrals made to Front Door Agencies 3. Time from screening to service connection	–	1. SPH Population Health Team 2. United Way
3	**Downstream: Housing**				–	
2	**High Intensity Support Services**					
	Housing is Health Care - Frequent Users Systems Engagement (FUSE)	Ongoing	1. Reduced emergency department visits and hospitalizations among high-utilizers. 2. Increased housing stability and connection to supportive services. 3. Improved care coordination across health, housing, and justice systems.	1. ED visits and hospitalizations pre/post enrollment 2. Housing placement and retention rates 3. Number of individuals connected to supportive services	▲	1. SPH Primary Care 2. SPH Population Health 3. United Way 4. SPH Foundation 5. Good Samaritan 6. PureView Health Center 7. SPH Emergency Department
	Established Process with the SPH Foundation to provide hotel vouchers for patients experiencing homelessness when discharge to the street would pose a health risk	New in 2024	1. Reduced discharges to unsafe or unstable environments for patients experiencing homelessness. 2. Improved short-term health and recovery outcomes post-discharge. 3. Increased connection to housing and supportive services during critical transition periods.	Number of hotel vouchers issued Number of patients connected to follow-up care or housing services	▲	1. SPH Primary Care 2. SPH Population Health 3. SPH Foundation 4. SPH Inpatient Care Management 5. SPH Emergency Department
1	**Long term Management & Recovery Support**					
	Explore Housing Navigator Role	TBD	TBD	TBD	TBD	TBD
-	**Evidence-based Treatment**					
-	**Acute Intervention**					