IMPLEMENTATION PLAN

Addressing Community Health Needs

**St. Luke Community Healthcare ~ Ronan, Montana**

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# The Implementation Planning Process

The implementation planning committee – comprised of St. Luke Community Healthcare’s leadership team– participated in an implementation planning process to systematically and thoughtfully respond to all issues and opportunities identified through the Community Health Services Development (CHSD) needs assessment process. The facility conducted the CHSD process in conjunction with the Montana Office of Rural Health (MORH).

The CHSD community health needs assessment was performed in 2023 to determine the most important health needs and opportunities for Lake and Sander’s Counties, Montana. “Needs” were identified as the top issues or opportunities rated by respondents during the CHSD survey process or during focus groups. For more information regarding the needs identified, as well as the assessment process/approach/methodology, please refer to the facility’s assessment report, which is posted on the facility’s website.

The implementation planning committee identified the most important health needs to be addressed by reviewing the CHNA, secondary data, community demographics, and input from representatives representing the broad interest of the community, including those with public health expertise.

The implementation planning committee determined which needs or opportunities could be addressed considering St. Luke Community Healthcare’s parameters of resources and limitations. The committee then prioritized the needs/opportunities using the additional parameters of the organizational vision, mission, and values, as well as existing and potential community partners. Participants then created a goal to achieve through strategies and activities, as well as the general approach to meeting the stated goal (i.e. staff member responsibilities, timeline, potential community partners, anticipated impact(s), and performance/evaluation measures).

The prioritized health needs as determined through the assessment process and which the facility will be addressing relates to the following healthcare issues:

1. Illegal Drug Use
2. Alcohol Abuse/Disorders
3. Mental Health Issues
4. Weight Management

In addressing the aforementioned issues, St. Luke Community Healthcare seeks to:

1. Improve access to healthcare services;
2. Enhance the health of the community;
3. Advance medical or health knowledge;
4. Relieve or reduce the burden of government or other community efforts

**St. Luke Community Healthcare’s Mission:**

The mission of St. Luke Community Healthcare is to be an integral component of the communities of the Mission Valley through the delivery of personal, compassionate, quality healthcare in a dignified manner that values our patients, clients and residents who are the very reason for our existence.

**St. Luke Community Healthcare’s Vision:**

Be THE pre-eminent healthcare provider in the Mission Valley Delivering:
 - Excellent Quality Care
 - Exceptional Customer Service
 - A patient centered approach to health care
 - Leadership in rural clinical education
 - A safe, positive work environment
 - Growth through innovation and investment in state of the art technology
 - Striving to listen and respond to the needs expressed by the community ensuring true community ownership.

St. Luke Community Healthcare epitomizes what a community healthcare organization symbolizes by listening to and responding to what the community wants. By doing this it gives the community true ownership.

**Implementation Planning Committee Members:**

* Steve Todd – CEO
* Joel Onsager – CFO
* Edred Vizcarra, M.D. - Chief of Staff-Physician
* Abigail Byers, RN – ACF DON
* Whitney Liegakos – CE/PR/Marketing
* Liane Clairmont – Executive Assistant
* Katie Harding- QI Manager

# Prioritizing the Community Health Needs

The implementation planning committee completed the following to prioritize the community health needs:

* Reviewed the facility’s presence in the community (i.e. activities already being done to address community need)
* Considered organizations outside of the facility which may serve as collaborators in executing the facility’s implementation plan
* Assessed the health indicators of the community through available secondary data
* Evaluated the feedback received from consultations with those representing the community’s interests, including public health

## St. Luke Community Healthcare’s Existing Presence in the Community

* St. Luke Community Healthcare offers childbirth classes throughout the year.
* Diabetes education classes are provided at the St. Luke Community Healthcare.
* St. Luke helps coordinate and actively participates in County Emergency Preparedness.
* St. Luke provides CNA classes where students earn an income while learning in the classroom as well as real-life settings.
* St. Luke Community Healthcare contracts with Montana Breast and Cervical Program to provide women’s health services to uninsured and underinsured women.
* St. Luke Community Healthcare provides health and wellness screenings at numerous community events including but not limited to, The Women 4 Wellness Expo, The Lake County Employee Health Fair, The Ronan Schools Kindergarten Round-up, and Tribal Early Childhood Services Baby Fair.
* St. Luke Community Healthcare provides First-aid stations for community events such as The Pioneer Days 3-on-3 JAM-Boree in Ronan and The Mission Valley Cruizers Car Show in Polson.
* Free CPR/First-Aid classes are open to the public.
* St. Luke provides tobacco education including displays during the Great American Smoke-out.
* St. Luke provides nurse on-call phone services.
* St. Luke is involved with the Friends of Regional Parks and Trails (FORPAT). FORPAT assists with trails and other outdoor activities in the Community. Signage is placed on the trails with wellness tips for the users.
* St. Luke provides financial support for the Flathead Reservation Boys and Girls Club, alcohol-free senior nights for local schools, as well as Safe Harbor domestic violence agency.
* St. Luke participates with local schools by talking about healthcare careers, providing a job shadow program, and encouraging middle school and high school students to consider health related careers with R.E.A.C.H. (Research and Explore Awesome Careers in Healthcare), a program of the Western Montana Area Health Education Center.
* St. Luke collaborates with the Salish Kootenai College nursing program to provide clinical rotations where students are paired with an RN for an entire semester.
* St. Luke collaborates with Montana State University nursing program to provide rotations to their students.
* St. Luke collaborates with Carroll College nursing program to provide rotations to their students.
* St. Luke participates in the Western Regional Trauma Advisory Council.
* St. Luke offers active intern programs in pharmacy, occupational therapy, speech therapy, medical assistants, certified nursing assistants, business office, lab, physical therapy, respiratory therapy, imaging, and clinical rotations for residents and medical students.
* St. Luke publishes an informational Heart to Heart newsletter regularly throughout the year. This publication is sent to all addresses in the Community. St. Luke also uses social media on a weekly basis to keep the community informed of health issues etc.
* St. Luke participates in the annual Job Service sponsored career fair
* St. Luke sponsors many events, including: The Annual St. Ignatius Good Old Days Buffalo Run, Ronan Pioneer Days Run, and various Polson Running Club events.
* St. Luke provides meeting space for Alcoholics Anonymous (AA) and Al Anon. Safe Harbor is also provided meeting space for their abuse support group.
* St. Luke provides Health Screening Certificates as silent auction items for many non-profit fundraisers.
* St. Luke provides conference rooms for neurodegenerative disease support group.
* St. Luke shares information to the community regarding a variety of support groups.
* Safe Sleep
* Trauma Prevention
* Community Café stakeholder group for decreasing substance use
* Provided support for Lake County Public Health Department for Women’s Health and Medical Director
* Monthly awareness through social media platforms
* Bingo for Breast Health

## List of Available Community Partnerships and Facility Resources to Address Needs

* Boys and Girls Club of the Flathead Reservation and Lake County
* Montana DPHHS
* Cedar Creek Recovery Center
* Intermountain Healthcare – Telecrisis Intervention
* Meadowlark Initiative project.
* Confederated Salish & Kootenai Tribes (CSKT) - has various programs related to suicide, alcohol and substance abuse awareness and prevention.
* Journey To Wellness
* AA, ALANON, NA
* Local Schools
* Local Pharmacies
* Lake County Drug Task Force
* State and Tribal Child Protective Services (CPS)
* Montana AHEC program
* HOSA- Health Occupation Students of America
* Post-secondary educational institutions- various academic programs with students seeking clinical rotations (Medical, PA, RT, OT, Lab, Nursing, etc.).
* Bread Basket – Ronan Food Bank
* Polson Fishes and Loaves Food Bank
* Mission Valley Food Pantry
* 4H
* Senior Center
* Food Corps
* 3RNet is the National Rural Recruitment and Retention Network.
* Al-Anon are weekly group meetings for family and friends of alcoholics.
* Alcoholics Anonymous (AA) is a group meeting that provides support and focuses on awareness for community members affected by alcohol abuse.
* Montana Food Growers Food Coop - Community Sustained Agriculture (CSA) provides community members with access to fresh fruits and vegetables.
* Care Coordinator and Care Navigator positions offer education, case management, and post-discharge follow-up to improve health outcomes for community members with chronic diseases.
* The Centers for Medicare & Medicaid Services (CMS) administers Medicare, Medicaid, and Healthy Montana Kids.
* Community Medical Center and St. Patrick Hospital in Missoula along with Logan Health Care in Kalispell provide health care specialty services to the region.
* Department of Health and Human Services Telestroke Program links Critical Access Hospitals to stroke specialists via a 2-way audio/video connection. TeleNICU and TeleCardiolgy services are also offered at St. Luke through collaboration with other providers and facilities in Kalispell and Missoula.
* Safe Harbor is a domestic violence prevention agency and safe home location.
* Family Medicine Residency of Western Montana is a three-year family medicine program sponsored by The University of Montana and affiliated with the University of Washington Family Medicine Residency Network.
* Fetal, Infant and Child Mortality Review (FICMR) is a statewide effort to reduce preventable fetal, infant and child deaths.
* The Health Information Exchange of Montana (HIEM) supports secure exchange of health information in Montana.
* Indian Health Services (IHS) and Tribal Health provide health services to tribal and native populations.
* Logan Health in Kalispell, St. Patrick Hospital in Missoula and Community Medical Center in Missoula provide healthcare resources and support.
* Lake County Council on Aging an Area VI Agency on Aging provides geriatric care management services for seniors.
* Lake County Child and Family Services provides services to families in need.
* Lake County Public Health is located in Polson, MT and provides services to protect and improve the community’s health.
* Lake County Sheriff’s Department, Tribal Police and local city police departments enforce the law and promote safety to the people of Lake County.
* Monida Healthcare Network connects healthcare providers.
* Montana Office of Rural Health & Area Health Education Center (MORH/AHEC) provides technical assistance to rural health systems and organizations.
* DPHHS/MSU/Billings Clinic perinatal quality collaborative (MOMS)
* Montana State University Lake County Extension provides educational outreach to Lake County residents in Montana.
* Pacific Northwest University for Health Sciences is a medical school in Yakima, WA that provides medical education to students from rural or underserved areas throughout the United States.
* A partnership with the University of Washington School of Medicine and the states of Washington, Wyoming, Alaska, Montana, and Idaho (WWAMI). Forty-four years of collaboration and innovation, all in the service of educating the future physician workforce.
* The Performance Improvement Network (PIN) assists member facilities in their efforts to achieve compliance with the Medicare Critical Access Hospital (CAH) Conditions of Participation quality assurance regulations and also supports a multitude of other CAH quality improvement efforts.
* The Quality Improvement Organization of the Mountain Pacific Quality Health Organization works to improve the quality of health care and assures the most appropriate utilization of health care services.
* Ronan School District is available to provide opportunities to students interested in pursuing health careers.
* The Senior Center bus provides transportation for senior citizens.
* VA [Veteran’s Affairs] contract with St. Luke Extended Care.
* The VA bus provides transportation for veterans.
* DHRD – CSKT Transit - tribal transportation for all community members
* Western Regional Trauma Advisory Committee- resource related to trauma care.
* CSKT warming house

## Lake & Sanders Counties Indicators

Low Income Persons

* Lake: 19% of persons are below the federal poverty level (dataysa.io)

Sanders: 16.3% of persons are below the federal poverty level

Uninsured Persons

* Lake: 15.4% of adults less than age 65 are uninsured

Sanders: 12.3% of adults less than age 65 are uninsured

* Data is not available by county for uninsured children less than age 18

Leading Causes of Death: Primary and Chronic Diseases (Both Counties)

* Heart Disease
* Cancer
* Unintentional Injuries

\* Note: Other primary and chronic disease data is by region and thus difficult to decipher community need.

Elderly Populations

* 23% of Lake County’s Population is 65 years and older
* 31.9% of Sanders County’s Population is 65 years and older (data.census.gov)

Size of County and Remoteness

* 31,509 people in Lake County; 21.1 people per square mile
* 12,615 people in Sanders County; 4.5 people per square mile

Nearest Major Hospital

* St. Patrick Hospital in Missoula, MT is 56.8 miles from St. Luke Community Healthcare

# Needs Identified and Prioritized

## *Prioritized Needs to Address*

1. 54% of survey respondents rated their community “Somewhat healthy.” 22% rated their community as “Unhealthy” or “Very unhealthy.”
2. Top 5 identified health concerns identified by survey respondents were: illegal drug use (64.6%), Alcohol abuse (63.1%), mental health issues (30.0%), overweight/obesity (29.7%), and depression/anxiety (19.6%).
3. Affordable housing was identified as the top component of a healthy community.
4. 30% of survey respondents indicated they had experienced periods of mental health struggles in the last 12 months.
5. Top 3 ways identified to improve the community’s access to healthcare were: more primary care providers (29.7%), expanded mental health specialists (29.7%), and more specialists (21.4%).
6. 22% of survey respondents rated their knowledge of health services as “fair” or “poor.”
7. 33% of survey respondents indicated they or someone in their household did not receive or had to delay getting needed healthcare services.
8. Top reason identified for not receiving/delaying needed healthcare was due to it being “too long to wait for an appointment” (51.6%)

*Needs Unable to Address*

1. 35.3% of survey respondents indicated they did not receive/delayed getting needed medical services due to cost.
2. Survey respondents felt an important way to improve the health of the community was to address the amount of people living in poverty.
3. Additional clinics in more locations
4. Lack of affordable housing
5. Availability of affordable health insurance
6. Access to affordable and healthy food
7. Good jobs and healthy economy
8. Low crime and safe neighborhoods
9. Religious or spiritual values

# Executive Summary

The following summary briefly represents the goals and corresponding strategies and activities which the facility will execute to address the prioritized health needs. For more details regarding the approach and performance measures for each goal, please refer to the Implementation Plan Grid section, which begins on page 17.

**Goal 1:** Improve access to mental health services.

 **Strategy 1.1:** Behavioral health integration into clinic practice

**Activities:**

* + Continue developing LCSW behavioral health integration.
	+ Develop sustainability plan for behavioral health program.
	+ Explore additional grant funding.
	+ Research and discuss alternative payment model with existing payers.
	+ Determine FTE need and explore staff expansion (mental health, behavioral health, addiction counseling).
	+ Develop education plan for St. Luke staff and providers related to new referral processes and benefits.
	+ Develop marketing campaign for community to educate on program and benefits.

**Strategy 1.2**: Increase St. Luke’s efforts related to suicide awareness and prevention for staff and community.

**Activities:**

* + Explore educational offerings related to suicide awareness.
	+ St. Luke staff will continue to screen for suicide risk detection and prevention.
	+ Provide suicide risk/prevention training to St. Luke staff and offer to community as appropriate.
	+ Continue providing St. Luke representation on various community based efforts related to suicide prevention.
* Continue to promote and strengthen crisis intervention services with mental health providers.

**Goal 2:** Strengthen and enhance community outreach related to alcohol and substance abuse. Strengthen outreach and internal programs related to alcohol and substance abuse

**Strategy 2.1:** Continue to offer current alcohol and substance abuse programs and services.

**Activities:**

* + Continue to provide acute alcohol detox services.
	+ Continue LCSW (licensed clinical social worker, licensed addiction counselor- ensure we are providing these services) in the clinic setting.
	+ Continue providing meeting space and other support of community events and programs providing support and education related to drug and alcohol abuse (i.e.: Ronan Senior Night/Project Graduation, AA and ALANON, Chronic Pain).
	+ Continue partnership with local police department on prescription drug drop off box which allows community to safely dispose of unused/unneeded drugs.

**Strategy 2.2**: Explore opportunities to expand St. Luke’s alcohol and substance abuse related efforts.

**Activities:**

* + Medication Assisted Therapy Treatment
	+ Continuation of opiod safety protocols and program within the clinics
	+ Continue partnership with the local police department for prescription medication disposal program. Determine possible locations for additional drop off boxes.
	+ Continue marketing campaign to educate community on drop off resource(s).
	+ Develop educational materials to educate community on proper/safe storage of prescription medications.
	+ Explore partnership with local pharmacies to enhance safe storage message and delivery.
	+ Reach out to local schools to explore participating in and supporting local Red Ribbon efforts with community youth.
	+ Explore expanding partnerships with local organizations (ex. Boys and Girls Club of the Flathead Reservation and Lake County, others) to provide drug and alcohol prevention education.

**Goal 3:** Improve access to healthcare services.

**Strategy 3.1:** Improve access to specialty care services available at St. Luke Community Healthcare.

**Activities:**

* + Explore feasibility for expansion of other specialty services.
	+ Create marketing campaign related to new specialty services developed (Type of specialty services provided, provider bios, schedules, etc.)

**Strategy 3.2:** Improve access to existing services offered at St. Luke Community Healthcare.

**Activities:**

* + Conduct assessment of medical staff needs.
	+ Create medical staff development plan.
	+ Explore open access scheduling to reduce wait times for patients.
	+ Create educational campaign to enhance community understanding of when to access different levels of care (i.e. primary care vs. convenient care, vs. ED).
	+ Continue to research new approaches to increasing access to care (via: virtual visits, innovative care models).

**Strategy 3.3**: Improve patient engagement in improving and understanding health information.

**Activities:**

* + Review and improve program to assist patients in enrollment of patient portal.
	+ Continue outreach plan and materials to educate patients on the patient portal and accessing their EHR.

**Strategy 3.4**: Continue development of healthcare workforce pipeline efforts.

**Activities:**

* + Continue to provide clinical rotations and shadowing opportunities for students of various medical fields.
	+ Continue to hold and sponsor annual REACH camp in partnership with MT AHEC program.
	+ Explore development of high school student internship program.

**Goal 4:** Enhance St. Luke’s efforts in population health in the St. Luke service area.

**Strategy 4.1:** Further develop and implement Chronic Care Management (CCM) program.

**Activities:**

* + Research best practices for CCM programs.
	+ Develop CCM protocols to integrate into clinic practices.
	+ Educate providers on new CCM protocol/processes.
	+ Identify patients who would benefit from CCM program.
	+ Engage/enroll patients into CCM program.

**Strategy 4.2:** Expand and develop Integrated Care Team.

**Activities:**

* + Convene provider team to develop/determine/define St. Luke’s Integrated Care Team model.
	+ Continue to develop care coordinator team.

**Strategy 4.3**: Continue and enhance St. Luke community health education and outreach efforts.

**Activities:**

* + Explore need for a community health fair.
	+ Explore potential community partners to co-sponsor/participate.
	+ Continue to provide health and wellness classes and programs (childbirth education, breastfeeding support, nutrition, smoking cessation, local runs and events).
	+ Explore development of kitchen/educational space onsite to provide nutrition and dietary education.
	+ Explore development of healthy cooking/healthy eating classes.
	+ Create marketing materials to educate community on health and wellness opportunities.
	+ Explore opportunities to expand health and wellness offerings in partnership with community partners.
	+ Continue participation in 5-2-1-0 program with a focus on childhood obesity.

# Implementation Plan Grid

|  |
| --- |
| **Goal 1:** Improve access to mental health services. |
| **Strategy 1.1:** Behavioral health integration into clinic practice. |
| **Activities** | **Responsibility** | **Timeline** | **Final Approval** | **Partners** | **Potential Barriers**  |
| Continue developing LCSW behavioral health integration. | Medical Staff, Clinic Manager, LCSW | Ongoing | Executive Committee | Montana Health Care Foundation (MTHCF)Signify Health | ReimbursementFundingQualified StaffHuman Resources |
| Develop sustainability plan for behavioral health program. Completed with the RHC designation of clinics. | Executive Committee, Clinic Manager, LCSW | Ongoing | Executive Committee | Signify Health | ReimbursementFundingQualified StaffHuman Resources |
| Explore additional grant funding. | Foundation Director | Ongoing | Executive Committee | Foundation | Resource limitations |
| Research and discuss alternative payment model with existing payers. | CFO | Ongoing | Executive Committee | Payors | Resource limitations |
| Determine FTE need and explore staff expansion (mental health, behavioral health, addiction counseling). | Medical StaffClinic Executive Committee | Ongoing | Executive Committee | MTHCF | Resource limitations, Financial limitations |
| Develop education plan for St. Luke staff and providers related to new referral process and benefits. | Clinic ManagerLCSW | Ongoing | Medical Staff |  | Resource limitations |
| Develop marketing campaign for community to educate on program and benefits. | Clinic ManagerLCSW, CE/PR | Ongoing | Executive Committee |  | Resource limitations, Financial limitations |
| **Needs Being Addressed by this Strategy:*** #1: 54% of survey respondents rated their community “Somewhat healthy.” 22% rated their community as “Unhealthy” or “Very unhealthy.”
* #2: Top 5 identified health concerns identified by survey respondents were: illegal drug use (64.6%), Alcohol abuse (63.1%), prescription drug abuse (30.0%), overweight/obesity (29.7%), and cancer (19.6%).
* #3: Healthy behaviors and lifestyles was identified as the top component of a healthy community.
* #4: 30% of survey respondents indicated they had experienced periods of mental health struggles in the last 12 months.
* #5: Top 3 ways identified to improve the community’s access to healthcare were: more primary care providers (29.7%), expanded mental health specialists (29.7%), and more specialists (21.4%).
* #6: 22% of survey respondents rated their knowledge of health services as “fair” or “poor.”
* #7: 33% of survey respondents indicated they or someone in their household did not receive or had to delay getting needed healthcare services.
* #8: Top reason identified for not receiving/delaying needed healthcare was due to it being “too long to wait for an appointment” (51.6%)
 |
| **Anticipated Impact(s) of these Activities:*** Increased access to behavioral health services.
* Improved health outcomes.
* Improved mental health care coordination.
* Increased knowledge of behavioral health services.
 |
| **Plan to Evaluate Anticipated Impact(s) of these Activities:*** Hire additional (1FTE) behavioral health staff.
* Referral plan developed and shared with staff.
* Track development of community outreach education related to behavioral health services.
* Track referrals to behavioral health services.
 |
| **Measure of Success:** St. Luke Community Healthcare has a fully integrated and operational behavioral health program.  |

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| **Goal 1:** Improve access to mental health services. |
| **Strategy 1.2:** Increase St. Luke’s efforts related to suicide awareness and prevention for staff and community. |
| **Activities** | **Responsibility** | **Timeline** | **Final Approval** | **Partners** | **Potential Barriers**  |
| Provide suicide risk/prevention training to St. Luke staff and offer to community as appropriate. | ACF DON, Education Coordinator | ongoing | Executive Committee | MT DPHHS |  |
| Continue to promote and strengthen crisis intervention services. | Medical StaffACF DON | ongoing | Executive Committee | ShodairFrontier PsychiatryProvidenceLogan HealthFast Psych Intermountain Health |  |
| Continue providing St. Luke representation on various community based efforts related to suicide prevention. | ACF DON | ongoing | Executive Committee | Journey to WellnessVisions & Voices |  |
| **Needs Being Addressed by this Strategy:*** #1: 54% of survey respondents rated their community “Somewhat healthy.” 22% rated their community as “Unhealthy” or “Very unhealthy.”
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 |
| **Anticipated Impact(s) of these Activities:*** Improved health outcomes.
* Increased access to mental health and crisis services.
* Increased youth access to suicide education and prevention resources.
* Improved community awareness of suicide and community resources.
* Reduction in suicide in Lake County.
 |
| **Plan to Evaluate Anticipated Impact(s) of these Activities:*** Track number of staff trained in suicide risk detection and prevention.
* Track number of community educational offerings provided.
* Track community meetings and community partner engagement related to suicide prevention.
 |
| **Measure of Success:** Reduction in suicide in Lake County |

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| **Goal 2:** Strengthen and enhance community outreach related to alcohol and substance abuse. |
| **Strategy 2.1:** Continue to offer alcohol and substance abuse programs and services. |
| **Activities** | **Responsibility** | **Timeline** | **Final Approval** | **Partners** | **Potential Barriers**  |
| Continue to provide acute alcohol detox services. | Medical StaffACF DON | Ongoing | Medical Staff |  |  |
| Continue LCSW, LAC efforts (licensed clinical social worker, licensed addiction counselor) in the clinic setting. | LCSWClinic Manager | Ongoing | Executive Committee |  |  |
| Continue providing meeting space and other support of community events and programs providing support and education related to drug and alcohol abuse (i.e., Ronan Senior Night/Project Graduation, AA and ALANON, Chronic Pain). | Administration | Ongoing | Executive Committee | Ronan Public Schools, AA, ALANON, OTHERS |  |
| Continue partnership with local police department on prescription drug drop off box which allows community to safely dispose of unused/unneeded drugs. | Pharmacy | Ongoing | Pharmacist | Local Law Enforcement |  |
| **Needs Being Addressed by this Strategy:*** #1: 54% of survey respondents rated their community “Somewhat healthy.” 22% rated their community as “Unhealthy” or “Very unhealthy.”
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 |
| **Anticipated Impact(s) of these Activities:*** Sustained access to detox services.
* Increased access to LCSW/LAC services in clinic.
* Increase staff knowledge of available community events and programs.
 |
| **Plan to Evaluate Anticipated Impact(s) of these Activities:*** Track number of detox patients
* Track SLCH participation in community events and programs related to alcohol and substance abuse.
 |
| **Measure of Success:** St. Luke will have increased partnerships/events in service area. |

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| **Goal 2:** Strengthen and enhance community outreach related to alcohol and substance abuse. |
| **Strategy 2.2:** Explore opportunities to expand St. Luke’s alcohol and substance abuse related efforts. |
| **Activities** | **Responsibility** | **Timeline** | **Final Approval** | **Partners** | **Potential Barriers**  |
| Meet with local police department to discuss expansion of prescription medication disposal program. Determine possible locations for additional drop off boxes. | PR/Marketing/Pharmacy | Ongoing | Executive Committee | Polson Police DepartmentSt. Ignatius Police DepartmentTribal Police Department |  |
| Create marketing campaign to educate community on drop off resource(s). | PR/Marketing | Ongoing | Executive Committee | Local PharmaciesLocal Law Enforcement |  |
| Develop educational materials to educate community on proper/safe storage of prescription medications. | PR/Marketing/Pharmacy | Ongoing | Executive Committee | MT DPHHS |  |
| Explore partnership with local pharmacy to enhance safe storage message and delivery. | PR/Marketing | Ongoing | Executive Committee | Pharmacy |  |
| Reach out to local schools to explore participating in and supporting local Red Ribbon efforts with community youth. | PR/Marketing/Pharmacy, Medical Staff | Ongoing | Executive Committee | Mission Valley Public Schools |  |
| Medication Assisted Therapy (MAT) | Providers | Ongoing | Executive Committee |  |  |
| Eat, Sleep, Console | ProviderOB staff | On going | Executive Committee | Logan Health NICUCMC NICUMeadowlark Grant |  |
| Explore expanding partnerships with local organizations (ex. Boys and Girls Club of the Flathead Reservation and Lake County, others) to provide drug and alcohol prevention education. | PR/Marketing | Ongoing | Executive Committee | Boys & Girls Club of Flathead Reservation & Lake County |  |
| **Needs Being Addressed by this Strategy:*** #1: 54% of survey respondents rated their community “Somewhat healthy.” 22% rated their community as “Unhealthy” or “Very unhealthy.”
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* #8: Top reason identified for not receiving/delaying needed healthcare was due to it being “too long to wait for an appointment” (51.6%)
 |
| **Anticipated Impact(s) of these Activities:*** Increased access to safe medication disposal.
* Enhanced relationships with community partners.
* Increased youth knowledge of alcohol and substance abuse issues and resources.
* Improved health outcomes.
 |
| **Plan to Evaluate Anticipated Impact(s) of these Activities:*** Medication disposal boxes.
* Development of new youth drug and alcohol prevention activities.
 |
| **Measure of Success:** SLCH develops and provides new drug and alcohol prevention education for community youth. |

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| **Goal 3:** Improve access to healthcare services. |
| **Strategy 3.1:** Improve access to specialty care services available at St. Luke Community Healthcare. |
| **Activities** | **Responsibility** | **Timeline** | **Final Approval** | **Partners** | **Potential Barriers**  |
| Explore feasibility for expansion of other specialty services. | CEO, COO, Clinics Manager | Ongoing | Executive Committee | CMC, Logan Health, Providence |  |
| Create marketing campaign related to new specialty services developed (Type of specialty services provided, provider bios, schedules, etc.). | CEO, COOClinics Manager, CE/PR | Ongoing | Executive Committee | CMC, Logan Health, Providence |  |
| **Needs Being Addressed by this Strategy:*** #1: 54% of survey respondents rated their community “Somewhat healthy.” 22% rated their community as “Unhealthy” or “Very unhealthy.”
* #2: Top 5 identified health concerns identified by survey respondents were: illegal drug use (64.6%), Alcohol abuse (63.1%), prescription drug abuse (30.0%), overweight/obesity (29.7%), and cancer (19.6%).
* #3: Healthy behaviors and lifestyles was identified as the top component of a healthy community.
* #4: 30% of survey respondents indicated they had experienced periods of mental health struggles in the last 12 months.
* #5: Top 3 ways identified to improve the community’s access to healthcare were: more primary care providers (29.7%), expanded mental health specialists (29.7%), and more specialists (21.4%).
* #6: 22% of survey respondents rated their knowledge of health services as “fair” or “poor.”
* #7: 33% of survey respondents indicated they or someone in their household did not receive or had to delay getting needed healthcare services.
* #8: Top reason identified for not receiving/delaying needed healthcare was due to it being “too long to wait for an appointment” (51.6%)
 |
| **Anticipated Impact(s) of these Activities:*** Increased knowledge of available specialty services at SLCH.
* Increased access to specialty services.
* Improved health outcomes.
 |
| **Plan to Evaluate Anticipated Impact(s) of these Activities:*** Assessment of specialty service utilization pre and post marketing campaign.
 |
| **Measure of Success:** Increased Patient Encounters |
| **Goal 3:** Improve access to healthcare services. |
| **Strategy 3.2:** Improve access to existing services offered at St. Luke Community Healthcare. |
| **Activities** | **Responsibility** | **Timeline** | **Final Approval** | **Partners** | **Potential Barriers**  |
| Conduct assessment of medical staff needs. | CEO/Medical Staff | Ongoing | Executive Committee/Medical Staff | n/a | Time |
| Medical staff plan. | CEO/Medical Staff Executive Committee | Ongoing | Executive Committee/Medical Staff |  |  |
| Explore open access scheduling to reduce wait times for patients. | Clinic Manager | Ongoing | Executive Committee/Medical Staff |  |  |
| Create educational campaign to enhance community understanding of when to access different levels of care (i.e. primary care vs. convenient care vs. ED). | PR/MarketingClinic ManagerMedical Staff | Ongoing | Executive Committee/Medical Staff |  |  |
| Continue to research new approaches to increasing access to care (via: virtual visits, innovative care models). | CEO/Medical Staff/Clinics Manager | Ongoing | Executive Committee/Medical Staff | Logan Health | Resources |
| **Needs Being Addressed by this Strategy:*** #1: 54% of survey respondents rated their community “Somewhat healthy.” 22% rated their community as “Unhealthy” or “Very unhealthy.”
* #3: Healthy behaviors and lifestyles was identified as the top component of a healthy community.
* #5: Top 3 ways identified to improve the community’s access to healthcare were: more primary care providers (29.7%), expanded mental health specialists (29.7%), and more specialists (21.4%).
* #7: 33% of survey respondents indicated they or someone in their household did not receive or had to delay getting needed healthcare services.
* #8: Top reason identified for not receiving/delaying needed healthcare was due to it being “too long to wait for an appointment” (51.6%)
 |
| **Anticipated Impact(s) of these Activities:*** Improved access to healthcare services.
* Improved understanding of how and where to best access appropriate healthcare services.
* Increased community/provider engagement.
 |
| **Plan to Evaluate Anticipated Impact(s) of these Activities:*** Track development and dissemination of education related to accessing appropriate levels of care.
* Track utilization of (appropriate levels of service) pre and post marketing campaign.
* Track development of provider engagement activities.
* Track community utilization of provider/community engagement events.
 |
| **Measure of Success:** Increased Patient Encounters. |

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| **Goal 3:** Improve access to healthcare services. |
| **Strategy 3.3:** Improve patient engagement in improving and understanding health information. |
| **Activities** | **Responsibility** | **Timeline** | **Final Approval** | **Partners** | **Potential Barriers**  |
| Review and improve program to assist patients in enrollment of patient portal. | HIM/IT | Ongoing | Executive Committee | Logan Health |  |
| Develop outreach plan and materials to educate patients on the patient portal and accessing their EHR. | HIM/ITPR/Marketing |  | Executive Committee | Meditech |  |
| **Needs Being Addressed by this Strategy:*** #1: 54% of survey respondents rated their community “Somewhat healthy.” 22% rated their community as “Unhealthy” or “Very unhealthy.”
* #3: Healthy behaviors and lifestyles was identified as the top component of a healthy community.
* #6: 22% of survey respondents rated their knowledge of health services as “fair” or “poor.”
 |
| **Anticipated Impact(s) of these Activities:*** Increased patient engagement.
* Increased community knowledge of how to access their EHR.
 |
| **Plan to Evaluate Anticipated Impact(s) of these Activities:*** Track development of enrollment education materials.
* Track number of new patients enrolled in the patient portal.
 |
| **Measure of Success:** Increase number of patients are enrolled in the patient portal. |

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| **Goal 3:** Improve access to healthcare services. |
| **Strategy 3.4:** Continue development of healthcare workforce pipeline efforts. |
| **Activities** | **Responsibility** | **Timeline** | **Final Approval** | **Partners** | **Potential Barriers**  |
| Continue to provide clinical rotations and shadowing opportunities for students of various medical fields. | Clinical ManagersProviders | Ongoing | Executive Committee | WWAMI, Universities & Colleges |  |
| Continue to hold and sponsor annual REACH camp in partnership with MT AHEC program. | Executive Committee | Ongoing | Executive Committee | MT AHEC |  |
| Explore high school student internship program. | HR, Leadership | Ongoing | Executive Committee | Ronan/St.Ignatius/Charlo Public Schools | Resources |
| **Needs Being Addressed by this Strategy:*** #5: Top 3 ways identified to improve the community’s access to healthcare were: more primary care providers (29.7%), expanded mental health specialists (29.7%), and more specialists (21.4%).
* #6: 22% of survey respondents rated their knowledge of health services as “fair” or “poor.”
* #7: 33% of survey respondents indicated they or someone in their household did not receive or had to delay getting needed healthcare services.
* #8: Top reason identified for not receiving/delaying needed healthcare was due to it being “too long to wait for an appointment” (51.6%)
 |
| **Anticipated Impact(s) of these Activities:*** Increased student engagement with SLCH.
* Increased knowledge of SLCH services.
* Increased knowledge of healthcare and healthcare delivery.
* Increased interest in working in a rural setting.
* Developing the workforce pipeline for future healthcare providers serving Sanders and Lake Counties.
 |
| **Plan to Evaluate Anticipated Impact(s) of these Activities:*** Track number of clinical rotations provided at SLCH.
* Track number of students participating in REACH program.
* Track development of high school student internship program.
 |
| **Measure of Success:** Recruitment and retention of staff. |
| **Goal 4:** Enhance St. Luke’s efforts in population health in the St. Luke service area. |
| **Strategy 4.1:** Further develop and implement Chronic Care Management (CCM) program. |
| **Activities** | **Responsibility** | **Timeline** | **Final Approval** | **Partners** | **Potential Barriers**  |
| Research best practices for CCM programs. | Clinics MangerClinics Nurse SupervisorClinic StaffMedical Staff | Ongoing | Executive Committee | Signify Health |  |
| Develop CCM protocols to integrate into clinic practices. Identify appropriate Staff | Clinics MangerClinics Nurse SupervisorClinic StaffMedical Staff | Ongoing | Executive Committee | Signify Health |  |
| Educate providers on new CCM protocol/processes. | Clinics MangerClinics Nurse SupervisorClinic StaffMedical Staff | Ongoing | Executive Committee | Signify Health |  |
| Identify patients who would benefit from CCM program. | Clinics MangerClinics Nurse SupervisorClinic StaffMedical Staff | Ongoing | Executive Committee | Signify Health |  |
| Engage/enroll patients into CCM program. | Clinics MangerClinics Nurse SupervisorClinic StaffMedical Staff | Ongoing | Executive Committee | Signify Health |  |
| **Needs Being Addressed by this Strategy:*** #1: 54% of survey respondents rated their community “Somewhat healthy.” 22% rated their community as “Unhealthy” or “Very unhealthy.”
* #2: Top 5 identified health concerns identified by survey respondents were: illegal drug use (64.6%), Alcohol abuse (63.1%), prescription drug abuse (30.0%), overweight/obesity (29.7%), and cancer (19.6%).
* #3: Healthy behaviors and lifestyles was identified as the top component of a healthy community.
* #4: 30% of survey respondents indicated they had experienced periods of mental health struggles in the last 12 months.
* #5: Top 3 ways identified to improve the community’s access to healthcare were: more primary care providers (29.7%), expanded mental health specialists (29.7%), and more specialists (21.4%).
* #6: 22% of survey respondents rated their knowledge of health services as “fair” or “poor.”
* #7: 33% of survey respondents indicated they or someone in their household did not receive or had to delay getting needed healthcare services.
* #8: Top reason identified for not receiving/delaying needed healthcare was due to it being “too long to wait for an appointment” (51.6%)
 |
| **Anticipated Impact(s) of these Activities:*** Improve health outcomes.
* Improve access to healthcare services.
 |
| **Plan to Evaluate Anticipated Impact(s) of these Activities:*** Track development of CCM program at SLCH.
* Track enrollment of patients into CCM program.
 |
| **Measure of Success:** Number of enrolled patients in CCM program. |

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| **Goal 4:** Enhance St. Luke’s efforts in population health in the St. Luke service area. |
| **Strategy 4.2:** Expand and develop Integrated Care Team. |
| **Activities** | **Responsibility** | **Timeline** | **Final Approval** | **Partners** | **Potential Barriers**  |
| Convene provider team to develop/determine/ define St. Luke’s Integrated Care Team model. | Clinics MangerClinics Nurse SupervisorClinic StaffMedical Staff | Ongoing | Executive Committee | Signify Health |  |
| Continue to develop care coordinator team. | Clinics MangerClinics Nurse SupervisorClinic StaffMedical Staff | Ongoing | Executive Committee | Signify Health |  |
| **Needs Being Addressed by this Strategy:*** #1: 54% of survey respondents rated their community “Somewhat healthy.” 22% rated their community as “Unhealthy” or “Very unhealthy.”
* #2: Top 5 identified health concerns identified by survey respondents were: illegal drug use (64.6%), Alcohol abuse (63.1%), prescription drug abuse (30.0%), overweight/obesity (29.7%), and cancer (19.6%).
* #3: Healthy behaviors and lifestyles was identified as the top component of a healthy community.
* #4: 30% of survey respondents indicated they had experienced periods of mental health struggles in the last 12 months.
* #7: 33% of survey respondents indicated they or someone in their household did not receive or had to delay getting needed healthcare services.
* #8: Top reason identified for not receiving/delaying needed healthcare was due to it being “too long to wait for an appointment” (51.6%)
 |
| **Anticipated Impact(s) of these Activities:*** Improve health outcomes.
* Improve access to healthcare services.
 |
| **Plan to Evaluate Anticipated Impact(s) of these Activities:*** Track development of Integrated Care Team.
* Track wellness coach/care coordinator position feasibility.
 |
| **Measure of Success:** Increased patient enrollment in CCM. |

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| **Goal 4:** Enhance St. Luke’s efforts in population health in the St. Luke service area. |
| **Strategy 4.3:** Continue and enhance St. Luke community health education and outreach efforts. |
| **Activities** | **Responsibility** | **Timeline** | **Final Approval** | **Partners** | **Potential Barriers**  |
| Explore need for a community health fair. | PR/Marketing | Ongoing | Executive Committee | Employers |  |
| Explore potential community partners to co-sponsor/participate. | PR/Marketing | Ongoing | Executive Committee |  |  |
| Continue to provide health and wellness classes and programs (childbirth education, breastfeeding support, nutrition, smoking cessation, local runs and events). | ACF, Clinic, CE/PR | Ongoing | Executive Committee |  |  |
| Explore development of kitchen/educational space onsite to provide nutrition and dietary education. | COO | Ongoing | Executive Committee |  |  |
| Explore development of healthy cooking/healthy eating classes. | Dietician | Ongoing | Executive Committee |  |  |
| Create marketing materials to educate community on health and wellness opportunities. | CE/PR | Ongoing | Executive Committee |  |  |
| Explore opportunities to expand health and wellness offerings in partnership with community partners. | CE/PR, Executive Committee | Ongoing | Executive Committee |  |  |
| Continue participation in 5-2-1-0 program with a focus on childhood obesity.  | 5-2-1-0 Committee | Ongoing | Executive Committee | Ronan/PolsonCharlo/St.Ignatius Public Schools |  |
| **Needs Being Addressed by this Strategy:*** #1: 54% of survey respondents rated their community “Somewhat healthy.” 22% rated their community as “Unhealthy” or “Very unhealthy.”
* #2: Top 5 identified health concerns identified by survey respondents were: illegal drug use (77.2%), Alcohol abuse (56.6%), prescription drug abuse (30.9%), overweight/obesity (29.4%), and cancer (16.9%).
* #3: Healthy behaviors and lifestyles was identified as the top component of a healthy community.
* #6: 22% of survey respondents rated their knowledge of health services as “fair” or “poor.”
* #7: 33% of survey respondents indicated they or someone in their household did not receive or had to delay getting needed healthcare services.
 |
| **Anticipated Impact(s) of these Activities:*** Increased access to health and wellness opportunities.
* Increased knowledge of health and wellness programs/resources.
* Improved health outcomes.
 |
| **Plan to Evaluate Anticipated Impact(s) of these Activities:*** Track feasibility of community health fair.
* Track utilization of SLCH offered health and wellness programs/classes pre/post marketing campaign.
* Track development of kitchen/cooking space on SLCH campus.
* Track new classes/programs developed with community partners.
* Track outcomes from 5-2-1-0 participation.
 |
| **Measure of Success:** Number of community members engaged  |

# Needs Not Addressed and Justification

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| **Identified health needs unable to address****by St. Luke Community Healthcare** | **Rationale** |
| 1. 35.3% of survey respondents indicated they did not receive/delayed getting needed medical services due to cost.
 | * SLCH provides patient financial assistance, payment plans and patient account representatives to assist patients in meeting financial obligations.
 |
| 1. Survey respondents felt an important way to improve the health of the community was to address the amount of people living in poverty.
 | * SLCH provides assistance to those is poverty in a variety of ways, but our ability to directly impact the economic earning capabilities of community members is limited
 |
| 1. Additional clinics in more locations
 | * Current demographics and market trends deem further capital projects non-feasible at this time
 |

# Dissemination of Needs Assessment

St. Luke Community Healthcare (St. Luke) disseminated the community health needs assessment and implementation plan by posting both documents conspicuously on their website as well as having copies available at the facility should community members request to view the community health needs assessment or the implementation planning documents.

The Steering Committee, which was formed specifically as a result of the CHSD [Community Health Services Development] process to introduce the community to the assessment process, will be informed of the implementation plan to see the value of their input and time in the CHSD process as well as how St. Luke is utilizing their input. The Steering Committee, as well as the Board of Directors, will be encouraged to act as advocates in Lake and Sander’s Counties as the facility seeks to address the healthcare needs of their community.

Furthermore, the board members of St. Luke’s will be directed to the hospital’s website to view the complete assessment results and the implementation plan. St. Luke Community Healthcare Board of Directors approved and adopted the plan on **5/22/23** as part of the Annual Program Evaluation. Board members are encouraged to familiarize themselves with the needs assessment report and implementation plan so they can publically promote the facility’s plan to influence the community in a beneficial manner.

St. Luke’s will establish an ongoing feedback mechanism to take into account any written comments it may receive on the adopted implementation plan document.