Community Health Improvement Plan

Lewis and Clark County and Greater Service Area, Montana

2025

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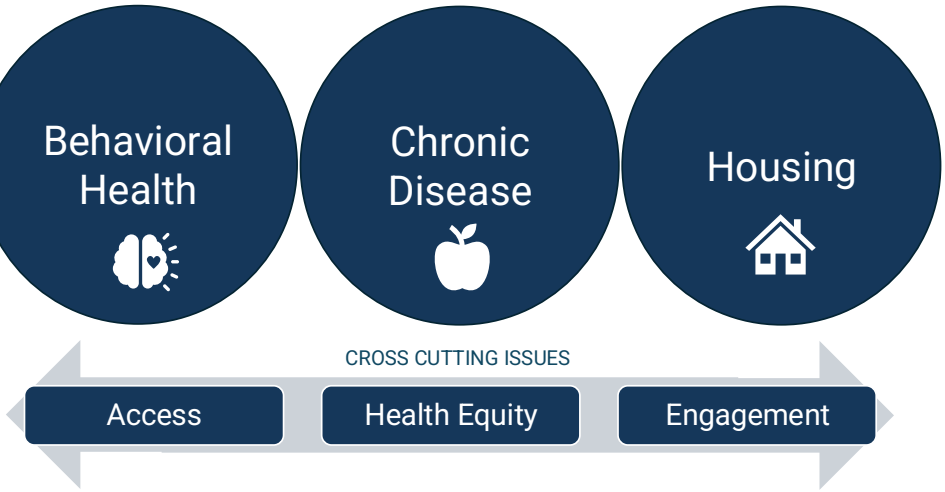
Community Health Improvement Planning

In the spring of 2025, Lewis and Clark Public Health and the Healthy Together Steering Committee convened a group of stakeholders to create our community's fourth Community Health Improvement Plan (CHIP).

Healthy Together leadership agreed on a framework for the plan based on the results of the Community Health Assessment. This framework includes three health priority areas that the community indicated were top priorities in the Community Health Assessment in 2024, along with a number of cross cutting issues that impact all of the priority areas.

Lewis and Clark County 2025 Health Improvement Plan Framework



To select strategies to improve the health of our community in these priority areas, the Healthy Together Steering Committee held four facilitated community planning sessions in February and March 2025, attended by 72 community leaders representing more than 30 organizations.

In these sessions, participants provided insight into the root causes of the health needs in our community, and used their expertise and experience to inform what should be done to improve the health of all. The resulting plan, outlined in this report, details strategies to improve the health of all county residents over the next three years, drawing on existing assets and resources including established, multi-sector coalitions.

CHIP strategies focus on increasing partnerships and engaging community members, expanding access to care and ensuring that those with the highest health needs are prioritized for intervention. CHIP participants were encouraged to select evidence-based strategies that will impact county residents across the lifespan.

Vital Conditions for Well-Being

The Lewis and Clark County Community Health Assessment and Community Health Improvement Plan emphasize seven vital conditions for well being that profoundly influence the health of individuals and the community. These conditions are the foundations upon which healthier lives are built, and they impact health across all dimensions and generations. CHIP Planning committee members considered these vital conditions and opportunities to promote them as they designed CHIP strategies.

Humane Housing

Access to secure, consistent places to live, homes and neighborhoods that are safe from hazards, and neighborhoods that provide access to healthy food, opportunity, and resources that promote healthy living.

Opportunities:

- Promoting community design that is human-centered, multimodal, and connects neighborhoods with resources
- Ensuring safe, affordable housing for all
- Diversifying the housing mix to meet the needs of all

Meaningful Work and Wealth

Good-paying, fulfilling jobs and financial security that extends across the life span. People's lives and self-worth flourish when doing productive, rewarding work.

Opportunities:

- Supporting policies that increase opportunities for gainful employment and livable wages
- Promoting wealth-building opportunities
- Advancing equitable prosperity

Lifelong Learning

Good education for all that ensures all people, regardless of age, background, or ability, are set up for success, and have the opportunities to reach their full potential. Education that launches people into meaningful careers, with ongoing opportunities to learn and grow.

Opportunities:

- Advancing learning opportunities in early childhood
- Connecting young people with opportunities for their futures, including quality public education
- Investing in adult education and job training programs

Retrieved October 2024 from: communitycommons.org/collections/Seven-Vital-Conditions-for-Health-and-Well-Being

Vital Conditions for Well-Being

Reliable Transportation

Transportation—whether walking, bicycling, wheeling, public transit, or driving—allows people to reach jobs, education opportunities, medical services, green outdoor space, community meetings, and family events; it acts as a connection to every other vital condition.

Opportunities:

- Building connected, accessible communities
- Investing in transportation systems that serve all modes

Basic Needs for Health and Safety

Access to fresh air and water, nutritious food; access to routine and critical health care; the security of a stable home; healthy relationships; and a life free from violence, injury, and toxic stress.

Opportunities:

- Expanding access to healthcare and preventive services
- Improving support systems
- Fostering safer, more just communities

Belonging and Civic Muscle

Fulfilling relationships and social support; a sense of belonging to a community and contribution to its vibrancy. Social support through friends, family, and other networks contributes to our practical and emotional needs, enhances mental well-being, helps us navigate the challenges of life, and reinforces healthy behaviors.

Opportunities:

- Cultivating community participation and leadership
- Resisting the rise of hate and dismantling systemic oppression and racism
- Building vibrant, inclusive communities

Thriving Natural World

Clean air, clean water, clean land, and well-functioning ecosystems. An environment free from hazards, resilient to future changes, and fulfills our needs to connect with nature.

Opportunities:

- Preserving and restoring environmental systems
- Implementing sustainable development practices
- Responding to the climate crisis and building resilience

Metrics and Trends

The 2025 CHIP will utilize the same priority areas and metrics as the 2022 CHIP, as Lewis and Clark County continues to prioritize and measure progress on behavioral health, chronic disease and housing. Below is a summary of the changes in the 2022 CHIP metrics in the three priority areas over the last three years. We saw positive change or maintenance in 64% and 73% of the behavioral health and chronic disease metrics respectively, but only 31% of the housing metrics.

Priority Area Metrics

Worse | Better | Little or no < 5% difference

Behavioral Health Metrics
Data displayed as: Estimate [95% confidence interval]
Data represent estimates for Lewis and Clark County residents

Adult Behavioral Health Metrics [1]		2017-2019	2020-2022	Change
Suicide mortality rate [2] (age-adjusted per 100,000)		**24**	**26** *2020-2023	Worse
Depressive disorder: adults		**22.9%** [20.2-25.6]	**23.6%** [21.1-26.0]	Little or no
Adults who binge drink		**16.6%** [14.0-19.2]	**20.2%** [17.8-22.6]	Worse
Tobacco use:	Current smokers	**16.5%** [13.9-19.0]	**13.5%** [11.5-15.6]	Better
	E-cigarette use	**2.4%** [0.36-4.4]	**5.7%** [4.1-7.3]	Worse
Marijuana use		**9.9%** [6.0-13.8]	**16.7%** [13.8-19.7]	Worse
Youth Behavioral Health Metrics [3]		**2021**	**2023**	**Change**
Experiencing depressive symptoms		**42%**	**37%**	Better
Tobacco use: adolescents	Ever smoked a cigarette	**25%**	**24%**	Little or no
	E-cigarette use	**49%**	**37%**	Better
Marijuana use: adolescents		**36%**	**24%**	Better
Binge drinking		**21%**	**15%**	Better

Priority Area Metrics

Worse | Better | Little or no < 5% difference

Chronic Disease Metrics

All rates are age-adjusted per 100,000 and represent estimates for Lewis and Clark County residents
Data displayed as: Estimate [95% confidence interval]

Cancer [4]	2012-2016	2017-2021	Change
Female breast: mortality rate	**23.6** [17.3-32]	**13.1** [8.8-19.5]	Better
Female breast: incidence rate	**133.9** [117.5-152.2]	**131.9** [116.2-149.6]	Little or no
Male prostate: mortality rate	**24.3** [16.8-34.1]	**22.6** [16.0-31.5]	Little or no
Male prostate: incidence rate	**130.6** [114.5-148.8]	**148.6** [132.7-166.3]	Worse
Colon cancer: mortality rate	**13.5** [10.1-18]	**18.7** [14.6-23.8]	Worse
Colon cancer: incidence rate	**46.8** [40.1-54.5]	**36.6** [30.8-43.4]	Better
Asthma [5]	**2017-2019**	**2020-2023**	**Change**
Hospital admission rate	**494**	**436**	Better
Emergency Department visit rate	**1,885**	**1,298**	Better
Heart Disease [2, 5]	**2017-2019**	**2020-2023**	**Change**
Hospital admission rate	**1,840**	**1,772**	Little or no
Emergency Department visit rate	**1,895**	**2,075**	Worse
Mortality rate	**148.3** [135.7-162.1]	**152.2** [139.8-165.5]	Little or no

Priority Area Metrics

Worse | Better | ~ Little or no < 5% difference

Housing Metrics				
Housing continuum	**2022**	**2023**	**2024**	**Change**
Number of emergency shelter beds	**80**	**80**	**80**	~
Number of individuals who are homeless that transitioned to permanent housing	**101**	**54**	**37**	Worse
Number of individuals who are homeless	**143**	**164**	**181**	Worse

Housing cost burden[6]			
Percent of households spending 30% of income or more on housing, by annual income group, Lewis and Clark County			
Total (Renters and Owners)	**2013-2017**	**2018-2022**	**Change**
$20K or less	**77%**	**89%**	Worse
$20K-$34,999	**51%**	**61%**	Worse
$35K-49,999	**35%**	**49%**	Worse
$50K-74,999	**17%**	**7%**	Better
$75K+	**2%**	**7%**	~
Renter-occupied only	**2013-2017**	**2018-2022**	**Change**
$20K or less	**81%**	**91%**	Worse
$20K-$34,999	**64%**	**77%**	Worse
$35K-49,999	**33%**	**47%**	Worse
$50K-74,999	**9%**	**14%**	Worse
$75K+	**0%**	**3%**	~

Priority Area 1
Behavioral Health

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Root Causes of Behavioral Health Concerns

The 2024 CHA identified behavioral health as a critical and growing concern in our community. CHIP participants were asked to use their expertise and experience to identify root causes of behavioral concern in our community.

A culture of isolation and independence, including distrust of government and the medical establishment.

Increasing financial pressures and stress as the cost of living rises, individuals are more socially isolated and our social safety net frays.

Alcohol, tobacco and marijuana are more accessible and affordable than healthcare.

The rise of cell phones contributes to loneliness and social isolation.

Disconnected, underfunded and understaffed systems of care with excessive red tape.

Almost no state or local investment in prevention.

Fragile system of Medicaid coverage that many providers do not accept and whose reimbursement rates do not always cover the cost of care.

Access to lethal means including guns and opioids.

Policy makers disconnected from the people that the policies are meant for.

Vision

CHIP participants developed a shared vision for a community that supports mental wellness and reduces substance misuse and abuse.

Every community member engaging in **safe and healthy relationships**, free from violence, substance misuse and toxic stress.

Behavioral healthcare that is fully accessible when and where it is needed, without stigma.

A community characterized by **trust, connectedness, and resilience.**

Assets and Resources

Mental Health and Substance Use Services in Lewis and Clark County

***This list is not exauhstive, but serves as a broad inventory of resources available in our community.**

Prevention and Awareness

- Question Persuade Refer (QPR), Suicide Safe Care, ASIST, Mental Health First Aid (MHFA), and Youth Mental Health First Aid (YMHFA) trainings for the community
- Adverse Childhood Experiences (ACE) training in faith-based settings, first responders, and other workforce settings
- Signs of Suicide, Youth Aware of Mental Health (YAM), and other youth trainings in the schools
- Naloxone training and master training
- NAMI classes and other support groups

Crisis Services

- MT 988 Suicide Prevention and Mental Health Crisis Lifeline
- St. Peter's Health (SPH) Mobile Crisis Response Team (MCRT)
- Law Enforcement: Helena Police Department, Lewis and Clark County Sheriff's Office trained in crisis intervention
- Veterans Services Crisis Line: Call or text 988, then press "1"
- Crisis Receiving and Stabilization Facilities: SPH Emergency Room, Journey Home to re-open in 2025

Outpatient Services

- Many Rivers Whole Health, Private providers, PureView Health Center, Helena Indian Alliance, Montana Telepsych Solutions
- Integrated Behavioral Health: PureView, Helena Indian Alliance (HIA), SPH outpatient, Helena OB/GYN, Shodair, Pretrial Services, Specialty Treatment Courts, Felony Drug Treatment Court, Mental Health Court

Youth Services

- Outpatient services: AWARE, Yellowstone Boys and Girls Ranch, Shodair, Intermountain, Charlie Health
- Day Treatment Programs: Many Rivers Whole Health, Intermountain, Shodair
- School Services: Comprehensive School and Community Treatment (CSCT), School Counseling (AWARE, Intermountain, Shodair, Pureview)

Residential and Inpatient Services

- Inpatient youth services: Shodair acute and residential treatment
- Acute inpatient services: SPH Behavioral Health Unit, State Hospital, Veterans' Services
- Residential SUD: Boyd Andrews, YWCA, Florence Crittenton, Instar Community Services (Hannon House), Salvation Army
- Youth Therapeutic Group Homes: Intermountain, Youth Dynamics
- Behavioral Health Group Home: Many Rivers Whole Health Sleeping Giant Group Home

Community Support and Recovery Services

- Peer Support Services: Boyd Andrew, Many Rivers Whole Health, Our Place, Good Samaritan Ministries, Instar, PureView Health Center, V.A.
- Respite care services: Rocky Mountain Development Council and Spring Meadow Resources' Developmentally Delayed/SDMI Services
- Support groups: AA, NA, NAMI (including family support), Holter Museum's Art for Survival

Suicide Postvention

- LOSS Team Suicide Postvention (Suicide Prevention Coalition)
- 'Breathe' suicide bereavement support group

Behavioral Health CHIP Strategies and Leads

Behavioral Health Focus Area 1 **1.1 Mental Health Promotion and Suicide Prevention**	
STRATEGY	**LEAD**
1.1.1 Outreach and engagement to promote suicide prevention and safe storage to community organizations ranging from public schools, colleges, food banks, and gathering places.	Safer Communities MT, Suicide Prevention Coalition
1.1.2 Increase availability and awareness of safe storage options for guns and prescriptions.	Suicide Prevention Coalition, Safer Communities MT
1.1.3 Increase awareness of 211 resource line and 988 crisis line for self -referral for behavioral health and crisis responder.	Safer Communities MT, Suicide Prevention Coalition, Local Advisory Council, UWLCA
1.1.4 Host and promote community events to spread awareness and prevention items.	Safer Communities MT
1.1.5 Distribute prevention items (988 information, lethal means prevention, substance use harm reduction) to community partners.	Safer Communities MT, suicide prevention and crisis coalitions, Local Advisory Council, Strong Roots Coalition
1.1.6 Provide training and increase available trainers for evidence-based prevention curriculum and tools in community, including schools, social service organizations, businesses, county partners, medical and behavioral health providers (e.g. ASIST, QPR, Safety Planning).	Suicide Prevention Coalition, St. Peter's Health
1.1.7 Resource the Mobile Crisis Team with secondary prevention resources and supports.	Safer Communities MT, Suicide Prevention Coalition
1.1.8 Research and create implementation plan for strategies to increase social connectedness.	Lewis and Clark Public Health, St. Peter's Health
1.1.9 Hold educational and informational meetings for policy makers and advocating for suicide prevention policy.	Safer Communities MT, Suicide Prevention Coalition

Behavioral Health Focus Area 2

1.2 Substance Use Prevention

STRATEGY	LEAD
1.2.1 Research and implement initiatives to reduce stigma.	Strong Roots Coalition
1.2.2 Raise awareness and availability of harm reduction solutions in the county.	Strong Roots Coalition
1.2.3 Support and promote early prevention in schools and the community.	Strong Roots Coalition
1.2.4 Investigate other sources of funding including a drug free communities grant.	Strong Roots Coalition
1.2.5 Host and promote fun, free, family friendly sober activities.	Strong Roots Coalition
1.2.6 Continue to strengthen the Strong Roots Coalition efforts.	Strong Roots Coalition

Behavioral Health Focus Area 3

1.3 Behavioral Health Crisis and Continuum of Care

STRATEGY	LEAD
1.3.1 Increase number and types of behavioral health providers.	Lewis and Clark Public Health, Substance Misuse Coalition, Connect Referral System, Local Advisory Council, PureView, St. Peter's Health, Helena Indian Alliance Providers, DPHHS
1.3.2 Increase knowledge of and access to services in rural communities including: • Expanding the Mobile Crisis Response Team's ability to provide telehealth services • Supporting the PureView mobile van • Crisis Facility • Promoting Many Rivers Whole Health satellite offices • Increasing access to telehealth and other care enhancing technologies	Mobile Crisis Response Team Community Coalition, Strong Roots Coalition, Local Advisory Council, PureView, Many Rivers Whole Health

Behavioral Health Focus Area 3 continued

1.3 Behavioral Health Crisis and Continuum of Care

STRATEGY	LEAD
1.3.3 Support provider mapping, including mapping capacity and need for detox facilities and residential group homes.	Lewis and Clark Public Health, Strong Roots Coalition, Local Advisory Council, JG Research & Evaluation
1.3.4 Develop more transition options such as detox facilities, a crisis facility, group homes and memory care.	Lewis and Clark Behavioral Health Systems Improvement Leadership, Local Advisory Council, Crisis Coalitions, Behavioral Health Providers
1.3.5 Increase access to Medication Assisted Treatment (MAT) for SUD.	Strong Roots Coalition, Local Advisory Council, Behavioral Health Providers
1.3.6 Increase the interaction and communication between providers, including optimizing the use of the Connect referral system and other resource databases and referral tools.	Lewis and Clark Public Health Behavioral Health and Prevention Team, Strong Roots Coalition, St. Peter's Health
1.3.7 Phase development of the Journey Home Crisis Receiving and/or Stabilization Facility.	Many Rivers Whole Health, Lewis and Clark Public Health Behavioral Health, Crisis Facility Community Coalition
1.3.8 Create a collaborative discharge planning Team and Policy and identify a data system to share accessible discharge information.	St. Peter's Health Behavioral Health Unit, Many Rivers Whole Health, Montana State Hospital, Detention Center, Local Advisory Council, Mobile Crisis Response Team, Connect Referral System, Shodair
1.3.9 Utilize peer support staff for continuum of care follow-up support.	St. Peter's Health Behavioral Health Unit, Mobile Crisis Response Team, Montana State Hospital, Detention Center, Local Advisory Council, Crisis Facility, Lewis and Clark Behavioral Health

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Priority Area 2
CHRONIC DISEASE

Root Causes of Chronic Disease

The CHA identified chronic disease as a significant cause of morbidity and mortality in our population. CHIP participants were asked to use their expertise and experience to identify root causes of chronic diseases in our community.

High food prices, especially for healthy, unprocessed food

Lack of access to free, year-round spaces for physical activity, including for children

Increased rates of stress, depression, and substance use

Lack of insurance, investment in prevention and universal screening, access to care coordination, and stigma related to asking for help

Vision

CHIP participants developed a shared vision for improved health and physical wellness in our community.

A community where **all people have what they need to live an active and healthy lifestyle**, including affordable and nutritious food, accessible opportunities for physical activity, and routine, preventative healthcare.

Assets and Resources

Coalitions addressing Chronic Disease in Lewis and Clark County

- Aging Well Workgroup
- Early Childhood Coalition
- Elevate MT (Helena Affiliate)
- Harvest of the Month Program
- Healthy Communities Coalition
- Helena School District Wellness Committee
- Helena Regional Sports Association
- Kids Hunger Coalition
- Lewis and Clark Public Health's Regional Cancer Screening Program
- St. Peter's Health Improvement Coalition
- Youth Connections

Chronic Disease CHIP Strategies and Leads

Chronic Disease Focus Area 1

2.1 Make the Healthy Choice the Easy Choice

STRATEGY	LEAD
2.1.1 Continue Harvest of the Month programming in the community.	St. Peter's Health
2.1.2 Work toward achieving county-wide age-friendly designation.	Lewis and Clark Public Health and Aging Well Workgroup
2.1.3 Assess and expand transportation options, especially for seniors.	Rocky Mountain Development Council
2.1.4 Increase access to healthy lifestyle programs.	Aging Well Workgroup – Fall Prevention Training
2.1.5 Host free, family-friendly community wellness events throughout the year such as the Helena Fun Fest.	St. Peter's Health
2.1.6 Support wellness activities for youth, including school funding, nutrition education, and opportunities for physical activities and wellness.	District Wellness Committee
2.1.7 Promote and expand SNAP (Supplemental Nutrition Assistance Program) education and Senior Famer's Market Vouchers.	Lewis and Clark Public Health
2.1.8 Support free community activities that promote active transportation such as bike and walk to school days, bike rodeos and active transport to work events.	Bike Walk Montana

Chronic Disease Focus Area 2

2.2 Access to Screening, Preventative Care and Care Management

STRATEGY	LEAD
2.2.1 Continue and expand use of the Connect Referral System at St. Peter's Health.	Lewis and Clark Public Health, St. Peter's Health
2.2.2 Strengthen the Chronic Care Managers team (part of the Complex Care Team) with personalized care plans, medication coordination, lifestyle coaching, and regular follow-ups.	St. Peter's Health
2.2.3 Establish more mobile mammography events.	Lewis and Clark Public Health, Intermountain Health/St. James Hospital
2.2.4 Expand reach and impact of mobile outreach van and chronic disease support, especially in rural areas.	Lewis and Clark Public Health, PureView
2.2.5 Engage RNs working in acute care to educate on prevention and connect patients to community supports through discharge planning.	St. Peter's Health

Chronic Disease Focus Area 3

2.3 Partnerships and Advocacy

STRATEGY	LEAD
2.3.1 Advocate for national and state Medicaid and Medicare access and reimbursement.	Confluence, American Public Health Association
2.3.2 Share opportunities for ongoing education for policy makers.	Healthy Communities Coalition
2.3.4 Continue Early Childhood Coalition's work.	Early Childhood Collaborative, St. Peter's Health
2.3.5 Ensure coalitions and collaboratives align and communicate regularly.	Healthy Communities Coalition

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Priority Area 3
HOUSING

Root Causes of the Housing Crisis

A lack of affordable and safe housing is a growing concern in our community. In the last five years, median home values in Lewis and Clark County **increased by 50%**, accelerating the crisis of affordability and access.[6] CHIP participants were asked to use their expertise and experience to identify root causes of the housing crisis in our community.

As our community grows, **housing demand outpaces housing supply.** There are not enough units in general, especially affordable units. The incentives and workforce needed to build affordable homes are lacking.

The **gap between wages and cost of housing** continues to widen, while the cost of building materials rises.

As unstably housed individuals spend a higher percentage of their income on housing, homelessness increases, and those who remain housed **struggle to meet other basic needs and face mounting levels of stress and economic pressure**.

The 2024 Continuum of Care Evaluation showed need for improved services across local Access Points for persons seeking housing:

- Improved Training for Access Point Facilitators
- Streamlining Services and shared info across Access Points
- Seeking partnership with local shelter, a key missing partner

Vision

CHIP participants developed a shared vision for a community where housing is a health priority.

- **Secure, consistent and affordable housing** in a safe neighborhood for every person.
- A community that champions **humane housing for all.**

Assets and Resources

Organizations and programs providing housing services in Lewis and Clark County:

- AWARE
- Broadwater Village
- Family Promise
- Firetower Apartments
- Florence Crittenton Family Services
- Freedom's Path
- Friendship Center
- FUSE (St. Peter's Health)
- Good Samaritan Ministries
- Guardian Apartments
- Habitat for Humanity
- Hannon House
- Helena Housing Authority
- Many Rivers Whole Health
- Rocky Mountain Development Council, Inc. (Rocky)
- Queen City Estates
- Salvation Army
- United Way
- Veteran's Affairs (VA)
- Volunteers of America (VOA)
- Youth Homes
- Youth Dynamics, Inc.
- YWCA

Partnership, policy and funding assets and resources:

- Continuum of Care – Managed by United Way of the Lewis and Clark Area
- City and County have passed pro-development policies such as allowing Accessory Dwelling Units (ADUs) and multi-family housing in the city limits
- City holds an $1 million Affordable Housing Trust Fund
- City is not tied to single family zoning laws
- State is currently considering providing funds in State Housing Fund

Housing Focus Area 1

3.1 Continuum of Housing Supports

STRATEGY	LEAD
3.1.1 Find funding for Housing Navigator position and other prioritized housing related positions as identified by Move the Dial Task Force led by the UWLCA.	Move the Dial Task Force
3.1.2 Fund additional shelter facilities and beds	All shelter facilities and Move the Dial Task Force
3.1.3 Support renovation and maintenance of existing building and low-income housing to maintain stock.	Move the Dial Task Force
3.1.4 Seek out emergency and other funding to prevent loss of housing for those unstably or precariously housed.	Move the Dial Task Force
3.1.5 Establish a formal Supportive Housing Program.	United Way of the Lewis and Clark Area
3.1.6 Study options for the development of senior and multi-generational housing.	Move the Dial Task Force
3.1.7 Support ongoing Peer Support programs, Independent Living, Good Neighbors United, and other programs designed to keep persons housed.	Good Samaritan Ministries, United Way of the Lewis and Clark Area
3.1.8 Expand the FUSE program.	St. Peter's Health
3.1.9 Support re-development of Helena Housing Authority Properties.	Helena Housing Authority
3.1.10 Incentivize and educate landlords to accept housing vouchers.	Helena Housing Authority

Housing Focus Area 2
3.2 Policy and Advocacy

STRATEGY	LEAD
3.2.1 Develop a community awareness campaign and hold Town Hall meetings to inform and listen.	United Way of the Lewis and Clark Area
3.2.2 Develop ongoing education and communication for renters, advocates, business owners and other stakeholders.	Move the Dial Task Force
3.2.3 Advocate for state housing funding for affordable rental development, rental preservation and 1st time home buyers.	Move the Dial Task Force, Rocky Mountain Development Council
3.2.4 Finish Senate Bill 382 implementation with Montana Land Use and Planning Act.	City of Helena
3.2.5 Promote state legislation to fund state housing trust fund- Senate Bill 405.	Community advocates
3.2.6 Encourage Inclusive policies to insure accessibility to those with criminal records, behavioral health issues and a history of evictions.	Move the Dial Task Force
3.2.7 Increase federal fair market rent rate for Montana.	Montana Department of Commerce
3.2.8 Develop and implement a “How to build an ADU” training for homeowners along with education for homeowners about the benefits of and policies supporting ADU development.	City of Helena

Housing Focus Area 3
Housing Capacity, Data Collection and Partnerships

STRATEGY	LEAD
3.3.1 Re-Engage a “Move the Dial” Task Force of Public, Non Profit, Government, Business, Contractors, and lenders to set focus for a clear path forward.	United Way of the Lewis and Clark Area, City County Chamber
3.3.2 Begin the process of conducting a new Housing Needs Assessment Survey for 2026.	Move the Dial Task Force
3.3.3 Increase ongoing communication between Nonprofits, Government, public and private Sector.	Move the Dial Task Force

Conclusion

Through the CHIP process, community partners identify pressing health challenges that must to be collectively addressed to improve the health of our community—challenges like increasing costs in housing, high suicide rates and substance use, barriers to healthcare access, and disparities in the vital conditions for well-being.

The CHA and CHIP processes also identified incredible strengths: the resilience of our neighbors, the collaboration of organizations, and the shared belief that every person deserves to live in a community that supports their health and aspirations.

Over the next three years, established, multi-sectoral coalitions and health partner leads will move the strategies outlined in this plan forward and monitor progress towards improving the conditions of for health in our community. Community members and partners in health, human services, education, and the private sector are invited to join these efforts to transform our community systems and advocate for policies that support the health of all.

Let us move forward together with purpose, knowing that every effort we make brings us closer to a future where everyone—regardless of their circumstances—can thrive. This is not just our responsibility; it is our opportunity to leave a legacy of health, dignity, and opportunity for all.

In partnership and progress,

The Healthy Together Steering Committee

Healthy Together
A community partnership to improve health

References

Metrics and Trends

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