

NORTHERN MONTANA HOSPITAL COMMUNITY HEALTH NEEDS ASSESSMENT EVALUATION FY 2026



STRATEGIC DIRECTION 2024-2027

An evaluation of the efforts of Northern Montana Hospital to address the priority community health needs of Hill County, Montana.

FY 2026 Progress

Priority Issue One: Mental Health and Substance Abuse

Northern Montana Hospital (NMH) has continued to strengthen its commitment to mental health and substance use care by expanding behavioral health integration throughout our organization. Building on the successful implementation of warm handoffs, we have further enhanced access to behavioral health services by ensuring seamless transitions between patients and behavioral health providers. Our Licensed Clinical Professional Counselor (LCPC) remains embedded within the primary care setting, allowing for real-time support, intervention, and connection to resources. Warm handoffs continue to be utilized across departments and serve as a cornerstone of our integrated approach to mental health care and social intervention services.

The success of this model has been supported through routine screening for depression, anxiety, substance use disorders, and social determinants of health (SDOH). Through the collaborative efforts of our LCPC and care teams, patients continue to receive timely referrals to psychology, psychiatry, and addiction counseling services, resulting in earlier access to treatment and improved engagement in care plans.

Behavioral health services have grown significantly. We have successfully implemented and facilitated behavioral health group programs, creating additional opportunities for education, support, and peer connection for patients experiencing mental health and substance use challenges. These groups have enhanced patient access to care and provided ongoing support beyond individual counseling services.

Our LCPC program has further strengthened its impact by successfully completing the required supervision training to provide mentorship for behavioral health students. This advancement allows us to support the development of future behavioral health professionals while expanding learning opportunities and helping increase behavioral health service capacity within our community. This commitment to education and professional development supports the long-term sustainability of behavioral health resources in our region. Recognizing that health outcomes are influenced by social and environmental factors, we continue to actively connect patients with external resources to address housing instability, food insecurity, access to communication services, transportation challenges, and safety concerns. Strong partnerships with organizations such as the Salvation Army, WIC, HRDC, CPS, LAC, and local psychiatry and counseling providers throughout Havre have improved awareness, accessibility, and utilization of community resources for our patients.

Northern Montana Hospital remains actively engaged in community education and outreach efforts aimed at reducing stigma and increasing awareness of mental health and substance use concerns. Over the past year, staff have participated in community events including suicide prevention initiatives, Montana NAMI Walk, cultural safety training at Rocky Boy and Fort Belknap, and community educational walks. These efforts promote behavioral health awareness, strengthen community partnerships, and connect individuals and families to available resources and support services.

In maternal health, behavioral health integration remains a key priority. Every new prenatal patient or pregnancy confirmation receives screening and intake through the Meadowlark Navigator program, along with a behavioral health screening conducted by our LCPC. Patients continue to be screened throughout

pregnancy, during the postpartum period, and up to one year following delivery. Our facility has expanded screening efforts by participating in the Montana Perinatal Quality Improvement Network–Substance Use Disorder (MPQI-SUD) quality improvement project. Through this initiative, we have implemented enhanced substance use disorder screening within our OB/GYN services to improve early identification of patients who may benefit from intervention, treatment, and supportive resources. This proactive approach helps connect patients to appropriate care earlier in their healthcare journey, ultimately improving both maternal and overall health outcomes.

Afterward, patients are transitioned to annual behavioral health screenings to ensure ongoing support and early identification of concerns. Our facility has continued to enhance prenatal workflows by streamlining pregnancy confirmations and ensuring prompt enrollment in the Meadowlark Registry, allowing for improved tracking, coordination of care, and patient support throughout the prenatal and postpartum journey.

These ongoing improvements reflect our continued dedication to expanding access to behavioral health and substance use services, improving patient outcomes, supporting community wellness, and integrating whole-person care throughout Northern Montana Hospital.

Priority Issue Two: Social Determinants of Health

NMH has made significant progress in addressing Social Determinants of Health (SDOH) by successfully planning, testing, and fully implementing SDOH screenings. Initial efforts focused on Primary Care, Chronic Care Management, Meadowlark, and Behavioral Health, where screening workflows were piloted and evaluated. Following a successful testing phase, the screening process is being integrated into routine patient care to ensure consistency in both screening questions and documentation practices. Staff received training on appropriate screening techniques, patient-centered communication, and accurate documentation to support effective implementation. By incorporating SDOH screening directly into the electronic medical record templates, we have streamlined documentation processes and improved the consistency of identifying and addressing patient needs. To better address identified needs, our facility established a partnership with the local Food Bank through the Food Farmacy Program, providing patients experiencing food insecurity with improved access to nutritious food resources. Additionally, we have implemented the Montana Connect referral system, which allows for electronic referrals and more efficient connections to community resources, including the local food bank. Through this partnership, patients experiencing food insecurity can be connected to needed services quickly and effectively. During the grant period, Northern Montana Hospital also supported the food bank by providing essential cooking equipment, including hot plates, skillets, and cooking utensils, helping individuals and families not only access nutritious food but also prepare healthy meals at home. These enhancements support our ongoing commitment to identifying barriers to health and connecting patients with resources that address economic, environmental, and social challenges.

To further improve access to support services, we developed a comprehensive community resource guide and designated staff members within each department to assist patients who screen positive for SDOH needs.

Through this coordinated approach, patients can be connected to resources related to housing, food security, transportation, financial assistance, communication access, and personal safety in a timely manner.

Our approach to SDOH screening extends beyond the individual patient and considers the needs of the entire family unit. We recognize that supporting family health and well-being contributes to healthier communities and improved patient outcomes. As a result, care teams actively assess household needs, provide education, and connect family members with appropriate community resources when social barriers are identified.

We have also continued to prioritize cultural awareness, diversity, equity, and inclusion through ongoing cultural competency and Indigenous safety education. Staff have participated in cultural safety training opportunities, including programs led by Dr. Stiffarm and events hosted by the Rocky Boy community. These efforts help ensure our practices align with principles of culturally responsive care and Indigenous cultural safety while strengthening relationships with the communities we serve.

Our patient-centered care model encourages the involvement of family members and support persons in healthcare planning and decision-making whenever appropriate. Patients are invited to include family and community support during appointments, helping them navigate changes in health status, treatment plans, and family dynamics while promoting continuity of care.

In collaboration with Dr. Marshall and the goals of the Unity initiative, our facility has continued to advance equitable healthcare access and evidence-based care practices. This work includes implementing updated prenatal testing protocols, evaluating and enhancing OB/GYN and prenatal care workflows, and aligning services with current American College of Obstetricians and Gynecologists (ACOG) recommendations. These efforts support consistent, high-quality care for all patients throughout the prenatal and postpartum periods. Our hospital has also strengthened its partnership with the Rocky Boy community to improve maternal and infant health outcomes. As part of this collaboration, we established processes to increase provider presence and access to prenatal care services, fostering stronger relationships and supporting healthier pregnancies, deliveries, and postpartum experiences.

Through customized yet standardized workflows within Family Practice and OB/GYN services, our facility has implemented a comprehensive process to ensure consistent screening and assessment at designated intervals throughout pregnancy. This includes updates to prenatal laboratory protocols and standardized clinical pathways designed to deliver uniform, high-quality care regardless of provider. The workflow begins with pregnancy confirmation and enrollment into coordinated prenatal services, creating a clear, efficient, and supportive pathway that promotes improved outcomes for mothers, infants, and families.

Our facility continues to host the Community Baby Shower as an important outreach initiative designed to increase awareness of available maternal, infant, and family support services throughout the Havre community. This event brings together local organizations, healthcare providers, and community partners to

educate expectant and new families about the resources available to them, including prenatal care, behavioral health services, nutrition programs, parenting support, and social service resources. By continuing to offer the Community Baby Shower, Northern Montana Hospital strengthens community engagement, promotes healthy pregnancies and infant outcomes, and helps connect families with the support systems they need for long-term success.

Priority Issue Three: Chronic Health Conditions

NMH continues to make meaningful progress in the management of chronic conditions, including hypertension, diabetes, and obesity, through a coordinated, patient-centered approach. By leveraging patient registries and population health tools, we proactively identify individuals who are overdue for preventive services, chronic disease follow-up appointments, and annual wellness visits. These registries allow care teams to conduct targeted outreach, improve care coordination, and ensure patients receive timely screenings, evaluations, and treatment interventions that support better health outcomes.

Over the past year, Northern Montana Hospital has further strengthened its population health efforts by joining an Accountable Care Organization (ACO). This partnership has enhanced our ability to coordinate care, utilize quality measures, monitor patient outcomes, and collaborate across the healthcare continuum to improve the overall health of our patient population. Through ACO participation, we continue to refine our approach to preventive care, chronic disease management, and care transitions while promoting high-quality, cost-effective care.

To address diabetes management, our primary strategy continues to focus on comprehensive primary care, patient education, evidence-based treatment plans, and appropriate specialty referrals. Social Determinants of Health (SDOH) screenings remain an integral component of this process, helping identify barriers that may prevent patients from attending appointments, obtaining medications, accessing healthy foods, or completing recommended annual evaluations. When needs are identified, patients are connected with resources and support services, including Chronic Care Management (CCM), care coordination, and assistance with diabetes-related devices and supplies. NMH is currently recruiting for a Clinical Diabetic Educator position.

Our Chronic Care Management program continues to expand its services through both individualized care plans and chronic disease-focused patient groups. These programs provide ongoing education, goal setting, self-management support, and regular follow-up to help patients successfully manage conditions such as diabetes, hypertension, and obesity. Care plans are reviewed and updated collaboratively with patients to ensure interventions remain personalized and aligned with each patient's health goals, resulting in improved engagement and quality of life.

We maintain a consistent outreach strategy for patients who are overdue for preventive screenings, annual wellness visits, and chronic disease follow-up care. Using established registries, our primary care nursing staff works closely with providers to identify care gaps, schedule appointments, update treatment plans, and ensure patients receive appropriate preventive services. This proactive approach supports early intervention and helps prevent disease progression.

In addition to expanding chronic disease management services, Northern Montana Hospital has invested in workforce development through the implementation of a Certified Medical Assistant (CMA) Apprenticeship Program. This initiative supports the growth of a skilled healthcare workforce within our community while creating opportunities for professional development and career advancement. The apprenticeship program helps strengthen staffing resources and enhances our capacity to provide high-quality patient care throughout the organization.

Through continued participation in the ACO, utilization of patient registries, expansion of Chronic Care Management programs, and investment in workforce development initiatives such as the CMA Apprenticeship Program, our facility remains committed to improving patient outcomes, enhancing care coordination, and supporting healthier communities across our service area.

The reimplementations of Grand Rounds for providers has strengthened collaboration and communication regarding chronic health conditions, creating valuable opportunities for shared learning, case discussion, and improved patient care outcomes. These sessions have enhanced providers' ability to identify, recognize, and appropriately document chronic diseases while fostering ongoing education and awareness of chronic condition management. By promoting the exchange of best practices and clinical insights, Grand Rounds supports providers in delivering consistent, evidence-based care and reinforces the organization's commitment to proactive chronic disease recognition, management, and quality improvement across our facility.