St. Peter's Health Implementation Strategy

Addressing the Community Health Needs Assessment (CHNA)
Fiscal Years 2022-2024

Background

The Treasury Department and the Internal Revenue Service (IRS) require not-for-profit hospital organizations to conduct a CHNA every three taxable years to meet the specifications set forth by Internal Revenue Code 501(r) of the Affordable Care Act (ACA) of 2010. Each hospital must also adopt an Implementation Strategy that addresses community health needs identified in the CHNA.

Development of this CHNA and Implementation Strategy was led by the St. Peter's Health (SPH) Population Health team with support from PRC Custom Research Consultants. Over 490 individuals within the Community Benefit Service Area (CBSA) participated in the effort through interviews, surveys, and small group discussions. The voices of key stakeholders including, but not limited to, independent and employed medical staff, educational institutions, other healthcare organizations, community not-for-profit organizations, business leaders, health

related associations, local task forces, elected officials, and faith-based organizations have helped inform SPH's CHNA and Implementation Strategy.

The Implementation Strategy must address each of the needs identified in the CHNA either by describing how SPH plans to take action to meet the need or by declaring why the need will not be an area of focus. Thus, SPH's CHNA Implementation Strategy line-items are tailored to its existing programs, resources, priorities, plans, and collaborations with partnering organizations.

The Communities We Serve

Located in Helena, SPH is the only full-service acute care facility in a five-county region of southwestern Montana including Lewis and Clark, Broadwater, Jefferson, Meagher and Powell Counties, which combined encompass 11,026 square miles with an estimated population of 100,000. SPH's CBSA is defined as 'rural' by several federal organizations: Office of Management and Budget; Federal Office of Health Policy; and U.S. Department of Agriculture.

As a not-for-profit, community-based health system, SPH provides general, specialty and emergency health care services for everyone, regardless of ability to pay, in a region where 10.2 percent of the population is considered to be in poverty, 27.4% of individuals live below 200% of the poverty level, and 7.9 percent of people under age 65 do not have health insurance.

2021 CHNA Findings

The 2021 CHNA report was based on several data inputs that were processed using epidemiological, qualitative, and comparative methods assessing health needs of the population relative to accessible services within SPH's CBSA. Heath needs identified in the 2021 CHNA include (in order of priority):

1. Mental health
2. Substance abuse
3. Nutrition, physical activity, and weight
4. Tobacco use
5. Diabetes
6. Potentially disabling conditions
7. Cancer

8. Heart disease and stroke

9. Injury and violence

10. Access to healthcare services

11. Respiratory disease

12. Kidney disease

Our Commitment to the Community

SPH's mission is "to improve the health, wellness and quality of life for the people and communities we serve." SPH is governed by a Board comprised of community members and has no shareholders to whom returns are distributed; all profits are reinvested in 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. Everything we do is to meet the health needs of the people we serve.

This Implementation Strategy represents a subset of the total portfolio of projects, programs, and partnerships that SPH is cultivating to meet health needs within its CBSA. The Action Plan items outlined below specifically address health needs identified in the 2021 CHNA. Furthermore, SPH has placed heavy emphasis on the top three health needs of the community: mental health, substance abuse, nutrition, physical activity, and weight as well as access to healthcare services.

SPH 2022 CHNA Implementation Strategy

#	Health Need	Target Population	Action Plan	Goal(s)	Partnering Organization(s)
1-1	Mental health	Patients in mental health crisis	Expand Mobile Crisis Response Team, adding tele-psych, and providing in-home mental health crisis care.	Reduce suicides, ED visits and incarceration rates for patients in mental health crisis. Build upon our community behavioral health crisis system. Decrease total cost of care (TCOC).	Frontier Psychiatry, Lewis & Clark County, Public Health, PureView FQHC, Lewis and Clark County Sherriff's Office

1-2	Mental health	Patients with severe depression, anxiety	Expand and enhance SPH integrated behavioral health (IBH), adding Collaborative Care Model behavioral health specialists.	Reduce depression and suicide rates. Expand access to specialized mental health support within SPH multidisciplinary primary and psychiatric care teams.	Lewis & Clark Medical Health Local Advisory Council and Suicide Prevention Coalition
1-3	Mental health	Mothers at risk of postpartum depression	Deploy Taking Care of You: A Parental Support Program including integrated behavioral health professional service on the SPH Women & Children's Unit.	Reduce and prevent post-partum depression. Reduce foster care. Identify and treat substance abuse issues. Improve referrals to depression treatment follow-up. Standardize maternal mental health protocols with independent community providers.	Maternal Mental Health Task Force, Mental and Social Wellbeing Workgroup, Early Childhood Coalition, Early Care and Education Task Force, Child Care Connections
1-4	Mental health	All patients at risk of suicide	Launch firearm safety program involving education and gun lock distribution.	Reduce suicide death by gun. Improve gun safety education and access to gun locks.	Safer Community Montana Leadership team, local firearms businesses, and pharmacies
1-5	Mental health	Patients in behavioral health crisis	Convert existing inpatient beds/rooms to deploy an EmPATH unit.	Improve care experience and outcomes for patients in mental health crises. Decrease mental health crisis patient time in ED.	Frontier Psychiatry, Lewis and Clark ED Physicians, funding partners pending.
1-6	Mental health	Community members at risk of suicide as well as primary care team members	National Suicide Prevention Month We Speak Mental Health Week of activities, education, and training.	Improve suicide awareness, screening, and prevention. Enhance provider awareness, skills, and resources. Standardize mental health care protocols with community partners.	National Alliance on Mental Illness, National Alliance on Mental Illness, local mental health practitioners

1-7	Mental health	Patients admitted to the behavioral health unit.	Build a calming sensory room in the SPH behavioral health unit.	Enhance patient experience while admitted on the unit.	Internal initiative
2-2	Substance abuse	Patients who abuse substances	Expand and enhance addiction medicine service line.	Add substance abuse specialty providers.	Internal initiative
2-2	Substance abuse	Patients at risk of or currently abusing substances	Implement universal screening abuse screening protocols throughout SPH's continuum of care.	Increase rates of patients screened using AUDIT-C and referred to addiction recovery services.	Child and Family Services
2-3	Substance abuse	Patients with substance abuse issues involving law enforcement	Join and participate in the Rural Addiction Implementation Network (RAIN).	Reduce ED visits and incarceration rates for patients experiencing substance abuse related issues.	Helena Police Department, Lewis and Clark County Detention Center and Sheriff's Office, University of Utah
2-4	Substance abuse	Parents of children suffering from substance abuse	Deploy Taking Care of You: a support program for parents of kids suffering from substance abuse.	Improve parental awareness and skills to identify and deal with substance abuse and suicide related issues.	Child and Family Services
2-5	Substance abuse	Community members who should dispose unused controlled substances	Implement Deterra Drug Deactivation systems throughout ambulatory clinics.	Decrease controlled substance diversion. Improve drug disposal safety.	Safer Communities Montana
3-1	Nutrition, physical activity, weight	Patients with food insecurity	Implement a food delivery program, Food is Care.	Reduce food insecurity, improve nutrition status for enrolled patients.	Helena Food Share

3-2	Nutrition, physical activity, weight	Children attending community elementary schools and their parents	Implement a healthy eating education program, Harvest of the Month.	Improve elementary child education on healthy nutrition. Enhance parenting skills for school preparedness. Improve school lunch menus.	Helena School District, Lewis and Clark County Kids Hunger Coalition, Montana Farm to School, National Center for Appropriate Technology, County SNAP-ED, Head Start, Helena Food Share
3-3	Nutrition, physical activity, weight	Obese and overweight patients	Deploy new weight management service line.	Reduce obesity rates. Expand access to specialty weight loss services.	Internal initiative
3-4	Nutrition, physical activity, weight	Any interested patient in the community	Deploy Carroll College Health Village.	Enhance access to nutrition, exercise, mental health, and education experiences within an engaging multi-disciplinary primary care & education center.	Carroll College
3-5	Nutrition, physical activity, weight	Patients at risk of developing chronic disease	Expand Inch-by-Inch program access and enrollment.	Participant weight reduction, lifestyle improvement. Improved prevention of chronic disease.	Montana Department of Public Health and Human Services
3-6	Nutrition, physical activity, weight	Patients with food insecurity as well as chronic disease	Pilot a Food Farmacy program	Reduce food insecurity. Improve access to health food options for people chronic disease.	Helena Food Share, Montana Department of Health and Human Services
4-1	Tobacco use	All patients	Implement universal tobacco screening throughout SPH clinics.	Improve screening rates. Improve tobacco cessation program referrals.	Internal initiative
4-2	Tobacco use	Patients who use tobacco	Implement the Freedom From	Reduce tobacco use rates. Optimize rate of course completion.	Montana Department of

			Smoking education program		Public Health and Human Services
5-1	Diabetes	Patients seen in the ED or admitted to the hospital with uncontrolled diabetes	Deploy an in-home diabetes care protocol including remote blood glucose monitoring.	Improve diabetes outcomes. Reduce ED visits and inpatient admissions for uncontrolled diabetes.	Partners pending
5-2	Diabetes	Patients with diabetes	Implement Diabetes Self-Management Education and Support virtual program.	Improve diabetes outcomes.	Montana Department of Health and Human Services
6-1	Potentially disabling conditions	Patients with moderate to severe arthritis at risk of falls	Implement arthritis movement class.	Reduce falls, improve mobility and function for patients with debilitating arthritis.	Montana Department of Public Health and Human Services
6-2	Potentially disabling conditions	Patients at risk for osteoporosis	Deploy osteoporosis screening and treatment protocols.	Improve osteoporosis screening rate. Increase rates of appropriate treatment for patients diagnosed with osteoporosis.	Internal initiative
6-3	Potentially disabling conditions	Patients diagnosed with osteoporosis	Implement best practice osteoporosis protocol.	Improve osteoporosis screening. Standardize treatment protocols in. multiple clinic sites.	Internal initiative
7-1	Cancer	Patients receiving cancer care at SPH	Affiliate with Huntsman Cancer Institute.	SPH care teams implementing best practice protocols. Improve access to sub-specialist support. Keep cancer care local. Improve oncology care outcomes.	Huntsman Cancer Institute, University of Utah

7-2	Cancer	Patients receiving primary care services at SPH.	Execute quarterly cancer screening outreach campaigns	Improve screening rates for targeted cancer types, and optimize referrals for recommended follow-up	Cancer Support Community Montana
7-3	Cancer	All patients who meet screening standards	Community education & engagement events. All cancers.	Improve screening, prevention, early identification, and improved mortality rates.	Carroll College, Montana Cancer Coalition
8-1	Heart disease and stroke	Patients with CHF exacerbation	Deploy CHF in-home care protocol.	Reduce length of stay, readmissions, and ED visits for CHF exacerbation.	Partners pending
8-2	Heart disease and stroke	Patients seen in the ED with stroke.	Deploy tele-stroke services in the ED.	Reduce time to intervention with acute stroke. Reduce hospital transfers for stroke.	University of Utah, Lewis and Clark ED Physicians
8-3	Heart disease and stroke	Patients at risk of or are diagnosed with hypertension	Implement evidence-based care protocol and medical technology upgrade.	Improve blood pressure screening rates. Prevent advancement of hypertension.	Internal initiative
8-4	Heart disease and stroke	Patients with new diagnosis or uncontrolled hypertension	Implement Health Coaches for Hypertension educational course.	Improve patient engagement and self-management of hypertension. Improve hypertension outcomes.	Montana Department of Health and Human Services
9-1	Injury and violence	Patients at high risk of falls	Implement Stepping On therapy program.	Reduce rate of falls. Optimize referrals to the program.	Internal initiative
9-2	Injury and violence	Patients who have been sexually assaulted	Implement Sexual Assault Nurse Examiner (SANE) program.	Improve service outcomes including quality of evidence	Internal initiative

				collection and patient experience.	
9-3	Injury and violence	SPH staff across work settings	Implement Workplace Violence Prevention Taskforce	Reduce workplace violence events. Increase education and training. Improve support for victims.	Local law enforcement partners pending
10-1	Access to healthcare services	All community members	Conduct community-wide medical staff development process.	Assess medical staff needs of the community. Partner with independent providers to collaboratively update medical staff recruitment plans to meet community health needs.	ECG consultants
10-2	Access to healthcare services	All patients in need of specialty care	Expand telemedicine service lines: psychiatry, stroke, and acute neurology.	Increase access to these specialties, particularly during non-business hours. Improve speed to care. Reduce transfers for these conditions.	University of Utah, Frontier Psychiatry
10-3	Access to healthcare services	All patients with urgent or emergent healthcare needs	Implement virtual on-demand care with SPH providers.	Improve access to immediate virtual care. Decrease unnecessary ED visits.	Partner pending
10-4	Access to healthcare services	Homebound patients who need medical attention	Expand and enhance community paramedic program, including virtual provider visits.	Decrease LOS, readmissions, unnecessary ED visits, and hospitalizations. Decrease TCOC.	HRSA
10-5	Access to healthcare services	All patient populations served at SPH	Implement best in class population health, care management,	Improve healthcare equity and attention to social determinants of health. Improve all	Intermountain – SCL Health

			patient engagement technology (Innovaccer).	preventive and chronic disease clinical quality metrics. Improve utilization metrics. Decrease cost of care.	
10-6	Access to healthcare services	Patients living in public supported housing who utilize the most healthcare resources	Launch community-wide Frequent Users Systems Engagement (FUSE) initiative.	Convene and administer the initiative. Employ community health workers (CHW) to attend high-risk social determinant needs of a targeted patient population. Decrease utilization and TCOC. Improve insurance coverage rates.	Montana Healthcare Foundation, Helena Housing Authority, United Way,
10-7	Access to healthcare services	Patients who we are able to care for at home as opposed to in the hospital	Implement an in-home care delivery and remote monitoring program.	Decrease length of stay and readmissions. Decrease unnecessary ED and hospital visits. Decrease TCOC. Create a new level of in-home care delivery access.	Partners pending
11-1	Respiratory disease	Patients with COPD who smoke	Implement Freedom from Smoking program.	Enhance community access to best practice tobacco cessation care (medication and counseling). Reduce rates of tobacco abuse.	Montana Quitline, American Lung Association, Rocky Mountain Development Center
11-2	Respiratory disease	Patients with COPD and/or pneumonia (including COVID-19)	Deploy in-home care protocols for COPD and pneumonia.	Reduce readmissions and length of stay for patients admitted to the hospital for COPD or pneumonia.	Partners pending

11-3	Respiratory disease	All community members	Sponsor and operate new vaccine clinics.	Improve vaccination rates, particularly COVID-19.	PureView FQHC, Lewis and Clark County Public Health
12-1	Kidney disease	Community members on dialysis	Expand and enhance home dialysis services.	Acquire and deploy new Tablo home dialysis machines. Increase percentage of patients on home dialysis (vs. in facility).	St. Peter's Health Foundation
12-2	Kidney disease	Community members on dialysis	Expand home dialysis services to regions in SPH's secondary service area.	Enhance patient quality of life and ease of access to dialysis. Decrease cost of dialysis services. Improve end of life care for patients on dialysis. Increase transplant rate to prevent need for dialysis.	Partnerships pending