Logan Health Medical Center and Logan Health Whitefish
2022 – 2024 Joint Implementation Plan
In Response to the 2021 Flathead County, MT Community Health Needs Assessment

As a result of the research and recommendations that appear in the 2021 Flathead County, MT Community Health Needs Assessment and further exploration with service line leadership, staff, and Board of Directors, the following strategies will guide the organizations in addressing the community's identified health needs over the next three years. These strategies were approved by the Logan Health Whitefish Board of Directors on December 14th, 2021 and by the Logan Health Medical Center Board of Directors on February 10th, 2022.

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COMPREHENSIVE CARE

1. MENTAL HEALTH AND SUBSTANCE ABUSE:

Logan Health Medical Center is committed to continuing the provision of mental health services and education through many existing services and activities including:

1. Logan Health Behavioral Health for inpatient psychiatric acute care, adolescents and adults.
2. Logan Health Newman Center for adult and pediatric outpatient behavioral health specialty clinics.
3. Behavioral Health screenings and referrals at School-Based Clinics.
4. Integrated Behavioral Health in Primary Care and Maternal Care.
5. Member of the Behavioral Health Collaborative Flathead County.
6. Member of Meadowlark Initiative state of Montana.
7. Member of Flathead County/ Flathead County Co responder program CIT Training Committee.
8. Funding for a consortium of community members for mental health professionals/crisis response.
9. Funding for local transportation to/from medical appointments.
10. Participation in the Drug Free Flathead Task Force, with an emphasis on the sub-committee for Maternal, Fetal, Infant, and Pre-pregnant Women Prevention Program to make a positive impact to reduce the use of opioid and other drugs within the valley deemed dangerous by Montana Code Annotated.

Logan Health Whitefish is committed to continuing the provision of mental health services and education through many existing services and activities including:

1. Logan Health Behavioral Health for outpatient psychiatric and counseling treatment for children, adolescents and adults.
2. Behavioral Health screenings and referrals at School-Based Clinics in Columbia Falls High School and Whitefish Elementary, Middle and High School.
3. Behavioral Health Telehealth Outreach Services available at Logan Health Primary Care Eureka as well as the Eureka School-Based Clinic in Eureka, MT.
4. Integrated Licensed Clinical Social Worker (LCSW) in the Logan Health Primary Care, Columbia Falls and add to Eureka.
5. Participation in the Drug Free Flathead Task Force, with an emphasis on the sub-committee for Maternal, Fetal, Infant, and Pre-pregnant Women Prevention Program to make a positive impact to reduce the use of opioid and other drugs within the valley deemed dangerous by Montana Code Annotated.
6. Logan Health Whitefish Birth Center staff member representation on the Fetal, Infant, Child, & Maternal Mortality Review Committee that reviews teen and maternal suicides for prevention potential with goals to:
    i. Decrease suicide rate in teens and mothers up to one-year post-partum in the valley; and
    ii. Promote programs to assist in prevention of future situations through analysis of current occurrences.
7. PPMD support referred by the Logan Health Whitefish Birth Center for community members at risk to provide a safe place for depressed and anxious clients to process their feelings and refer to specialists in our community.

8. Logan Health Whitefish will continue to support suicide prevention efforts through collaborative work and financial support of the Nate Chute Foundation (NCF) and provide annual funding as available to the NCF.

To augment these services, Logan Health Medical Center and Logan Health Whitefish will:

a. **Alcohol and Substance Abuse**:

***Logan Health Medical Center Will*:**

Actions	***Anticipated Impact***	***Logan Health Resources***	***Potential Collaborations***
1. Promote and educate providers and primary care to routinely screen for alcohol use and other substances both in adults and pediatrics during wellness visits and sports physicals.	Provider knowledge related to the importance of early intervention and impact of SUD screening and brief interventions. Patient identification, education, and referral to treatment when warranted.	Cost for development of educational resources, training, and education time RN Nurse navigation care coordination Youth development school based health	Oxytocin Gateway Recovery Flathead Greater Valley School Health
2. Actively recruit addiction medicine providers to enhance addiction medicine services.	Availability and expansion of knowledge in addiction medicine. Improved Medication Assisted Treatment and early interventions. Additional resources for patient care options.	Logan Health Recruiting Dept. Current Addictionolgists Current Addiction Psychiatrist Cost in marketing	Community Medical Services Gateway Recovery
3. Pursue use of peer supports both in primary care patient settings and Emergency Room.	Decreased Emergency Room visits. Increased outcomes for completion of treatment, increased patient engagement, viability of new evidenced based community service.	Cost related to education training of use of peer supports	Gateway Recovery Greater Valley Sunburst MHC

***Logan Health Whitefish Will*:**

Actions	*Anticipated Impact*	*Logan Health Whitefish Resources*	*Potential Collaborations*
1. Maintain a care pathway for education and support of patients who use alcohol.	Timely identification of referral resources. Increased staff and provider knowledge related to importance of screening as well as resources available to support patients and their families in a team based approach to treatment and cessation.	Logan Health Whitefish care coordination members and clinic staff	Logan Health Nurse Navigation Team
2. Provide education outreach to staff on alcohol addiction screenings (SBIRT). Include inpatient and outpatient staff in training opportunities.	Patient identification, education and referral as necessary to access the appropriate treatment.	Logan Health Whitefish Behavioral Health	

b. Suicide Prevention and Post Vention

***Logan Health Medical Center Will*:**

Actions	*Anticipated Impact*	*Logan Health Resources*	*Potential Collaborations*
1. Participate in Behavior Health Collaborative to set up a Suicide Task Force.	Effective collaborated effort to address the public health issue of suicide in a systematic way. Looking at prevention and post-vention services, education and support. Awareness and impact of securing lethal means and decrease injury.	Staff time and hours dedicated to committees and training Marketing time and materials	Nate Chute Foundation Great Valley Community Sporting goods stores Pharmacy
2. Increase implementation of depression and suicide screening	Increased identification of needs for support and treatment of depression and suicide.	Costs related to education and training	Nate Chute Foundation

(PHQ9) as system wide tool being identified as VITAL sign.		materials for staff and providers	Logan Health Whitefish Foundation
3. Develop crisis intervention and follow up system.	Increased access to providers and crisis planning and follow up. Decreased Emergency Room visits.	Staffing hours Recruiting campaign Cost related to equipment and staff education and training	Flathead Co Responder Glacier House Sunburst Drop in Center Peer support services

***Logan Health Whitefish Will*:**

Actions	***Anticipated Impact***	***Logan Health Whitefish Resources***	***Potential Collaborations***
1. Provide financial support for patients qualifying financially and needing Transcranial Magnetic Treatment for severe depression or other mental health diagnosis.	Logan Health Behavioral Health is continually being evaluated by Med Staff and Administration for added space and an additional TMS treatment chair/room.	Funding from the foundation if patients qualify for financial aid and do not have coverage for TMS.	Nate Chute Foundation
2. Contract with Frontier Psychiatry Services through the Emergency Department to provide telemedicine psychiatric consultations.	Bridge the gap for psychiatric care when patient doesn't meet inpatient criteria for mental health care and follow up.	Emergency Department Logan Health legal services for contracting	Pathways
3. Have specially trained staff in this area, and that staff can perform in-service to a larger population of staff.	More disciplines and levels of staffing will have an understanding of the signs presenting, and more appropriate actions to take when those signs arise. There will be internal resources identified as "house-experts" to turn to with concerns and questions.	Logan Health Whitefish Behavioral Health Providers to provide education	Emergency Department Primary Care Clinics

4. Standardization of depression screening in the hospital and clinic settings and expand patient population that is screened.	Increased identification of needs for support and treatment of depression and suicide.	Logan Health Whitefish staff and providers to develop screening protocol and algorithms to connecting with resources.	Behavioral Health Providers Nate Chute Foundation

2. CHRONIC DISEASE MANAGEMENT AND PREVENTION:

Logan Health Medical Center has invested and will continue to invest in many programs and services to treat some of the most prevalent causes of death in our county including:

1. Chronic Care Management Program to help patients navigate and improve healthcare outcomes by addressing barriers to healthcare and decreasing emergency department and inpatient utilization.
2. Asthma Education Program for hospital inpatients and outpatients.
3. 3D Mammography and participation in the Logan Health "Save a Sister" free mammography initiative.
4. Preventative breast/rectal/prostate cancer screening in the clinic setting.
5. Tele-Stroke program to identity patients that may have had a stroke and to deliver appropriate treatment.
6. Individualized care plans for patients with chronic diseases who are high utilizers of the Emergency Department.
7. Evaluate additional opportunities for targeted work related to screening for chronic disease management.
8. Evaluate opportunities to create system-wide community support for chronic disease management utilizing community partners and healthcare resources.
9. A comprehensive cardiovascular program that included general cardiology, Heart Failure Clinic, Interventional Cardiology, Structural Heart Program, electrophysiology, cardiac surgery, cardiac rehab and cardiovascular risk prevention.
10. Comprehensive pulmonary/respiratory care program to include pulmonary care, critical care, sleep medicine program, respiratory therapy services, interventional pulmonology, pulmonary function and CPET testing, pulmonary and respiratory rehab including rehabilitation of patients suffering from post COVID respiratory symptoms.
11. Development of a comprehensive Vascular Program to include surgical and interventional vascular care, vascular disease screening, surveillance and treatment across the region. Wound and ostomy care program currently established.
    Cardiovascular risk factor screening, prevention and patient education opportunities offered to the community.
12. Comprehensive Cancer Program that includes medical hematology and oncology, infusion services, radiation oncology, telemedicine support of regional patients including infusion centers in Ronan and Libby, dedicated cancer support services department to include social outings and support groups, social work and financial counseling support for cancer patients in the region. Developing expanded regional cancer care. The cancer program also has the only naturopathic physician certified in oncology in the state of Montana.
13. Regional Cancer Care: Cardiology and Pulmonary Care is provided in Eureka, Libby, Polson, Ronan, Browning, Shelby, Cut Bank, and Conrad. We are Meeting with Tribal Health in December 2021 to discuss future cardiology support of their program. The cancer program provides telehealth in Libby and support of the CPMC infusion center. We are currently recruiting for an outreach oncologists so that we may expand the reach of the program.

14. The Imaging services at Logan health support the radiology technologist program with a focus to assist with education and staffing in our regional critical access hospitals. Imaging services are supported by mobile units across NW Montana. Mobile imaging support includes MRI, Nuclear Imaging and Mammography.
15. Logan Health provides access to clinical trials for pharmaceuticals and devices in the following specialties: Oncology, Cardiology, Pulmonology, Rheumatology, Endocrinology and GI.
16. Logan Health Genetics currently employs two genetics counselors and a PHD trained practitioner. This program is in development with hopes of expansion over the next two years.
17. Logan Health Palliative medicine offers comprehensive, interdisciplinary care for patients with complex illness. Provides patient and family emotional and social support with assistance in advance care planning. Providing outreach in Libby and offer telemedicine and care facility consultation visits. We do not offer home visits at this time, but work closely with Home Health and Hospice teams.
18. Continued enhancement of mammogram access through funding with Save a Sister and self-referral opportunities.
19. Tobacco and alcohol screening at clinics to gauge patient alcohol and tobacco use, and refer to local resources including Montana Quit Line.
20. Support for the Montana State tobacco cessation program to reduce tobacco effects on maternal, fetal, infants, and children.
21. Continue to effectively provide influenza vaccines throughout all of Logan Health.
22. Continue to provide COVID-19 testing locations throughout Logan Health.
23. Continue to provide COVID-19 vaccinations through our Logan Health primary care clinics and pharmacies.

Logan Health Whitefish has invested and will continue to invest in many programs and services to treat some of the most prevalent causes of death in our county including:

1. Chronic Care Management Program to help patients navigate and improve healthcare outcomes by addressing barriers to healthcare and decreasing emergency department and inpatient utilization.
2. Asthma Education Program for hospital inpatients and outpatients.
3. 3D Mammography and participation in the Logan Health Save a Sister free mammography initiative.
4. Preventative breast/rectal/prostate cancer screening in the clinic setting.
5. Tele-Stroke program to identity patients that may have had a stroke and to deliver appropriate treatment.
6. Free EKG's and sleep studies for Shepherd's Hand Free Clinic patients.
7. Individualized care plans for patients with chronic diseases who are high utilizers of the Emergency Department.
8. Diabetes Prevention Program for community members.
9. Continue Sleep Apnea screenings and referral to a sleep specialist.
10. Education of school staff, parents and children on the dangers of smoking and e-cigarettes.
11. Tobacco and alcohol screening at clinics to gauge patient alcohol and tobacco use, and refer to local resources including Montana Quit Line.
12. Support for the Montana State tobacco cessation program to reduce tobacco effects on maternal, fetal, infants, and children.
13. Create a Population Health Committee to monitor data and outcomes of chronic conditions.

To augment these services, Logan Health and Logan Health Whitefish will:

a. Heart, Vascular and Cancer

***Logan Health Medical Center Will*:**

Actions	*Anticipated Impact*	*Logan Health Resources*	*Potential Collaborations*
HEART and VASCULAR DISEASE			
1. Provide Community Education regarding cardiac risk factors and prevention. Participate in public radio spots, provide referring physician / primary care education, health fairs and speaking opportunities in community setting including patient and community lectures specifically during February's Heart Month.	Improve knowledge and understanding of cardiac symptoms risk factors and effective prevention.	Marketing Physician and staff Conference rooms for education Screening equipment Education Marketing	Fitness Center Community Health Department Schools
2. Provide provider education regarding risk factors and screening: Standardized hypertension screening, cholesterol screening, ABI screening for vascular disease etc.	Effective risk factor screening programs across continuum of care Improved cardiac and vascular disease surveillance and earlier detection of disease progression.	Marketing Physician and staff Conference rooms for education Screening equipment Education Marketing	Fitness Center Community Health Department Schools
3. Provide phase 1, 2 and 3 Cardiac Rehabilitation and expand to outreach communities.	Improved access to cardiac rehabilitation for patients who have had a cardiac event or exacerbation of heart failure. Improved access and compliance to program participation with the goal to improve patient outcomes.	Staff Monitoring Technology Education Marketing	Local fitness centers

CANCER:			
1. Provide cancer support and survivorship services through quality programs such as emotional support, education, well-being through active outings, art therapy and community building, image renewal through wigs/head-coverings, therapeutic retreats, and one-to-one support.	Additional tools to address holistic needs of patients and survivors to help ensure optimal care and outcomes.	Patient education materials Staff labor hours Cancer Support and Survivorship Program Save a Sister Initiative	
2. Advance patient financial advocacy including hiring a financial advisor to assist with patient and medication assistance programs.	Help connect patients with available resources to decrease financial toxicity to help ensure optimal care and outcomes.	Patient education materials Staff labor hours	
3. Advance Patient Navigation, Care Coordination, and Symptom Support by expanding our navigation offerings and adding an additional nurse navigator to our team to focus on lung cancer and urologic cancers.	Help patients get and stay connected with care and available resources to support screening, diagnosis, treatment, and survivorship to help ensure optimal care and outcomes.	Patient education materials Staff labor hours	
4. Utilize Telehealth and Tele-teach technology to promote patient and family education through individual and group classes and interventions.	Help support patients and families/caregivers by providing education for treatment and side effects to reduce emergency department utilization and help ensure optimal care and outcomes.	Patient education materials Staff labor hours Telehealth Technology	
5. Breast Cancer Screening services provided by the mobile Mammography Coach which	Improved Cancer Screening rates and subsequent treatment plans for breast cancer.	Marketing Mammography Tracking technology	

travels to underserved areas with 3-D technology. Expand to the hi-line and explore expansion into Lake County and Lincoln County.		Staffing/Navigation	
6. Continued focus on the Lung Cancer Screening Program (low dose CT) across the region. Advance process improvement project to address incidental nodule tracking and improved surveillance and compliance.	Improved Cancer Screening rates and subsequent treatment plans for lung cancer.	Marketing EON technology Staffing / Navigation	
7. Colon Cancer Screening focus group working on improving processes and surveillance.	Improved Cancer Screening rates and subsequent treatment plans for colon cancer.	Marketing Staffing / Navigation	

***Logan Health Whitefish Will*:**

Actions	***Anticipated Impact***	***Logan Health Whitefish Resources***	***Potential Collaborations***
HEART DISEASE:			
1. Utilize the Chronic Care Management Program to risk strategize and outreach to enroll patients in the program.	Assist patients to navigate and improve healthcare outcomes by addressing barriers to healthcare and decreasing emergency department and inpatient utilization.	Logan Health Care Coordinators/Navigators	
2. Initiate Phase 1 for Cardiopulmonary Rehab.	Phase 1 includes an inpatient consult and education for patients on services they would benefit from on an outpatient basis. Early/Real time referral and handoffs would increase patient engagement and compliancy.	Cardiac Rehab Staff	Logan Health Cardiac Rehab

CANCER:			
1. Create a Cancer Care Pathway for patients with newly diagnosed cancer.	Address holistic needs and provide navigation assistance to medical care teams to ensure optimal care and outcomes, address barriers to healthcare.	Logan Health Care Coordinators/Navigators	Logan Health Oncology
2. Utilize the Chronic Care Management Program to risk strategize and outreach to enroll patients in the program.	Assis patients to navigate and improve healthcare outcomes by addressing barriers to healthcare and decreasing emergency department and inpatient utilization.	Logan Health Care Coordinators/Navigators	Logan Health Oncology
3. Eureka will continue to offer a space for the mobile mammogram coach to park 1-2 x/month.	Provides the opportunity to reach the population who either don't have finances or transportation to travel to Whitefish or Kalispell to receive their mammogram as recommended.	Logan Health Eureka Staff	
4. Explore opportunities for patients with cancer who live in Eureka to connect with a support group via telehealth.	There are no cancer support groups in Eureka currently. Cancer patients would benefit to attend a group virtually if available.	Logan Health Eureka Staff	Lincoln County

b. Stroke, Pain Management and Rehabilitation

***Logan Health Medical Center Will*:**

Actions	***Anticipated Impact***	***Logan Health Resources***	***Potential Collaborations***
1. Work collaboratively with integrated care teams to optimize door to needle times for stroke patients.	Improved outcomes for patients that are emergently presenting with a stroke.	Stroke coordinator Neurology Physicians ER and Radiology staff Inpatient nursing	EMS ER physician group Long-term care Neighboring communities and care sites
2. Implement the Pulsara software.	Improved care team communication. Improved response time for treating stroke patients.	Stroke coordinator Neurohospitalist ER and Radiology staff	EMS ER physician group

	Improved patient outcomes. Improved coordinated follow-up care.		
3. Implement a Neurohospitalist program.	Improve response times to urgent acute care needs. Improved level of specialty services to hospitalized patients. Expand tele stroke capabilities and level of service to surrounding communities. Timely outpatient follow-up from an acute neurological event.	Full-time 365 Neurohospitalist	
4. Establish a unified spine care program.	Coordinated cared for patients with acute and chronic back pain conditions. Reduce ER visits by providing timely access to acute back pain Reduced patient costs	Physiatrist Neurologist Neurosurgeon Pain Specialist	Independent primary care sites
5. Implement a referral process and educational opportunity to collaborate with physical therapy clinics on appropriate referrals for rehabilitation.	Support for those living with chronic conditions to address opportunities to assist with holistic health approaches and outcomes.	Logan Health Physical Therapy Clinics Clinic Staff Inpatient Care Managers	Whitefish Physical Therapy

***Logan Health Whitefish Will*:**

Actions	***Anticipated Impact***	***Logan Health Whitefish Resources***	***Potential Collaborations***
1. Utilize the Chronic Care Management Program to risk strategize and outreach to enroll patients in the program.	Assist patients to navigate and improve healthcare outcomes by addressing barriers to healthcare and decreasing emergency department and inpatient utilization.	Logan Health Care Coordinators/Navigators	

2. Implement a referral process and educational opportunity to collaborate with physical therapy clinics on appropriate referrals for chronic pain.	Support for those living with chronic conditions to address opportunities to assist with holistic health approaches and outcomes.	Logan Health Physical Therapy Clinics Clinic Staff Inpatient Care Managers	Logan Health Physical Therapy

c. Healthy Behaviors | Physical Activity, Nutrition, Body Mass, and Tobacco Use

***Logan Health Medical Center Will*:**

Actions	*Anticipated Impact*	*Logan Health Resources*	*Potential Collaborations*
1. Promote individual and community wellbeing through a variety of community events that provide residents and visitors physical activity / exercise opportunities and other health/wellness activities.	Provides community wide physical activity opportunities, social interactions and promotes health and wellbeing through healthy lifestyle behaviors.	Logan Health Medical Fitness Center Event Coordinators	Community Organizations Schools Local businesses
2. Expand the Logan Health Medical Fitness Center's "Journey to Wellness" program to provide coaching services for overweight and obese children and their families.	Provides lifestyle coaching to nuclear families in the areas of physical activity, nutrition, stress reduction and mindfulness. Promotes lifelong healthy lifestyle choices that include being physically active and adopting healthy nutritional habits.	Logan Health Medical Fitness Center's Journey to Wellness Program and Coaches	Dietitians Medical providers Schools
3. Integrate "fall prevention" program components into the "Journey to Wellness" coaching services.	Reduction in preventable falls in individuals at moderate and high risk of incurring a fall event through assessment, physical activity/exercise training, education and wellness coaching.	Logan Health Medical Fitness Center's Journey to Wellness Program and staff	Medical providers Dietitians Senior centers

4. Provide tobacco education and cessation coaching services for tobacco users through the Fitness Center's Journey to Wellness Program.	Tobacco cessation coaching and support for individual of all ages, with a specific focus on tobacco cessation and overall lifestyle behaviors.	Logan Health Medical Fitness Center's Journey to Wellness program	Pulmonary/cardiac Rehab & Cardiovascular services Medical providers
5. Develop a comprehensive smoking cessation program and education for patients and the community including the youth in the community.	Effective risk factor screening programs across continuum of care Improved pulmonary/respiratory disease surveillance and earlier detection of disease progression.	Staff Marketing Education	
6. Expand youth development program services across the community and local schools.	Provides children and youth opportunities for motor skill development, sport-specific training and mental and physical well-being coaching.	Logan Health Youth Development Program Logan Health Medical Fitness Center Logan Health Orthopedic and Neuro services	Local Schools Community youth sport and recreation programs Community that Cares Nate Chute Foundation Local service clubs

***Logan Health Whitefish Will*:**

Actions	***Anticipated Impact***	***Logan Health Whitefish Resources***	***Potential Collaborations***
1. Incorporate healthy behavior coaching for patients enrolled in chronic care management.	Wellness coaching for those living with chronic conditions to address holistic health outcomes.	Logan Health Whitefish Care Coordinators	Summit Medical Fitness Wave Fitness Center
2. Family Strong program is in the early stage of development in Eureka. The program was designed as an early childhood prevention program with care giver support group and	Mitigate early childhood risk factors around education, nutritional, mental/behavioral support for children and parents. Goal is connect parents of young children to provide support and networking to build healthy behaviors for parents and children.	Logan Health-Whitefish foundation funding support. Eureka Care Coordinator leads the program.	Lincoln County and Creative Arts Center in Eureka.

educational resources, targets 0-5 age group and parents.			
3. Foundation will continue to fundraise to support both the Food Rx and the Planetree Healing Garden to support Food Accessibility for patients who screen as food insecure.	Funding available for Food Accessibility Programs.	Foundation funding	Farm Hands
4. Community Relations will extend an MOU with Farm Hands to operate the Food Rx program and the Manager at the Planetree Healing Garden.	Expansion of the Food Rx program into the Diabetes Care Cohort and other clinics besides Logan Health Primary Care Columbia Falls – Talbot and the CF School Based clinic. Consideration to expand into both primary care programs to include Eureka.	Clinics and Providers referring patients and participating in the process. Care coordinators to facilitate the program with patients and track data.	Farm Hands
5. Assemble a Smoking Cessation packet that would be a take home education tool for our tobacco addicted patients, including smokeless. Additional education to by RT and Cardio Pulmonary staff during in and outpatient visits.	Respiratory therapist and cardiopulmonary staff to provide education during their outpatient visits and monitor success. Referral opportunities for any inpatients that screen positive for tobacco use.	Respiratory Therapist and CPR staff.	

d. Diabetes

***Logan Health Medical Center Will*:**

Actions	*Anticipated Impact*	*Logan Health Resources*	*Potential Collaborations*
1. Continue to review and enhance referral pathways for Diabetic patients.	Identify effective referral pathways that will lead to enhanced diabetes prevention and care management.	Clinic Providers and Staff Care Management	
2. Enhance diabetes prevention including Diabetes Prevention Program, group program and care management	Improve the outcomes of diabetic patients, improving their quality of life and future prevention.	Clinical Providers and Staff Care Management	

***Logan Health Whitefish Will*:**

Actions	*Anticipated Impact*	*Logan Health Whitefish Resources*	*Potential Collaborations*
1. Create a Primary Care Diabetes Pathway to connect patients with diabetes to support and resources they need.	Engage more patients in team-based care approach to connect patients to diabetes support and services they need.	Logan Health Whitefish Care Coordinators Diabetic Educator Registered Dietician	Logan Health Diabetic Educator
2. Continue Cardiovascular Disease and Diabetes Prevention Program classes for patients with cardiovascular disease risk factors and/or Prediabetes. Plan is to have a cohort meeting in person and another cohort through an online platform.	The objective of the DPP classes are for participants to reach the goals of the program: 1. Weight loss of 5-7% of their starting weight and 2. Increase physical activity to 150 minutes or more per week. Reaching these goals has shown a reduction in developing DM2 by 58% in patients less than 65 years old.	Logan Health Whitefish receives grant funding from the state of MT quarterly to provide these classes and online platform for the community.	Logan Health Diabetic Educator

3. Utilize the Chronic Care Management Program to risk strategize and outreach to enroll patients in the program.	Assist patients to navigate and improve healthcare outcomes by addressing barriers to healthcare and decreasing emergency department and inpatient utilization.	Logan Health Care Coordinators/Navigators	

e. Respiratory / Pulmonary Care

***Logan Health Medical Center Will*:**

Actions	*Anticipated Impact*	*Logan Health Resources*	*Potential Collaborations*
1. Provide Community Education regarding pulmonary risk factors and respiratory disease prevention. Participate in public radio spots, provide referring physician / primary care education, health fairs and speaking opportunities in community settings.	Improve knowledge and understanding of respiratory/pulmonary symptoms risk factors and effective prevention.	Staff Marketing Education	
2. Provider education on risk factor screening and prevention to standardize screening and treatment. Participate in public radio spots, provide referring physician / primary care education, health fairs and speaking opportunities in community settings including patient and community lectures and print.	Effective risk factor screening programs across continuum of care. Improved pulmonary/respiratory disease surveillance and earlier detection of disease progression.	Staff Marketing Education	

3. Establish process for routine sleep apnea screening (Stopgap) in primary care and in other care opportunities including pediatrics as appropriate.	Earlier detection of sleep apnea, resulting in earlier treatment.	Staff Marketing Education	
4. Expand utilization and referral to pulmonary/respiratory rehab. Increase utilization of this service for post COVID patient suffering with long term respiratory symptoms.	Improved recovery and outcomes for patients with chronic pulmonary disease and post COVID Respiratory Syndrome.	Staff Marketing Monitoring equipment	
5. Utilize the Chronic Care Management Program to risk strategize and outreach to enroll patients in the program.	Assist patients to navigate and improve healthcare outcomes by addressing barriers to healthcare and decreasing emergency department and inpatient utilization.	Logan Health Care Coordinators/Navigators	

***Logan Health Whitefish Will*:**

Actions	***Anticipated Impact***	***Logan Health Whitefish Resources***	***Potential Collaborations***
1. Expand the Asthma Education Program to outpatient clinics.	Help patients identify symptoms and manage their asthma.	Logan Health Whitefish Respiratory Therapists	
2. Utilize the Chronic Care Management Program to risk strategize and outreach to enroll patients in the program.	Assist patients to navigate and improve healthcare outcomes by addressing barriers to healthcare and decreasing emergency department and inpatient utilization.	Logan Health Care Coordinators/Navigators	
3. Implement offering vaccines at every visit.	Offering vaccines to patients at any visit, not just annual wellness visits, anticipate being able to reach more of the population.	Logan Health Primary Care Staff	

4. Implement a process in Eureka where the care coordinator will collaborate with school nurse to identify care plans needs for students with Asthma and the provider to teach peak flows so that action plan can be appropriately completed.	Ensure school students have a proper care plan to treat their asthma.	Logan Health Eureka Care Coordinator and Providers	Eureka School
5. Explore expanding our current Pulmonary Function capabilities and process.	Providing the opportunity to perform testing here in Whitefish would allow easier access to the population in our community and greater outreach.	Cardiac Rehab Staff	Pulmonologist

3. ACCESS TO CARE:

Logan Health has invested and will continue to invest in many programs and services to improve access to care including:

1. Ongoing evaluation of the need for additional providers in the areas we serve.
2. Tracking "third next available" appointments, a measure from CMS to help us understand patient access to a given provider, as well as their clinic in general.
3. A trauma prevention program that includes school presentations and a helmet safety program through the Save the Brain initiative and the Emergency Room.
4. Over 1,000 helmets are given away annually at "Spring into Safety" day.
5. Financial scholarships provided through the Logan Health Healthcare Foundation to patients for fitness center memberships, weight loss programs, wellness programs, and other prevention activities.
6. The Healthy Measures program to facilitate corporate wellness, both at Logan Health Medical Center and other employers throughout the region.
7. Free mammograms to women in financial need through the Save a Sister initiative.
8. Funding for local transportation to/from medical appointments via Mountain Climber, Northern Transit, and ASSIST.
9. Leadership representation on the Mountain Climber Board of Directors.
10. Same-day availability in primary care practices.
11. Primary care extended hours including continuity and walk-in primary care services.
12. Financial Assistance and Sliding Fee Scale Programs to aid patients who do not have the capability to pay for healthcare services.
13. Outreach to schools on education that includes oral hygiene.
14. Expand partnerships with local schools to expand school based clinic programs.
15. Ongoing evaluation for providers for the areas we serve throughout Logan Health's patient population.

Logan Health Whitefish has invested and will continue to invest in many programs and services to improve access to care including:

1. Ongoing evaluation of the need for additional providers in the areas we serve.
2. Tracking "third next available" appointments, a measure from CMS to help us understand patient access to a given provider, as well as their clinic in general.
3. Offering blocked "same day" appointments in primary care clinics to allow our patient population prompt availability to providers for acute needs.
4. Designation of a walk-in provider for the rural patients in Eureka that do not have nearby access to urgent care or emergency services.
5. Extended hours for primary care clinics.
6. Charity care, sliding fee scale, uninsured/under insured discounts, and payment options for those in financial need.

7. Emergency Department Acute Care Plans to help Emergency Department patients transition to external follow-up care.
8. Representative to participate on the Transportation Advisory Committee to address transportation to access care.
9. Continue participation in Save a Sister initiative to provide free mammograms to women in financial need.
10. Continue participation in the Save the Brain Program that develops and promotes cohesive and coherent concussion education, evaluation and treatment system related to concussion care.
11. Expand partnerships with local schools to expand school based clinic programs.

To augment these services, Logan Health and Logan Health Whitefish will:

a. Expanding Access Initiatives (Location, Hours, Telemedicine, Templates, Productivity)

***Logan Health Medical Center Will*:**

Actions	***Anticipated Impact***	***Logan Health Resources***	***Potential Collaborations***
1. Implement centralized appointment scheduling.	Streamline process for patients to improve accessibility across LHMC.	Logan Health Clinic HIT Logan Health employed Physicians	Unidentified External Vendor Guidehouse
2. Implement 24-hour Nurse Call Center.	Better support for patients to help navigate to the appropriate level of care.	Logan Health Clinic Logan Health Nursing	Guidehouse
3. Enhance on-line scheduling options through the patient portal.	Enhance options for patients to improve their experience and allow for after-hours scheduling opportunities.	Logan Health Clinic HIT	
4. Expanding Care Coordination to include Principle Care Management and Chronic Care Management services.	Improved patient care for population in need of chronic care management.	Logan Health Nurse Care Managers Logan Health Clinics	
5. Collaborate with community partners to expand transportation access.	Improved patient compliance with appointments by breaking down transportation barriers.	ASSIST	Mountain Climber Transit Community Transit Groups

6. Expand partnerships with local schools to increase school-based health center services.	Increased attendance rates at schools for faculty and students. Improve access to medical services for faculty and students. COVID support for faculty and students.	Logan Health School-Based Center	Local school districts Greater Valley Health Center Flathead County Health Department
7. Advance telemedicine onto a singular platform while advancing behavior health, urgent care, and acute care telehealth services.	Improved patient outcomes and enhance the patient experience for the Logan Health population.	Logan Health patient experience team Logan Health Information Technology Team	Logan Health Whitefish patient experience team

***Logan Health Whitefish Will*:**

Actions	***Anticipated Impact***	***Logan Health Whitefish Resources***	***Potential Collaborations***
1. Expand Behavioral Telehealth to outlying areas: Conrad, Shelby, and Chester.	Outreach to rural areas using tele health to help those who suffer with mental health issues.	Logan Health Whitefish Behavioral Health	Rural Health Center
2. Ensure our patient population is aware of our added service in Columbia Falls of walk-in services.	Patients have same day access for unplanned concerns.	Marketing and clinic management strategize on multi-faceted approach of sharing newly offered service.	Primary care system-wide service offerings.
3. Eureka to recruit an approved additional provider.	By adding a provider to our staff, patients will be able to make an appointment sooner than what our third next available currently shows, and hopefully at a time more convenient for them.	Logan Health Eureka	
4. Explore opportunities for care coordinators to schedule chronic care management appointments when appropriate to allow for	When appropriate level of care, RN Care Coordinators can be utilized to schedule appointments with in collaboration with providers to address chronic care needs and outcomes. Focus could include concentrating on patient engagement as well.	Logan Health Whitefish Care Coordinators and Providers.	

more access to acute care appointment with providers.			

b. Oral Health

***Logan Health Medical Center Will*:**

Actions	*Anticipated Impact*	*Logan Health Resources*	*Potential Collaborations*
1. Refer oral health needs for underserved community members to organizations offering free or discounted oral health services.	Help facilitate a greater number of families obtaining oral health care.	Financial support for Shepherd's Hand Clinic Primary Care Clinic care coordinators	Shepherd's Hand Clinic Greater Valley Health

***Logan Health Whitefish Will*:**

Actions	*Anticipated Impact*	*Logan Health Whitefish Resources*	*Potential Collaborations*
1. Refer oral health needs for underserved community members to organizations offering free or discounted oral health services.	Help facilitate a greater number of families obtaining oral health care.	Financial support for Shepherd's Hand Clinic Primary Care Clinic care coordinators	Shepherd's Hand Clinic Greater Valley Health
2. Explore opportunities for assistance in oral health in Eureka.	Finances seem to be a barrier in receiving proper oral health. By educating ourselves to the resources, we can better educate our patients.	Logan Health Eureka Staff	Lincoln County Public Health

SOCIAL DETERMINANTS OF HEALTH (SDoH)

1. ENVIRONMENTAL DETERMINANTS:

Logan Health Medical Center recognizes the importance of social determinants of health and wellbeing for our community members and will continue to provide:

1. Financial Assistance and sliding fee scale programs to aid patients who do not have the capability to pay for healthcare services.
2. Support for other non-profits who work to alleviate challenges related to SDoH.
3. Support for Mountain Climber Transit and the Northern Transit to provide public transportation to healthcare facilities.
4. Continue to work with community partners to help with housing and shelter needs through Complex Care Navigation and ASSIST.
5. Participate in community discussions about need for affordable and low-income housing.
6. Continue to support utilization of ASSIST Center for patient transportation options and short-term non-medical lodging options.
7. Support ASSIST Program in coordinating specific clinic days to maximize ride sharing.
8. Continue to partner with State of Montana for gas cards to improve patient compliance with Diabetes Prevention Program.
9. Continue to help patients through ASSIST program and Complex Care Navigation in access to local and federal food resource programs.
10. Organizational involvement in the development of community walking/biking paths in all Flathead County cities/areas.
11. Engagement with local area organizations and governments on active transportation initiatives.
12. Delivery by the Logan Health Foundation Community Outreach Committee of backpacks to schools to address food insecurity.
13. Outreach to schools providing education on body image, tobacco use, hygiene, oral hygiene, nutrition, activity, substance abuse and healthy cooking.

Logan Health Whitefish recognizes the importance of social determinants of health and wellbeing for our community members and will continue to provide:

1. Financial assistance and sliding fee scale programs to aid patients who meet financial guidelines regarding ability to pay for healthcare services.
2. Support for other non-profits who work to alleviate challenges related to SDoH.
3. Support for transportation services to provide public transportation to healthcare facilities.
4. Continue and expand Food Rx programs for patients screened as food insecure; support and partnership with other non-profits who specialize in providing food resources to the food insecure.
5. Collaboration with the Flathead Valley Breastfeeding Coalition and Baby Friendly USA certification program to promote breastfeeding; free community classes on breastfeeding, including an ongoing weekly support group, to promote optimal family nutrition by the Logan Health Whitefish Birth Center.
6. Continue to work with community partners on education of housing and shelter needs and availability.

7. Partner with ASSIST for transportation assistance, short-term non-medical lodging option, connect to food resources, and completing local and federal assistance programs applications.

To augment these services, Logan Health Medical Center and Logan Health Whitefish will:

a. Poverty

***Logan Health Medical Center Will*:**

Actions	*Anticipated Impact*	*Logan Health Resources*	*Potential Collaborations*
1. Expand screening of Social Determinates of Health to identify patient needs and establish pathways to connect patients with needs.	Consistently provide opportunities to identify at risk patients and align access to community resources.	Care Coordinators Clinic Staff	Community Action Partnership of MT
2. Create a system committee to establish a Logan Health approach to understanding SDoH components and their connection to population health.	A Logan Health strategy and road map in order to more effectively care for patients within our community who are at risk and need access to community resources.	Logan Health Leadership	
3. Participate and support community efforts toward offering food, transportation and housing options for those in need.	Participation in community organizations to allow Logan Health Medical Center to be aware of potential solutions for those in poverty.	Logan Health staff to serve on community boards	Community Action Partnership of MT Flathead Food Bank Samaritan House Flathead Warming Center Ray of Hope

***Logan Health Whitefish Will*:**

Actions	*Anticipated Impact*	*Logan Health Whitefish Resources*	*Potential Collaborations*
1. Continue screening for social determinants of health in the clinic setting and expand the population that is screened.	Identify at risk patients and align access to community resources.	Care Coordinators Clinic Staff	
2. Implement screening tool for social determinants of health in the ED and Inpatient setting.	Identify at risk patients and align access to community resources.	Staff to develop screening protocol and implement.	

b. Housing

***Logan Health Medical Center Will*:**

Actions	*Anticipated Impact*	*Logan Health Resources*	*Potential Collaborations*
1. Participate in community efforts towards providing affordable housing options for those in need.	Participate in community discussions and organizations addressing emergency, low income, temporary and permanent housing.	ASSIST	Community Action Partnership of MT Flathead Food Bank Samaritan House Flathead Warming Center Ray of Hope

***Logan Health Whitefish Will*:**

Actions	*Anticipated Impact*	*Logan Health Whitefish Resources*	*Potential Collaborations*
1. Continue screening for social determinants of health in the	Identify at risk patients and align access to community resources.	Care Coordinators Clinic Staff	Community Action Partnership of MT

clinic setting and expand the population that is screened.			
2. Implement screening tool for social determinants of health in the ED and Inpatient setting.	Identify at risk patients and align access to community resources.	Staff to develop screening protocol and implement.	Community Action Partnership of MT

c. Transportation

***Logan Health Medical Center Will*:**

Actions	***Anticipated Impact***	***Logan Health***	***Potential Collaborations***
1. Collaborate with community partners to expand transportation access for those lacking resources.	Collaboration between Mountain Climber and ASSIST will increase access to medical appointments for those who lack personal transportation.	ASSIST	Mountain Climber Public Transportation Flathead County Commissioners

***Logan Health Whitefish Will*:**

Actions	***Anticipated Impact***	***Logan Health Whitefish Resources***	***Potential Collaborations***
1. Continue screening for social determinants of health in the clinic setting and expand the population that is screened.	Identify at risk patients and align access to community resources.	Care Coordinators Clinic Staff	
2. Implement screening tool for social determinants of health in the ED and Inpatient setting.	Identify at risk patients and align access to community resources.	Staff to develop screening protocol and implement.	

3. Logan Health Whitefish representative sits on TAC, Transformation Advisory Committee. Continue to partner to address transportation barriers to healthcare.	Address needs and solutions to support and advocate on behalf of patients on barriers to access to care and transportation.	Staff member to attend committee	Mountain Climber Uber Taxi services Assist Northern Transit Interlocal
4. Eureka to provider vouchers by Cowboy Taxi to those in need.	Transportation for certain individuals is difficult as they depend family/friends and may not always be convenient. By providing a voucher to a patient with this need, will allow them to receive the healthcare they need.	Logan Health Eureka staff	Cowboy Taxi

d. Population in Poverty | Food Insecurity

***Logan Health Medical Center Will*:**

Actions	***Anticipated Impact***	***Logan Health Resources***	***Potential Collaborations***
1. Evaluate current identification of patient food insecurity and provide information on available community resources to help meet patient food needs.	Provide information and access to community food resources and anticipate a reduction in food insecurity on SDOH surveys by 2023.	Care Coordination Guiding Council Care Coordinators Inpatient and Outpatient staff	Local food banks Community Kitchens Faith-based Organizations
2. Assess and evaluate opportunities currently provided through Food RX program and create assessment tools to show efficacy of program and to consider opportunities to expand.	Assessment tools will allow analysis of the strengths and weaknesses of the program and opportunities for improvement and possible expansion of the Food RX program.	Diabetes Program Staff	Local farmers and farmer's markets when in season Local grocery stores year-around

***Logan Health Whitefish Will*:**

Actions	*Anticipated Impact*	*Logan Health Whitefish Resources*	*Potential Collaborations*
1. Screening tool for social determinants of health in the clinic setting.	Identify at risk patients and align access to community resources.	Care Coordinators	
2. Implement screening tool for social determinants of health in the ED and Inpatient setting.	Identify at risk patients and align access to community resources.	Staff to develop screening protocol and implement.	
3. Continue to partner with Farm Hands and Food Rx Program, and explore opportunities to expand to Eureka.	Expand on current initiatives to improve healthy food access.	Logan Health Whitefish Care Coordinators and clinic staff	Farm Hands

SOCIAL DETERMINANTS OF HEALTH (CONTINUED)

2. COMMUNITY RESILIENCE:

Logan Health Medical Center is committed to providing care that focuses on an individuals' overall wellbeing by continuing:

1. To follow its core values including "showing compassion to every person, every time."
2. Chronic Care Management program to identify barriers to health and social services and assist with navigation to community partners with expertise in the identified services.
3. Identify medical exams and procedures that exacerbate trauma and approach patients from a culture of safety, empowerment and healing.
4. Continue to support ASSIST Program in providing non-medical lodging, transportation, Neighbors Helping Neighbors, and connection to community resources.
5. Continue to invest in Community Resource Partners who visit people in their homes to connect them to community resources to help them regain their health and independence. Examples include: Medicaid, food stamps, disability and Veteran benefits.

Logan Health Whitefish is committed to providing care that focuses on an individuals' overall wellbeing by continuing:

1. Its culture of Planetree Patient Centered Care that focuses on caring for the mind, body and spirit in a healing environment at the hospital, Logan Health Whitefish clinics and associated offices.
2. Logan Health Whitefish Birth Center clinical staff training and monthly community support groups for Postpartum Mood Disorders and Perinatal Loss, weekly Mother/Baby Support groups.
3. Chronic Care Management program to identify barriers to health and social services and assist with navigation to community partners with expertise in the identified services.
4. Expand screening of adverse childhood events (ACE) to incorporate into patients' plan of care.
5. Continue to collaborate with ASSIST Program in providing non-medical lodging, transportation, neighbors helping neighbors, and connection to community resources.

To augment these services, Logan Health Medical Center and Logan Health Whitefish will:

a. Trauma Informed Care

***Logan Health Medical Center Will*:**

Actions	*Anticipated Impact*	*Logan Health Resources*	*Potential Collaborations*
1. Provide Trauma Informed Training once a year for hospital and clinic staff.	Recognizing the health needs of patients that have experienced trauma through screenings and interventions to incorporate into treatment plan and optimal health outcomes.	Behavioral Health	Community behavioral health providers.

***Logan Health Whitefish Will*:**

Actions	*Anticipated Impact*	*Logan Health Whitefish Resources*	*Potential Collaborations*
2. Logan Health Whitefish Birth Center implementation of human trafficking and domestic violence screening.	Address holistic screenings and provide navigation assistance to ensure the safety of the population we serve.	Cost of staff time to develop screening process and staff education.	Abbie Shelter Law enforcement
3. Provide Trauma Informed Training for hospital and clinic staff.	Recognizing the health needs of patients that have experienced trauma through screenings and interventions to incorporate into treatment plan and optimal health outcomes.	Logan Health Whitefish Behavioral Health	Community behavioral health providers.

b. Access to Non-Clinical Services

***Logan Health Medical Center Will*:**

Actions	*Anticipated Impact*	*Logan Health*	*Potential Collaborations*
1. Chronic Care Navigation program to identify barriers to social	Help patients obtain the non-clinical assistance they need as a foundation for overall health and wellbeing.	Care Coordinators	ASSIST, Agency on Aging, Flathead City-

services and assist with navigation to community partners with expertise in the identified services.			County Health Department, Community Action Partnership, United Way, Kalispell Veterans Center, Samaritan House & more
2. Develop an evidence based bereavement program.	Help patients obtain the non-clinical assistance they need as a foundation for overall health and wellbeing	Social Workers Chaplains Care Coordinators	

***Logan Health Whitefish Will*:**

Actions	***Anticipated Impact***	***Logan Health Whitefish Resources***	***Potential Collaborations***
1. Continue to expand Chronic Care Management program to identify barriers to health care for hospital and clinic patients and assist them with navigation to needed non-clinical services.	Help patients obtain the non-clinical assistance they need as a foundation for overall health and wellbeing.	Care Coordinators	ASSIST, Agency on Aging, Flathead City-County Health Department, Community Action Partnership, United Way, Kalispell Veterans Center, Samaritan House & more
2. Expand screening to identify needs of non-clinical services on admission and referral to social worker.	Early identification of needs will help ensure a safe and effective discharge plan and referrals as needed.	Logan Health Whitefish Social Workers	ASSIST, Agency on Aging, Flathead City-County Health Department, Community Action Partnership, United Way, Kalispell Veterans Center, Samaritan House & more