# Social Determinants of Health
# ACCELERATOR PLAN

August 2023

Lewis & Clark County, Montana

# Contents

# Acknowledgments

In late 2022, Lewis & Clark County contracted with two public health consulting groups - Yarrow, LLC and WE Public Health - who collaborated to provide facilitation of team meetings, strategic planning, and technical writing of this report.

## Land Acknowledgment

We thank and honor the Séliš (Salish), Q̓lispé (Pend d'Oreille/Kalispel), Ksanka (Kootenai), Niitsitapi-Pikuni (Blackfeet), Annishinabe (Chippewa [Ojibwe]), Ne-i-yah-wahk (Plains Cree), A'aninin (Gros Ventre), Nakoda, Nakona (Assiniboine), Lakota, Dakota (Sioux), Tsetsêhesêstâhase and So'taa'eo'o (Northern Cheyenne), Apsáalooke (Crow), Annishinabe and Métis (Little Shell Chippewa) people as the traditional inhabitants of Montana. This acknowledgment is a first step in reconciliation and demonstrates a commitment to the original peoples and their descendants.

## SDOH Leadership Team and Key Informants

The creation of this Social Determinants of Health Accelerator Plan would not have been possible without the contributions from the Social Determinants of Health Leadership Team. Their ideas, expertise, and dedication to this project are greatly appreciated.

- Nancy Andersen, AARP Montana
- Melissa Baker, Cancer Screening Health Educator (LCPH)
- Quincy Bjornberg, Helena Indian Alliance
- Stephanie Burkholder, Yarrow
- Emily Burton, Mountain Pacific
- Jennifer McKeever, WE Public Health
- Tim Mielke, Montana Pride and Helena Indian Alliance
- Joel Peden, Montana Association of Centers for Independent Living
- Sarah Sandau, Lewis and Clark Public Health
- Haylie Wisemiller, St. Peter's Health
- Michele Zentz, Helena Public Schools

Additional gratitude is extended to the nine key informants who were interviewed during the early stages of this plan. These local partners provided input on community strengths and weaknesses, shared experiences/interactions, and provided ideas on how to address SDOH. Their guidance and support are appreciated in helping to lay the foundation for this work.

# Background

## Community Background

***Describe and define the tribe, community, or catchment area that the SDOH Accelerator Plan will address. Include any relevant background or historical information that contributes to the current health and social community context.***

Lewis and Clark County (L&C County) is an urban-rural county in west-central Montana. Covering 3,459 square miles, the county has an estimated population of 70,973.[1] The county includes two municipalities, Helena and East Helena, with additional small communities (≤1,000 pop) spread throughout the county. Almost half of the residents live within Helena at the southern end of the county, which is the county seat and state capitol. Over 90% of the county's population resides within the greater Helena area (within 20 miles of the city center). The predominant racial group within L&C County is White (93.7%), followed by Hispanic or Latino (3.8%) and American Indian/ Alaska Native (2.2%).[1] English is the primary language (97%) spoken in the county.[1]

Within L&C County, the greater Helena area is served by two major healthcare organizations, St. Peter's Health and Benefis Health System. St. Peter's Health is a nonprofit healthcare system that includes a 99-bed acute care hospital, physician clinics, a cancer treatment center, a 24-bed behavioral health unit, urgent care clinics, home health and hospice care, a dialysis center, and ambulance services.[2] Benefis Health System is a more recent addition to the healthcare landscape in L&C County. Currently, its Helena services include internal medicine, family practice, urgent care, gastroenterology, and imaging services.[3] Expansion of services from Benefis is currently underway with several new buildings under construction in Helena.

PureView, a Federally Qualified Healthcare Center (FQHC), provides primary care, integrated behavioral health and dental services, and supports the Healthcare for the Homeless program.[4] There is also one Urban Indian Health Center in Helena - Leo Pocha Memorial Clinic - which is a designated FQHC that provides comprehensive primary care and related services to American Indians and Alaska Natives.[5] A few other smaller, privately-owned clinics provide some primary care, urgent care, and other healthcare services, mainly in the greater Helena area.

Despite the variety of healthcare entities in the greater Helena area, there is very limited access to healthcare and community services in the rural county areas outside of Helena. For example, the town of Lincoln is home to approximately 1,000 year-round residents.[6] PureView has a satellite clinic in Lincoln (Parker Medical Center) that provides primary care services Monday-Friday, yet there are no pharmacy services, labs/imaging, specialty, or dental services located within the community. Residents needing those services often travel to Helena (56 miles one way), Missoula (77 miles one way), or Great Falls (88 miles one way). The small town of Augusta (pop. 233[7]) is only served by one part-time county health nurse. No other healthcare services are available in the community.

1 U.S. Census Bureau. (2020). *Quick facts: Lewis & Clark County, Montana; United States*. Retrieved April 6, 2023, from https://www.census.gov/quickfacts/fact/table/US/PST045222

2 St. Peter's Health. (n.d.). *About us*. Retrieved April 12, 2023 from https://www.sphealth.org/about-us

3 Benefis Health System. (n.d.) *Benefis in Helena MT*. Retrieved April 12, 2023 from https://www.benefis.org/benefis-in-helena/helena-home

4 PureView Health Center. (n.d.) *About PureView*. Retrieved April 12, 2023 from https://pureviewhealthcenter.org/about-and-history

5 Leo Pocha Memorial Clinic. (n.d.). *Our services*. Retrieved April 12, 2023, from https://www.hia-mt.org/leo-pocha

6 World Population Review. (2023). Lincoln, Montana population 2023. Retrieved June 6, 2023, from https://worldpopulationreview.com/us-cities/lincoln-mt-population

7 World Population Review. (2023). *Augusta, Montana population 2023*. Retrieved June 6, 2023, from https://worldpopulationreview.com/us-cities/augusta-mt-population

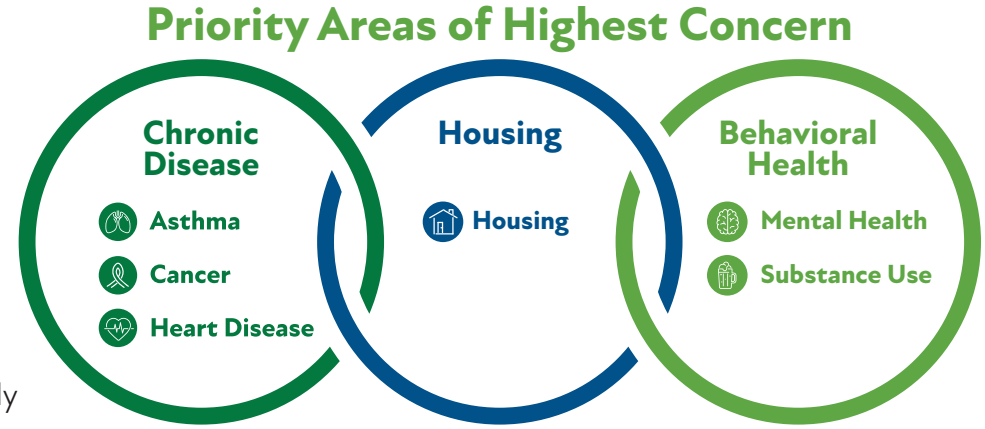
Fortunately, the percentage of L&C County residents who have health insurance increased from 90% in 2012 to 94% in 2019, meaning the county's health insurance coverage rate was higher than rates for both Montana and the United States.[8] However, in 2021, the most common (22%) barrier to obtaining healthcare for county residents was difficulty in getting a medical appointment.[8]

# Community Health Issues

***Identify primary health issues in the community and describe how the recipient used data to determine primary health issues in the community including information about the Community Health Needs Assessment if relevant.***

In 2021, Lewis and Clark Public Health (LCPH) collaborated with community partners to publish its Community Health Report that summarizes the overall health of county residents with regard to chronic disease, communicable disease, environmental health, and mental health among many other indicators. Through this process, the top priority areas[8] identified as primary health concerns for L&C County are:

- Asthma
- Cancer
- Heart disease
- Housing
- Mental health
- Substance use




Each of these health concerns can be significantly impacted by social determinants of health (SDOH), and these SDOH impacts are amplified for those populations that face the most barriers to accessing health and community services, which includes the county's rural residents, American Indians, LGBTQ+ residents, seniors, and people living with disabilities.

The most recent Community Health Improvement Plan (published by LCPH in 2022) identifies the following priority areas[9] based on the results of the Community Health Assessment:

- Chronic disease
- Behavioral health
- Housing

8 Lewis & Clark County Healthy Together Steering Committee. (2021). *Community health report: A community partnership to improve health*. Retrieved from https://www.lccountymt.gov/fileadmin/user_upload/Health/Communications/Publications/Community Health Assessment_LC_2021_adjusted.pdf

9 Lewis & Clark County Healthy Together Steering Committee. (2022). *Lewis & Clark County community health improvement plan*. Retrieved from https://www.lccountymt.gov/fileadmin/user_upload/Health/Communications/Publications/Community Health Improvement Plan_2022_FINAL-revwithdate.pdf

## Chronic Disease

Importantly, chronic disease has been a key issue in L&C County for the past several Community Health Assessments and Community Health Improvement Plans. In L&C County, chronic diseases such as cancer, heart disease, and chronic lower respiratory diseases are the leading causes of death among county residents.[2] L&C County also has higher mortality rates due to cancer and chronic lower respiratory diseases when compared to both the state of Montana and the United States as a whole.[2]

The Community Health Assessment cites data demonstrating that food insecurity can make individuals more susceptible to developing chronic disease or make the health conditions more difficult to manage. Populations living in neighborhoods with low incomes, communities of color, and rural areas are less likely to have access to supermarkets and health food and tend to have a higher density of fast-food restaurants and other sources of unhealthy food such as convenience stores.[8] Additionally, L&C County Capital Public Transportation is mostly established in the more densely populated cities of Helena and East Helena, making public transportation options out of reach for residents not residing in those two municipalities.[8]

The Community Health Improvement Plan outlines strategies to improve the health of all county residents over the next three years, with the SDOH Accelerator Plan helping to activate efforts to decrease rates of chronic disease. The development of a comprehensive, action-based Social Determinants of Health Accelerator Plan that is focused on target populations and priority areas is a necessary next step to further health equity in L&C County and to successfully implement the Community Health Improvement Plan priorities.

### Overarching Chronic Disease Goal

Design culturally responsive policies, systems and environments in Lewis and Clark County for making the healthy choice the easy choice so that all community members can thrive in a culture that sustains health and prevents chronic disease.

# Selected Population(s)

***Describe the population(s) selected and the process by which this population was identified. Include a description of data used to identify selected population(s) (e.g., demographic, geographic, political boundaries, size of population).***

Among residents of L&C County, five target populations were identified as facing the greatest barriers to healthcare access, greater health inequities, and poorer health outcomes specifically related to chronic disease. These five populations are rural residents, American Indians, seniors, LGBTQ individuals, and people living with disabilities.

**Rural Residents:** Two of the most rural towns in L&C County are Lincoln and Augusta. Augusta is only served by one part-time county health nurse; no other healthcare services are available in the community. The nearest hospital to Augusta is 58 miles away (Benefis Teton Medical Center in Great Falls). Lincoln has primary care services available at Parker Medical Center (PureView Health Center), but the nearest hospital is 59 miles away (St. Peter's Health in Helena). Rural communities

have fewer resources to prevent and treat chronic diseases compared to urban communities, and they also face higher rates of multiple chronic conditions, which are difficult and expensive to treat.[10] Thus, residents of Augusta and Lincoln not only face significant geographic barriers to healthcare services but also shoulder a greater proportion of chronic diseases needing comprehensive treatment.

**American Indians:** Residents identifying as American Indian/Alaska Native comprise 2.2% of the total population in L&C County and is the second largest minority group among residents.[1] There are no federally designated American Indian Reservations within the borders of L&C County; however, there is a significant population of American Indians who live and work in the greater Helena area. According to the L&C County Community Health Assessment, "in 2017-2019 L&C County mortality age-adjusted rate per 100,000 population for cardiovascular disease among the American Indian population was significantly higher (321 per 100,000) compared to rates of White (194 per 100,000) and Hispanic (122 per 100,000)" (p. 20).[6] In addition, the Community Health Assessment reports that non-White L&C County residents had a higher rate of disabilities.[6]

**Seniors/Older Adults:** Per the 2020 Census,19.7% of L&C County residents are 65 years and older.[1] Older adults in a rural county are more likely to be isolated, which leads to challenges in mental health, nutrition, physical activity, engagement, and more. According to the 2018 Needs Assessment from the county's local Area on Aging, 30% of senior respondents listed nutrition as a need, and 36% listed hunger as a serious concern.[11] Subsequently, the 2021 Needs Assessment from the same local Area on Aging found that rural seniors have a barrier of transportation for services, specifically detailing that "Augusta has no transportation and older adults need help in getting groceries and going to doctor appointments" (p. 327).[12]

**LGBTQ Individuals:** Lesbian, gay, bisexual, transgender, and queer (LGBTQ) populations across the United States encounter significant barriers to healthcare. Many members of the LGBTQ community have difficulty finding providers who are knowledgeable about their needs, encounter discrimination from insurers or providers, or delay or forgo care because of concerns about how they will be treated.[13] Given these barriers to care and discrimination, many LGBTQ people may not receive the timely and important screening and prevention efforts that are critical to early identification and treatment of chronic diseases. There is a lack of data specific to LGBTQ individuals residing in L&C County. Anecdotal reports from community members describe discrimination in seeking healthcare services and barriers to care based on their gender identity, gender expression, and/or sexual preference. Objective data regarding this topic is significantly limited and demonstrates a need to further collect population-specific information to aid in county-wide planning efforts. According to Healthy People 2030, collecting population-level data is key to meeting the needs of the LGBTQ community, but not all state and national surveys include demographic questions on sexual orientation and gender identity.[14] Therefore, part of this  Accelerator Plan will entail a strategy for data collection for this group.

10 Rural Health Information Hub. (n.d.). *Chronic disease in rural America*. Retrieved from https://www.ruralhealthinfo.org/topics/chronic-disease#overview

11 Rocky Mountain Development Council. (2018). *Rocky's Community Needs Assessment*. Retrieved from https://www.rmdc.net/impactbar/community-needs-assessment.html

12 Rocky Mountain Development Council. (2021). *Rocky's Community Needs Assessment*. Retrieved from https://www.rmdc.net/impactbar/community-needs-assessment.html

13 Human Rights Watch. (2018). *You don't want second best: Anti-LGBT discrimination in U.S. healthcare.* Retrieved from https://www.hrw.org/sites/default/files/report_pdf/us_lgbt0718_web.pdf

14 Office of Disease Prevention and Promotion. Healthy People 2030. (n.d.) *Overview and objectives: LGBT*. Retrieved from https://health.gov/healthypeople/objectives-and-data/browse-objectives/lgbt

**People Living With Disabilities:** People living with disabilities represent 13.3% of the county population, with arthritis being the most common cause of disability among adults.[8] Compared with individuals without disabilities, those with disabilities are less likely to get recommended preventive services such as teeth cleanings and cancer screenings; are at a higher risk for obesity, high blood pressure, falls, and mood disorders; and are more likely to engage in unhealthy behaviors, like using tobacco and avoiding physical activity. According to the survey in 2018 done by the local Area on Aging, over 19% of senior respondents indicated that their disability is the main barrier to their health.[11]

# Partnerships

## Leadership Team

***Describe the Leadership Team, including the organizational affiliation of each team member, the community and/or population that each member represents, and the role they will serve in developing and reviewing the SDOH Accelerator Plan.***

Recruitment for the SDOH Leadership Team began in January 2023, and the complete team was finalized in March 2023. A previous survey by the L&C County Healthy Communities Coalition (HCC) - a group of local health advocates who work together on policies, programs, environmental challenges, and systems change - had identified several gaps in representation among coalition members. Those gaps included LGBTQ and American Indian populations, so significant recruitment efforts were made to include representation of those populations in the SDOH Leadership Team.

A diverse group of ten partners and residents of L&C County make up the SDOH Leadership Team. One additional member (consultant) resides outside of Montana. The following table lists each member's area of representation and their affiliated organization. Please note that two of the partners also reside in rural areas (one of the target populations) of the county.

| Area of representation | Organization |
|---|---|
| Seniors/older adults* | AARP Montana |
| Care coordination/chronic disease/Seniors* | Mountain Pacific |
| Cancer/chronic disease | Cancer Screening Health Educator (LCPH) |
| American Indians/Native Americans* | Helena Indian Alliance |
| Hospital/healthcare | St. Peter's Health |
| People with disabilities* | Montana Association of Centers for Independent Living |
| LGBTQ+* | Montana Pride |
| People experiencing homelessness | Helena Public Schools Homeless Liaison |
| Public health | Lewis and Clark Public Health |
| Public health | Yarrow (public health consulting group) |
| Public health | WE Public Health (public health consulting group) |

*Target Population

Members of the Leadership Team were provided the opportunity to attend the Montana Public Health Association (MPHA) annual conference in Billings, MT April 3-5, 2023. Of the ten Leadership Team members, six were able to attend the conference to engage in further public health education, networking, and team building.

The Leadership Team assisted in developing and reviewing the SDOH Accelerator Plan. In addition to contributing ideas and expertise, Helena Indian Alliance also hosted the majority of in-person meetings and provided technical support during the meetings. Two public health consultants - Yarrow and WE Public Health - provided facilitation of the team meetings, strategic planning, and technical writing of this report.

# Multi-Sector Partners

***Describe new partner linkages and how duplication of services across partners was minimized or avoided.***
Throughout the plan's development, the Leadership Team shared information and resources about activities already being implemented within the county to assure that duplication of services was avoided in the final plan. Several of these activities were seen as programs that could be replicated or expanded, which would further reduce potential duplication.

***Identify potential missing partners that may contribute to improving SDOH.***
The Leadership Team identified other partnerships necessary to successfully implement the SDOH Plan (see Implementation Plan). These include representatives from public transportation and city planning, and other healthcare facility representatives (particularly one facility that has a DEI team). In addition, although the Leadership Team and persons interviewed included rural residents, there is a need to ensure engagement from rural communities moving forward.

***Describe methods used to engage diverse and inclusive new and existing partners in program planning and implementation efforts.***
In addition to a diverse Leadership Team, additional partners were engaged through key informant interviews (KIIs) to inform the plan's development (described below). A few of the key informants asked to be kept apprised of the plan and any future implementation work, and they will be provided a copy of the final Accelerator Plan.

# Programs and Resources for SDOH

## Existing Resources and Programs

***Describe the existing resources and programs available for the selected population(s).***
Numerous programs and resources exist in L&C County to address several of the social determinants of health. The Community Health Improvement Plan identifies several programs and resources on page 9 of the plan:

## Chronic Disease Continuum | Lewis and Clark County

### Data and Surveillance

- Community Health Report
- State Health Improvement Plan
- State epidemiologists
- Healthy People 2030
- LCPH epidemiologist
- Sources: Behavioral Risk Factor Surveillance Survey (YRBS), Insurance Data, Vital stats
- Today's Air DEQ
- Montana Tumor Registry

### Environmental Approaches

- Active Living Wayfinding Plan
- Tobacco free policies Clean Indoor Air Act (CIAA), parts, point of sale
- Community gardens
- Harvest of the month: Schools and Community
- Helena Food Program
- Complete Streets
- WIC Farmer's Market
- Double snap dollars for produce
- Senior food vouchers at farmers market/senior commodities
- School Meal Program
- Air quality monitoring
- Asthma monitoring in schools

### Community Programs Linked to Clinical Services

- Diabetes prevention program and self management education
- reACT Tobacco prevention in schools
- St. Peter's Health (SPH) - Food Rx, Food is Care, Food Farmacy
- Chronic Disease self management courses
- Worksite wellness programs
- Tobacco cessation courses
- SNAP Ed Nutrition Classes
- Peer breast feeding supports
- Helena schools District wellness committee
- Asthma home visiting
- Health coaches for Hypertension

### Healthcare System Interventions

- SPH Dietitians
- Culinary Medicine SPH
- Arthritis movement classes
- SPH Cancer Navigators
- Breast and Cervical Health Program

Additionally, during the first few brainstorming sessions with the SDOH Leadership Team, members identified the following existing community assets, some of which overlap with what was recognized in the CHIP. The following are organized by the three priority areas:

1. **Community Clinical Linkages**
    a. Helena Indian Alliance has a program (through a Native-only grant) that sends their nurses to patients' homes for vital signs, physical assessment, and blood draws, then connects them with a clinician via telehealth on site
    b. Mobile mammography van through St. James Healthcare (SCL Health) to serve rural residents in SW Montana
    c. Care Van provides access to vaccines and preventive services to Montanans, with an emphasis on rural and underserved populations. The Care Van has supported providers in providing access to free and/or low costs immunizations, health screenings (such as bone density screenings, A1C testing, etc.), sports physicals, mammograms, oral care and educational resources.
    d. Statewide telehealth programs (see more at the Montana Telehealth Alliance website)
    e. Helena Indian Alliance Elders Program, which is a partnership with Rocky Mountain Development Council (RMDC). HIA will pick up the prepared meals from RMDC each day and bring the meals back to HIA. There is a room with a TV where the elders can sit and visit while they eat together.
    f. MonTECH (University of Montana) provides technology, support, and services that improve the quality of life for Montanans with disabilities
2. **Food and Nutrition Security**
    a. Food pantry at Helena Indian Alliance: a separate food pantry open to enrolled tribal members and descendants
    b. Helena Food Share currently supplies food to approximately 8,000 individuals in the Helena area (99% are at or below the poverty level) and is actively fundraising to build a new Community Food Resource Center to expand services and offerings to Helena and its surrounding communities
    c. Augusta has a small food bank (run by the local public health nurse) that offers $20 gift cards to use only on fresh produce at the local grocery store
    d. Helena Community Gardens provides the tools and knowledge to grow food, and increases access to healthy and affordable food.
    e. A local Community Food System Assessment (including all of Lewis & Clark County) is currently being conducted and will be completed in August 2023 with priority areas and an action plan.
    f. Food is Care program run in partnership with St. Peter's Health and Helena Food Share helps people with diet-sensitive health conditions get the nutrition they need from free food boxes filled with specific items to help manage or improve their health condition.
    g. Harvest of the Month program showcases Montana-grown foods in Montana communities and is open to K-12 schools, after school programs, Summer Food Service Programs, early care and education facilities, producers, businesses, farmers markets, food banks, and healthcare institutions in Montana.

h. Montana State University Extension offers cooking classes in Augusta

i. Natural Grocers grocery store in Helena has a quality space for community cooking classes

j. Food Rx program through St Peter's Health includes connections to a dietitian and food cards to a local grocery store

3. **Built Environment**

a. The Helena South Hills trail system is expansive (70+ miles of trail), open to hikers and bikers, well-maintained, and in close proximity to Helena. Other trails can be found all throughout the county, although some require driving quite a distance to reach.

b. Helena has been awarded Silver-Medal Ride Center status by the International Mountain Biking Association (IMBA)

c. Helena Indian Alliance provides gas cars to its patients to help decrease transportation barriers to the clinic

d. Capital Transit system (Helena/East Helena) free curb-to-curb service (ride scheduling model)

e. AARP Outdoor Fitness Classes in East Helena's Kennedy Park on equipment donated by AARP

f. AARP NeighborWalk 6-week program based on the Arthritis Foundation's Walk With Ease program

# Approach

To prepare for developing the SDOH Accelerator Plan, the consultant conducted background research and preparatory work, including reviewing the L&C County Community Health Report and Community Health Improvement Plan, presenting to the full Healthy Communities Coalition on the SDOH Accelerator Plan, and conducting nine key informant interviews.

***Methods used to engage diverse and inclusive new and existing partners.***
Key informants represented a diverse pool of partners who provided input on community strengths and weaknesses, shared experiences/interactions, and provided ideas on how to address SDOH. Key informants were identified by the local consultant and through contacts from LCPH. The following perspectives and areas of expertise were included across the interviewees:

- Lived Experience
- Rural Residents*
- American Indians/Native Americans*
- Seniors/Older Adults*
- LGBTQ+*
- Persons with Disabilities*
- Clinical Services

*Target Population

After the KIIs and with their input and other community connections, ten representatives were invited to participate on the Leadership Team and participate in four brainstorming sessions to develop the SDOH Accelerator Plan.

The L&C County Community Health Improvement Plan was foundational to helping the Leadership Team understand the impact of chronic disease on residents, as well as to identify health disparities and community concerns. All Leadership Team members were provided copies of the Community Health Assessment and Community Health Improvement Plan to read before the first brainstorming session.

After the KIIs were completed, a review of the data from these interviews was presented at the first SDOH Leadership Team brainstorming session to generate ideas and discussion on areas to explore more. After this initial brainstorming session, three more in-person brainstorming sessions were held to a) articulate barriers, b) identify strengths and opportunities, c) prioritize opportunities and d) create an implementation plan with goals, strategies, and activities.

The team then reviewed the activities against the five priority populations to ensure that each was being considered in the activities. Where gaps were identified, additional activities were introduced, or existing activities modified, to assure each priority population was considered in the planned efforts.

# Shared Mission

***The Leadership Team will articulate a shared mission statement that represents the purpose of the SDOH Accelerator Plan, with mutually agreed upon goals.***

The mission of the SDOH Accelerator Plan is to create and assure culturally responsive policies, systems, and environments in L&C County that focus on the social determinants of health and health equity as critical components of chronic disease prevention and management.

The plan's goals are bold and will require close collaboration with a wide array of collaborators - staff, community members, partner organizations, and civic leaders - to tackle the complex health challenges that people in L&C County experience. The COVID-19 pandemic illustrated the critical need for public health organizations to apply practices that 1) engage multiple voices from all sectors of the community and 2) enable room for learning, experimentation, and adaptive practices based on what is being learned along the way.[15] There are no known answers or quick fixes to remove the long-standing structural barriers to equitable health.

The plan outlines a pathway to guide collaborative strategy and action to improve the health of all L&C County residents. It is laid out as a 3-year plan; however, it is intended to be flexible. Through the process of regular reviews of progress, the plan will be edited or updated to assure that it remains current and relevant.

15 See Adaptive Strategy Building Blocks for additional information: https://tinyurl.com/yckm3bdv

# Priority Areas, Goals, and Outcomes

- ***Describe the short-, intermediate, and long-term outcomes that will result from the planned SDOH strategies and activities.***
- ***Methods used to engage diverse and inclusive new and existing partners***
- ***Describe the selected SDOH priority areas (a minimum of two (2) and provide justification for selecting the priority areas).***

The planning process resulted in the identification of three priority areas, which formed the goals for the SDOH Accelerator Plan:

- Support and sustain chronic disease efforts by increasing training opportunities in cultural humility for healthcare providers.
- Support and sustain chronic disease efforts by increasing transportation options/methods for those experiencing transportation-related barriers to healthcare services.
- Support healthy, accessible, and affordable food systems by increasing mobile food service options.

## Goal: Increase the number of healthcare providers in L&C County who participate in cultural humility training

One theme that emerged from KIIs was the concern that many healthcare providers in L&C County do not have proper training and/or knowledge of cultural practices and cultural humility. As one key informant said, "There are gaps in education and tolerance by the providers themselves," which often leads to patients avoiding particular clinics/providers, delaying screenings/treatments, or feeling a need to seek healthcare services outside of the county completely (but only if they have the financial and transportation means to do so). Examples from the SDOH Leadership Team include providers using the wrong pronouns, not getting support or referrals at the time of a diagnosis of Alzheimer's dementia, and clinics or healthcare buildings that are not always ADA-compliant or welcoming to people with disabilities. Examples of discrimination were shared that specifically involved most of the target populations (LGBTQ+, American Indians, people with disabilities, and seniors/elderly).

The majority of SDOH Leadership Team members suggested increasing the number of healthcare providers in L&C County who receive cultural humility training, and this priority area received the highest number of votes. Cultural humility is active engagement in an ongoing process of self-reflection, in which individuals seek to[16]:

- Examine their personal history/background and social position related to gender, ethnicity, socio-economic status, profession, education, assumptions, values, beliefs, biases, and culture, and how these factors impact interpersonal interactions.
- Reflect on how interpersonal interactions and relationships are impacted by the history, biases, norms, perception, and relative position of power of one's professional organization.

16 Centers for Disease Control and Prevention. (n.d.) *Principle 1: Embrace cultural humility and community engagement.* Retrieved from https://www.cdc.gov/globalhealth/equity/guide/cultural-humility.html

- Gain deeper realization, understanding, and respect of cultural differences through active inquiry, reflection, reflexivity, openness to establishing power-balanced relationships, and appreciation of another person's/community's/population's expertise on the social and cultural context of their own lives (lived experience) and contributions to public health and wellbeing.
- Recognize areas in which they do not have all the relevant experience and expertise and demonstrate a nonjudgmental willingness to learn from a person/community/population about their experiences and practices.

**Short-term outcome:** More healthcare providers have received training in cultural humility.
**Intermediate outcome:** Healthcare organizations in L&C County require all staff to complete training in cultural humility, both upon hire and throughout their tenure at the organization.
**Long-term outcome:** All persons in L&C County receive respectful, culturally-informed, quality care.

## Goal: Reduce transportation-related barriers to healthcare access

Inconvenient or unreliable transportation can interfere with consistent access to healthcare, potentially contributing to negative health outcomes, and evidence supports that transportation barriers are an important barrier to healthcare access, particularly for those with lower incomes.[17] As noted by one key informant, "Helena is mostly a walkable city when the weather is good but ice, potholes, chaotic intersections, trains, etc. create substantial issues for even able-bodied people to access locations." A different key informant mentioned that "Helena needs a more robust and advertised public transit system" and that Helena "could be much more bike-friendly."

Additional transportation barriers specific to L&C County are highlighted by significant geographic isolation experienced by small, rural communities. As discussed in the Community Background section, Lincoln residents may need to travel to Helena (56 miles one way), Missoula (77 miles one way), or Great Falls (88 miles one way) to receive services beyond primary care. The small town of Augusta (pop. 233) is only served by one part-time county health nurse; no other healthcare services are available in the community. As one key informant said, "I would like to see L&C County be more engaged with the rural components of the county. We are easy to forget because we're a small voice, not loud, and we've learned to be quiet."

Ideas and examples that emerged from the SDOH Leadership Team brainstorming sessions included providing gas cards to patients, expanding Helena's public transit system, looking into ride-share programs, and increasing telehealth or mobile healthcare services. This priority area received the second-highest number of votes from the SDOH Leadership Team.

**Short-term outcome:** At least two additional options to make accessing needed care easier for persons experiencing transportation-related barriers.
**Intermediate outcome:** More L&C County residents who face transportation barriers are able to access healthcare.
**Long-term outcome:** All persons in L&C County have access to healthcare, without limitations.

17 Syed, S. T., Gerber, B. S., & Sharp, L. K. (2013). Traveling towards disease: Transportation barriers to healthcare access. *Journal of Community Health, 38*(5), 976–993. doi: 10.1007/s10900-013-9681-1

## Goal: Support healthy, accessible, and affordable food systems by increasing mobile food service options

As described by Healthy People 2030, "access to foods that support healthy dietary patterns supports health not only at that point in time but also across the lifespan. Consistent evidence demonstrates that a healthy dietary pattern is associated with beneficial outcomes for all-cause mortality, cardiovascular disease, overweight and obesity, type 2 diabetes, bone health, and certain types of cancer (breast and colorectal). Having access to healthy, safe, and affordable food is crucial for an individual to achieve a healthy dietary pattern."[18] When interviewed, key informants shared numerous challenges surrounding food access, affordability, and nutrition. Regarding access and affordability, key informants living in rural areas mentioned extremely limited access to food (for example, having only one small grocery store without much fresh produce), lack of farmers' markets, and extremely expensive produce if it was available. Additionally, one key informant stated that "sometimes Native residents don't like going to [Helena] Food Share because of all of the personal questions they ask" meaning there may be cultural or discrimination concerns dissuading residents from seeking out particular services. Key informants also voiced concerns about education or assistance programs that once worked but have fizzled out. For example, healthy cooking classes that no one attended, grant-funded fresh food boxes that are no longer available, CSAs that are no longer available, and local produce sellers that decided to take their business to bigger and busier locations.

Throughout the brainstorming sessions, several discussions centered around if there is a way to get food to somebody who doesn't have a reliable way to get it themselves. Ideas and examples that emerged from the SDOH Leadership Team brainstorming sessions included exploring the Mail a Meal program (through the Montana Food Bank Network), expanding the Food is Care food box delivery program, learning more from the Helena Indian Alliance food pantry, and discharging patients home from the hospital with a sack lunch so they have a meal for that night when going home.

**Short-term outcome:** At least 2 additional or enhanced options for food available to L&C County residents.
**Intermediate outcome:** More L&C County residents have access to needed food.
**Long-term outcome:** All persons in L&C County have access to the food they need without limitations.

# Activities

***Describe the process for identifying and tailoring approaches to the selected tribe, community, or catchment area.***
In the first SDOH Leadership Team brainstorming session, the group reviewed the key findings from the interviews, including opportunities/assets and barriers in community-clinical linkages, food and nutrition security, and the built environment. The approach to developing the plan included identifying tactics (activities) that build on or expand existing opportunities to reach the target populations. In some cases where appropriate, tactics were added or modified to assure reach to vulnerable individuals (e.g., persons experiencing housing instability).

18 Office of Disease Prevention and Health Promotion. (n.d.). *Healthy People 2030. Access to foods that support healthy dietary patterns.* Retrieved from https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-foods-support-healthy-dietary-patterns

*Please see the Implementation Plan starting on page 21 for additional details on the activities required to improve SDOH for the selected population(s).*

***Describe the number and types of evidence-based practices identified and tailored to improve SDOH for the selected population(s).***

1. **Training on cultural humility / cultural safety**
   a. Think Cultural Health (USDHHS Office of Minority Services) includes several resources, including a free, online educational program on culturally and linguistically appropriate services (CLAS) accredited for physicians, physician assistants, and nurse practitioners.
   b. Introduction to Cultural Safety training course through Frontier Nursing University. This free, 3-hour online course defines cultural safety, identifies the three key tenets of cultural safety, explains the impacts of colonization on Indigenous people in the U.S., describes what culturally safe vs. culturally unsafe care may look like, and discusses personal and systems strategies for improving the cultural safety of care.
   c. Access to Care for Rural People with Disabilities Toolkit teaches about approaches rural communities can use to improve access to care for people with disabilities
   d. Health Equity Resources from the National Association of Chronic Disease Directors
2. **Transportation**
   a. The Rural Transportation Toolkit contains resources and information focused on developing, implementing, evaluating, and sustaining rural transportation programs. Specifically for this SDOH Accelerator Plan, a specific section on Models to Overcome Transportation Barriers provides further details and examples of models such as telehealth, mobile clinics, school and workplace-based health, and home visiting programs.
3. **Food Access**
   a. St. Peter's Health uses The Hunger Vital Sign, a validated two-question screening tool designed to identify individuals and families at risk for food insecurity. It helps healthcare providers assess and address food insecurity during patient visits.
   b. At the Rural Health Information Hub, Approaches to Increase Access to Foods that Support Healthy Eating Patterns includes details and examples of diverse approaches, including Food Systems Models (such as food policy councils and land use policies), Food Hubs, Community Gardens, Mobile Markets, Healthy Corner Stores, Community Supported Agriculture, Farmers Markets, and Farm to School Models
4. **Other general evidence-based models/resources:**
   a. Social Determinants of Health in Rural Communities Toolkit compiles evidence-based models and resources to support organizations implementing programs to address social determinants of health in rural communities.

***Describe how policy, systems, environmental, programmatic and infrastructure activities build on each other to sustain health improvements and the achievement of selected outcomes.***
The SDOH Accelerator Plan aligns with the chronic disease portion of the Community Health Improvement Plan, such that each is reinforcing the other. The HCC will be responsible for overseeing and monitoring this portion.

In addition, because the SDOH Accelerator Plan deliberately builds on existing opportunities and assets, the Plan's activities will better sustain health improvements than if they were implemented independently.

***Describe the types of community and systemic barriers encountered and addressed during the plan development process.***
The following barriers and opportunities were identified by the key informants and the SDOH Leadership Team.

## Community-Clinical Linkages

**Barriers**

- Gaps in education and tolerance by healthcare providers. For example, not all providers are trained and have knowledge of cultural practices and cultural humility.
- Augusta: Logan Health's Winkley Mobile Mammography only travels to Choteau, not Augusta. Additionally, there are no physical therapy, counseling, pharmacy or other medical care options in town.
- Distance to services (even primary care but especially specialty care) is too great. Difficult access for rural residents or residents working 9-5 jobs.
- Parker Medical Clinic in Lincoln does not have a lab and can't draw blood for lab work for someone who isn't their patient.
- Parker Medical Clinic in Lincoln does not have a physician.
- L&C County could be more engaged with the rural components of the county. We are easy to forget because "we're a small voice, not loud, and we've learned to be quiet."
- It is hard to know all of the resources available.

**Opportunities/Assets**

- Helena Indian Alliance Elders Program
- Vans/mobile health units
- Telehealth
- Nurse practitioners: good at linking community services, case management services

## Food and Nutrition Security

**Barriers**

- Sometimes Native residents don't like going to Helena Food Share because of all of the personal questions they ask.
- Lincoln has one grocery store and that's the only access in Lincoln. No farmers markets, no fresh markets, no access to local, fresh produce. What is available at the grocery store is what they get.
- Food access is not wonderful and we talk about it a lot in Envision Lincoln.

- Farmers Markets in Lincoln: they heard "there were already so many farmers markets elsewhere" and it wasn't worth their time because there were bigger and better options, so it didn't make sense for them to come [to Lincoln].
- Augusta: Being affiliated with Montana Food Bank Network "is too much paperwork." They (Augusta) "are a small community and can do it themselves."
- Food is getting expensive. It is getting scarier.
- Lower allocation of food stamps now.
- Farmers Market is good but it's only in the summer.
- Nutrition sometimes fights strongly against affordability and access. Specifically for people with Celiac disease, access to cheap and staple foods is significantly more difficult (and sometimes impossible) depending on where you live and what stores you can access.
- Large population with diabetes, but it's hard to get fresh fruits and vegetables.

**Opportunities/Assets:**

- Strengthen projects in the community that are currently running and effective, and seeking their input. Working with groups like the food bank or other programs for media boost, support, and to inform the public about.
- Camp Child (YMCA) in Elliston, MT is a food provider location and they would bring the food there and allow local kids in Elliston to come to get food. Going pretty smoothly. Bring it to the people vs. making them come to us.
- Billings and Missoula: their food pantries are very robust and don't feel like a literal pantry (Helena).
- Augusta: Started a program with the local grocery store - can come in for a $20 gift certificate to buy fresh fruits and veggies only at the local grocery store.
- Tried Bountiful Baskets (Lincoln) and that went well for a while and then it fizzled out...took what you could get but often had unfamiliar foods that people didn't know what to do with.
- Helena Indian Alliance (HIA) Food Pantry for enrolled tribal members and descendants.
- Deals with local entities, like the Helena Community Gardens, or local stores to have a sort of rebate, extra coupons, etc.
- Abundant Montana is working with stakeholders to create a local food assessment with gaps, strengths, and strategies.

## Built Environment

**Barriers**

- Helena is mostly a walkable city when the weather is good but ice, potholes, chaotic intersections, trains, etc. create substantial issues for even able-bodied people to access locations.
- Helena needs a more robust and advertised public transit system.
- One area that could be improved is Helena being bike friendly - Missoula is so much more bike-friendly.

- E-bikes on trails is controversial
- There are a lot of skiing/hiking opportunities but they aren't all that well known or accessible from town (Lincoln)
- Only a recent interest in expanding access to trails for people with disabilities.

**Opportunities/Assets**

- Lincoln Downtown Master Plan coming soon
- Reigniting relationship between Lincoln and Prickly Pear Land Trust
- Elders Uber (Rosebud Reservation - South Dakota)

# Anticipated Reach of the Activities

***Describe the potential reach of the activities for the selected population(s).***
The Plan's activities are intended to reach all target populations. The Plan focuses on learning from existing programs that have been successful and expanding these to reach larger populations, particularly in rural areas with limited transportation options.

# Anticipated Policy, Systems, Environmental, Programmatic and Infrastructure Outcomes

***Describe sustainable outcomes that will result from the implementation of the SDOH Accelerator Plan strategies and activities.***
The formation and convening of the Leadership Team has resulted in the formation of new partnerships and the sharing of existing resources and assets available across the county. The partnerships gained during the planning include agencies that have been historically hard to engage in the coalition. After implementation, those partnerships will be sustained and continuously engaged in a mutually beneficial manner. This will create additional inter-agency support, communication, and referral between agencies. In addition, the SDOH Plan will be incorporated into the infrastructure of the HCC.

The expected outcomes from the SDOH Accelerator Plan strategies and activities include:

- All persons in L&C County receive respectful, culturally-informed, quality care.
- All persons in L&C County have access to healthcare, without limitations.
- All persons in L&C County have access to the food they need, without limitations.

# Evaluation of the SDOH Accelerator Plan Strategies

***Describe how the SDOH Accelerator Plan strategies and outcomes will be measured, with a particular focus on the social and public health impact on the selected population(s).***
Early in the Plan's implementation (see Goal 1), an evaluation plan and approach will be determined with the HCC. The Plan will provide an opportunity for the HCC to develop an evaluation and monitoring system for all initiatives, including those outlined in the SDOH Accelerator Plan.

Please see the Implementation Plan starting on page 22 for specific measures.

***Describe the evaluation purpose, goals, evaluation questions, data collection, and methods.***
The purpose of the evaluation is to identify whether the strategies and tactics of the plan are having the intended results. The HCC will work with the LCPH Epidemiologist to create the evaluation plan in the first year. Where possible, existing sources of data will be used (rather than conducting primary data collection) to establish a baseline and track progress over time. Goal 1 of the Implementation Plan calls for identifying data sources and processes to compile and review data over time. Process measures are included in the work plan below. Impact measures will be included with each goal to track progress with the evaluation questions in mind during the first year of implementation.

For long term outcome measures, the Community Health Improvement Plan created a dashboard to track long term chronic disease metrics. At the end of the implementation of the SDOH Accelerator Plan, the leadership team will compare to the CHIP Dashboard to see if long term progress has been made.

## Data Integration

***Describe existing data sources across partners.***

- L&C County Community Health Improvement Plan Portal houses a specific dashboard that records chronic disease metrics
- Montana Community Health Insights includes data from Montana-specific public health surveillance sources, including vital statistics, hospital discharge, emergency department discharge, the Behavioral Risk Factor Surveillance Survey (BRFSS), and the cancer registry.
- Census and Economic Information Center provides data on population, housing, income/poverty, and community profiles in Montana
- Healthdata.gov
- CDC Places
- Robert Wood Johnson Foundation County Health Rankings & Roadmaps provide county-level data in terms of health outcomes and health factors.
- Montana Public Health Data Resource Guide may provide additional data sources relevant to selected populations

- L&C County Community Health Assessment (the next Community Health Assessment will be published in Fall 2024)
- L&C County Community Health Improvement Plan
- Behavioral Risk Factor Surveillance Survey (BRFSS)
- Youth Risk Behavior Survey

***Describe the process for monitoring and integrating data elements to create a comprehensive system for tracking selected population(s) resource utilization.***
One resource available includes Community Health Insights. The CONNECT Referral System is another avenue to obtain data about referrals between agencies with a possibility of disaggregating by demographics. As noted above, the first goal of the plan includes the identification of data sources and establishing a process for monitoring progress on the plan's activities. As this is a 3-year plan, additional effort will be placed on assuring a comprehensive system for tracking resource utilization in future years, provided additional funding is obtained.

# Responsible Party

The SDOH Plan will be an initiative of the HCC. The HCC meets quarterly. Two working groups - Food/Nutrition/Physical Activity and Aging Well - meet monthly. The HCC will maintain responsibility for evaluating the SDOH Plan, along with other HCC initiatives. The Coalition does not have existing processes for evaluation, but developing and formalizing these is part of Goal 1 of the Implementation Plan.

# Implementation Plan

***Provide a budget for implementing the strategies and activities.***
L&C County does not have sufficient funding to cover the plan's implementation and oversight at this time but has begun the process of identifying and securing funding. To provide leadership to the plan's implementation, at least one part-time position will be needed as well as resources to coordinate regular meetings with the SDOH working group. The first year implementation will require community collaborations, helping organizations change their systems, looking for funding, and helping with evaluation. The budget will cover the FTE for a person and additional materials needed for collaborations. It is estimated that at least $80,000 will be needed for the first year of implementation.

***Provide a work plan with a timeline to complete proposed strategies and activities.***
The initial work plan is a 3-year plan starting on January 1, 2024. When the implementation begins, the plan will be updated to include target completion dates and assign responsible parties for each of the tactics.

Champions will be assigned to each work plan goal. The champions will be responsible for engaging appropriate partners to complete the activities and providing updates to the coalition at quarterly meetings.

The plan is meant to be adapted as it is implemented. There are no known answers or quick fixes to remove the long-standing structural barriers to equitable health. Given the complex challenges, the aim is to address them by positively influencing SDOH, and it is intended to engage multiple voices, continue learning and adapting, and review, edit, and revise the plan on at least a twice-annual basis.

In addition, there are multiple tactics in the plan to investigate more about the landscape and opportunities to expand or replicate existing programs. As such, the HCC will add new strategies and tactics based on what is being learned along the way.

# SDOH Accelerator Work Plan

## Goal 1: Establish the necessary infrastructure to begin implementation of the plan's activities (Goals 2-4) and track progress over time.

**Goal Champion:** Sarah Sandau, LCPH

**Target Populations:** Rural residents, American Indians, Seniors/Elders, LGBTQ, and Persons with Disabilities

**Partners:** SDOH Leadership Team and Healthy Communities Coalition

| Strategies | Tactics | Measures | Timeframe to Complete |
|---|---|---|---|
| **Secure funding to support staff time, systems coordination, coalition expenses, and training.** | **1.** Conduct a scan and document all potential sources of funding. | # Funding sources | Month 2 |
| | **2.** Submit at least 2 proposals for funding (See Sustainability/funding strategy section below for more detail). | # Proposals submitted | Year 1 |
| **Incorporate the SDOH Plan into the HCC operations and processes.** | **1.** Create and adopt a Charter for HCC that outlines plans to diversify membership, monitor and track progress on key initiatives (including the SDOH plan), responsibilities, and leadership roles. | Coalition Charter developed | Month 3 |
| | **2.** Add agenda item to the November meeting to propose ideas for incorporating the SDOH plan and Leadership Team into existing coalition structures (e.g., workgroups, process evaluation activities, etc.). | Complete/ Not Complete. | Month 1 |
| **Establish a process for monitoring and tracking resource utilization.** | **1.** Identify existing data sources that can be accessed to track progress on measures. | # Data sources identified | Year 1 |
| | **2.** Create and implement a standard process for collecting/compiling the data. | Complete/ Not Complete | Year 1 |
| | **3.** Establish a process for reviewing data/measures twice per year. | On track/ Off track | Year 1 |
| | **4.** Implement the process in years 2-3. | On track/ Off track | Years 2-3 |

## Goal 2: Increase the number of healthcare providers in L&C County who participate in cultural humility training.

**Goal Champion:** To be assigned by the HCC and SDOH Leadership Team

**Target Populations:** Rural residents, American Indians, Seniors/Elders, LGBTQ Individuals, and Persons with Disabilities

**Partners:** Helena Indian Alliance; Mountain Pacific; PureView; SPH Diversity, Equity and Inclusion Taskforce; LCPH Inclusiveness Committee; CMS (health equity strategy); Benefis Health System

| Strategies | Tactics | Measures | Timeframe to Complete |
|---|---|---|---|
| **At a county-wide level, Medical Directors and/or healthcare facility CEOs require cultural humility training for staff.** | | **Long-term measures: # persons who receive culturally appropriate and respectful care.** | |
| | **1.** Identify parameters for what constitutes a quality training opportunity. Review and compile a recommended list of training available and cost, balancing the need for population-specific/ cultural-specific education and education on issues such as housing instability. | # Training resources identified | Year 1 |
| | **2.** Identify and document the potential motivators for leaders to implement the requirement (e.g., CMS requirements) that can be shared with healthcare facility leaders). | Complete/ Not Complete | Month 6 |
| | **3.** Pilot the training process with a local healthcare clinic. | # new staff that participate in required training | Pilot ready to launch end of Year 1 Launch and conduct QI in Year 2 |
| | **4.** Conduct Quality Improvement (QI) project to identify strengths and opportunities for improvement. | 1 new facility implements training requirement | Year 3 |

## Goal 3: Reduce transportation-related barriers to healthcare access.

**Goal Champion:** To be assigned by the HCC and SDOH Leadership Team

**Target Populations:** Rural residents, Seniors/Elders, Persons with disabilities

**Partners:** Helena Indian Alliance (diabetes program), St. James Mobile Mammography, Transportation Advisory Council (start with City Manager and L&C County to explore how to expand and how to fund), LCPH Cancer Screening Coordinator, PureView, LCPH Behavioral Health Services, United Way of Lewis and Clark County, Mountain Pacific

| Strategies | Tactics<br>*The tactics for this goal are focused on learning: Connect with existing programs to learn more about these, and how they may be replicated or expanded. Additional tactics will be developed after the learning phase. | Measures | Timeframe to Complete |
|---|---|---|---|
| **Increase transportation options to healthcare facilities.** | **1.** Develop a county map of all transportation resources and identify gaps and opportunities. Note: Completion of the below 'learning tactics' will inform the map. | **Long-Term Measures:**<br># missed appointments due to transportation issues<br># new transportation options | |
| | | Map completed | Year 1 |
| | **2.** Investigate rideshare and provision of gas cards. Provide a summary of findings to HCC/SDOH Leadership Team. | Summary provided and discussed | Month 6 |
| | **3.** Engage with the City Transportation Council to share transportation concerns and attempt to collaborate to identify opportunities to reduce barriers. | Summary provided and discussed | Month 6 |

| | | | |
|---|---|---|---|
| **Increase mobile healthcare services (including expanded mobile mammography) that reach rural residents and persons experiencing housing instability.**<br><br>**Increase mobile healthcare units that are accessible for persons with disabilities.** | **1.** Develop a county map of all mobile healthcare services, aligned with the map of transportation resources (see above). Identify gaps and opportunities. Note: Completion of the below 'learning tactics' will inform the map. | Map completed | Year 1 |
| | **2.** Learn about the St. James mobile mammography route (what is their long-term plan to reach more communities?). Provide a summary and discuss it with HCC/SDOH Leadership Team. | Summary provided and discussed | Month 6 |
| | **3.** Meet with HIA to learn about their diabetes program. | Complete Not Complete | Month 6 |
| | **4.** Identify personnel (St. Peter's Health and PureView) to learn more about their diabetes prevention programs, and see if there is opportunity to pilot similar mobile diabetes programs for homebound, elderly, and persons with disabilities. Provide a summary of findings to HCC/SDOH Leadership Team. | Summary provided and discussed | Month 6 |
| | **5.** Learn about "ASSIST" in the Flathead area. Provide a summary of findings to HCC/SDOH Leadership Team. | Summary provided and discussed | Month 6 |
| | **6.** Investigate community paramedics as a resource for mobile healthcare (e.g., current program through Logan Health Cut Bank). Provide a summary of findings to the HCC/SDOH Leadership Team. | Summary provided and discussed | Month 6 |
| | **7.** Investigate the opportunity to partner with behavioral health providers who are launching a mobile service in the near future (PureView/LCPH Behavioral Health mobile services). Provide a summary of findings to HCC/SDOH Leadership Team. | Summary provided and discussed | Month 6 |
| **Advocate for continued expanded telehealth (initiated during COVID-19) and the related supports (e.g., broadband).** | **1.** TBD: The Leadership Team identified telehealth as an important strategy to increase access to healthcare. However, specific tactics were not discussed. The strategy remains in the plan; tactics will be developed after Year 1. | On track/ Off track | Year 2 |

## Goal 4: Support healthy, accessible, and affordable food systems by increasing mobile food service options.

**Goal Champion:** To be assigned by the HCC and SDOH Leadership Team

**Target Populations:** Rural residents, American Indians, Seniors/Elders, LGBTQ Individuals, Persons with Disabilities

**Partners:** Helena Food Share, Montana Food Bank Network, Rocky Mountain Development Council, Aging Well Workgroup, Food/Nutrition/Physical Activity Workgroup, SPH Clinical Nutrition and Population Health, Envision Lincoln, Mountain Pacific, Salvation Army

| Strategies | Tactics | Measures | Timeframe to Complete |
|---|---|---|---|
| **Identify gaps in food service delivery/mobile food options.** | **1.** Create a map of the food access resources for our higher need community members. Who is serving whom? Where are the gaps? Can we help these programs work together?<br>**2.** Prioritize programs to support/ expand based on the gaps and opportunities identified in the map. | **Long-term measures:** # of families, # individuals, # children who experience food security on a consistent basis (6 months or more). # persons from target populations who experience food security on a consistent basis. | |
| | | Complete/ Not Complete | Year 1 |
| | **3.** Share the map with community partners. | Map disseminated to # community partners | Month 18 |
| | **4.** Connect with Montana Food Bank Network to learn from other communities using the service (Augusta, Lincoln). | Complete/ Not complete | Month 6 |

| | | | |
|---|---|---|---|
| **Provide sack lunch/meal (in accordance with the patient's specific diet order) to persons who wish to receive the service upon discharge from a medical facility.**<br><br>**Refer seniors to Meals on Wheels when discharged from a medical facility.** | **1.** Assess if there is a need this group can fill. | Complete/ Not Complete | Year 1 |
| | **2.** If there is a need determined, research best practices and develop recommendations about and when food should be offered upon discharge. | Complete/ Not Complete | Year 2 |

# Sustainability / Funding Strategy

***Describe strategies to expand, diversify, and sustain implementation efforts, including funding.***
Funding for the SDOH Accelerator Plan will require diverse and braided sources. The goal is to apply for and receive funding for items relating to systems coordination, FTE, coalition expenses, and training. Those federal sources could be the Centers for Disease Control and Prevention, the National Association of Chronic Disease Directors, or the White House. State and local sources could supplement a federal source by helping with participant stipends, incentives, supplies, and media. State funding sources include the Montana Department of Public Health and Human Services, Montana Area Health Education Center, Rural Health Institute, and Montana Healthcare Foundation. Local sources could include Helena Community Foundation, St. Peter's Health Foundation, or AARP mini-grants. Local sources would need a 501(c)3 to apply, which the HCC does not have. Thus, a partner organization would have to be backing in order to apply for those funds.

To support sustainability and expand and diversify the efforts, the SDOH Plan will be incorporated into the HCC infrastructure. The HCC is developing a charter that will outline steps to diversify membership and continue to engage a widening circle of community members and partners who hold a piece of the puzzle to improving chronic disease conditions in L&C County.

At the next quarterly HCC meeting, the group will determine the process for incorporating the SDOH Accelerator Plan's oversight and evaluation into its existing infrastructure (e.g., create a 3rd working group or identify an existing community coalition focused on implementing some or all of the plan).

Champions will be assigned to each work plan goal. The champions will be responsible for engaging appropriate partners to complete the activities and providing updates to the coalition at quarterly meetings.

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