2025-2028 IMPLEMENTATION STRATEGY

Frances Mahon Deaconess Hospital

TABLE OF CONTENTS

IDENTIFYING SIGNIFICANT HEALTH NEEDS

ABOUT FRANCES MAHON DEACONESS HOSPITAL

Frances Mahon Deaconess Hospital (FMDH), based in Glasgow, Montana, is a not-for-profit, 25-bed critical access hospital serving the Valley County Region. With 250 employees, FMDH provides services primarily to residents of Valley County, but also serves those in neighboring cities and towns. FMDH is accredited by The Joint Commission.

It is our mission to provide quality healthcare services with efficiency. FMDH provides the following services:

- Anesthesia/Pain Management Services
- Audiology & Hearing Services
- Dietary
- EMS Services
- Glasgow Clinic Primary Care
- General Surgery
- Hi-Line Med Spa
- Home Oxygen & Durable Medical Equipment
- Labor, Delivery and Recovery
- Laboratory Services
- Nutrition Services
- OB/GYN
- Orthopedic and Sports Medicine
- Outpatient Infusion Therapy
- Privacy Officer
- Radiology Services
- Rehabilitation Services (including Physical and Occupational Therapy)
- STAT Air
- Surgical Services
- WIC Program

FMDH maintains a department dedicated to addressing its outreach objectives of serving the entire community, not only those who come through its doors. Building on a long tradition of service, the Community Outreach Department utilizes hospital strengths alongside those of other well-established community partners.

This strategy allows FMDH to better understand and reach the most vulnerable sectors of the community, while meeting pressing healthcare needs. The goal is to improve the community's health status by empowering citizens to make healthy life choices.

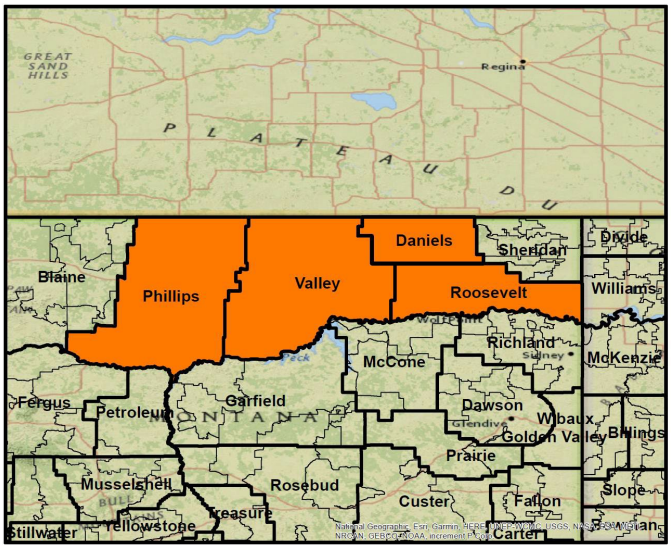
Frances Mahon Deaconess Hospital completed its last Community Health Needs Assessment in 2025.

OUR COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA)

FMDH recently embarked on a comprehensive Community Health Needs Assessment (CHNA) process to identify and address the key health issues for our community.

Definition of the Community Served

Frances Mahon Deaconess Hospital's community, as defined for the purposes of the Community Health Needs Assessment and Implementation Strategy, include four Montana counties: Daniels, Phillips, Roosevelt, and Valley. This community definition, determined based on the areas of residence of most recent patients of Frances Mahon Deaconess Hospital, is illustrated in the following map.



How CHNA Data Were Obtained

The CHNA incorporated data about the community from multiple sources, including both primary and secondary data:

- A population-based survey among a representative sample of community residents (the PRC Community Health Survey)
- An online survey of public health representatives, health providers, and a variety of other community service providers and stakeholders (the PRC Online Key Informant Survey)
- A review of existing vital statistics, public health, census, and other data

The CHNA allowed for extensive comparison to benchmark data at the state and national levels.

The assessment was conducted on behalf of Frances Mahon Deaconess Hospital by PRC, a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

Identifying & Prioritizing Health Needs

Areas of Opportunity

Significant health needs (or “Areas of Opportunity”) were determined in our CHNA after consideration of various criteria, including standing in comparison with benchmark data; identified trends; the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue.

Prioritized List of Health Needs

After reviewing the Community Health Needs Assessment findings, internal team members and community stakeholders met to evaluate and prioritize the top health needs for our community. The participants were asked to evaluate each health issue along two criteria: 1) scope and severity of the health issue; and 2) the hospital’s/community’s ability to impact that issue. Individual ratings for each criterion were averaged for each tested health issue, and then these composite criteria scores were averaged to produce an overall score. This process yielded the following prioritized list of health needs for our community:

1. Mental Health
2. Substance Use
3. Tobacco Use
4. Diabetes
5. Cancer
6. Nutrition, Physical Activity & Weight
7. Oral Health
8. Disabling Conditions
9. Heart Disease & Stroke
10. Sexual Health
11. Infant Health & Family Planning
12. Access to Health Care Services
13. Injury & Violence
14. Respiratory Diseases

ADDRESSING THE SIGNIFICANT HEALTH NEEDS

HOSPITAL-LEVEL COMMUNITY BENEFIT PLANNING

This summary outlines FMDH's plan (Implementation Strategy) to address our community's health needs by 1) sustaining efforts operating within a targeted health priority area; 2) developing new programs and initiatives to address identified health needs; and/or 3) promoting an understanding of these health needs among other community organizations and within the public itself.

Priority Health Issues to Be Addressed

In consideration of the top health priorities identified through the CHNA process — and considering hospital resources and overall alignment with the hospital's mission, goals, and strategic priorities — it was determined that FMDH would focus on developing and/or supporting strategies and initiatives to improve:

- Mental Health
- Heart Disease & Stroke
- Diabetes

Issues That Will Not Be Addressed & Why

In acknowledging the wide range of priority health issues that emerged from the CHNA process, FMDH *determined* that it could only effectively focus on those which it deemed most pressing, most under-addressed, and/or most within its ability to influence.

Health Priorities Not Chosen for Action	*Reasons*
Nutrition, Physical Activity & Weight	*The advisory committee believes initiatives outlined for Heart Disease & Stroke and Diabetes will also drive improvements in diet, activity, and weight. Creating a separate program would duplicate effort and strain limited staff and fiscal resources.*
Substance Abuse	*Substance-use treatment and prevention in our region are led by the Valley County Health Department and Eastern MT Community Mental Health Center. Given FMDH's lack of inpatient detox or MAT services and the availability of existing community resources, the advisory committee ranked this a lower priority for direct hospital action.*
Cancer	*Regional oncology services already provide screening, infusion, and navigation. Advisory-committee members agreed that, relative to other areas of opportunity, cancer presented a lower gap FMDH could uniquely fill with current resources.*
Access to Health-Care Services	*Access barriers (insurance, transportation, workforce) are being tackled through ongoing initiatives. The committee felt designating an additional, stand-alone objective would dilute effort without adding measurable benefit.*
Infant Health & Family Planning	*Valley County WIC, VCHD, and Tribal Public Health programs already lead prenatal, postpartum, and family-planning services. FMDH will continue to refer patients but lacks the capacity to launch new, hospital-led programming in this area during the current cycle.*
Tobacco Use	*Existing TUPP, Quit Line, and school programs already cover cessation and prevention; with limited additional capacity, the advisory committee placed this below our selected priorities.*
Respiratory Disease	*COPD/asthma hospitalization rates in the service area are lower than state averages, and major drivers (tobacco, air quality) overlap with other priorities. Limited resources and lower relative burden led the committee to defer focused respiratory-disease initiatives.*
Sexual Health	*Sexual-health education and STI services are coordinated by county public-health nurses and Tribal clinics. Cultural considerations and the availability of specialized programs indicate a low incremental impact from hospital-led efforts in the current plan.*
Injury & Violence	*The advisory committee determined that primary prevention of injury and violence is best addressed by law enforcement and community coalitions. FMDH's role remains clinical treatment; limited resources and low ability to influence upstream factors preclude a dedicated hospital initiative.*
Disabling Conditions	*Long-term management of disabling conditions hinges on social-service networks, housing, and state policy. With limited resources and minimal leverage over these determinants, the committee concluded FMDH has a low capacity to effect change in this area during this cycle.*
Oral Health	*FMDH does not provide dental services, and private dentists/Public Health dental programs serve the community. Advisory-committee members rated oral health a lower priority relative to mental health, heart disease, and diabetes, given limited hospital capacity to intervene directly.*

2025-2028 IMPLEMENTATION STRATEGY

Action Plans

The following displays outline FMDH's plans to address those priority health issues chosen for action in the 2025-2028 period.

Priority Area #1: Mental Health	
Community Health Need	Expand access to mental-health care and strengthen prevention, early intervention, and ongoing support.
Goal(s)	• Reduce stigma and increase community awareness of available mental-health resources. • Build and retain a qualified mental-health workforce.
Target Population(s)	This strategy will focus on residents in Glasgow and other communities in Valley County as often as possible.
Partnering Organization(s)	Internal: Glasgow Clinic and SAIL program team External: Valley County Health Department, Eastern Montana Community Mental Health Center, Valley Care Coalition
Action Plan	*Strategy 1: Service Awareness & Access* • Assess market awareness of current mental health services and identify outreach gaps *Strategy 2: Increase Awareness of Self-Referral Options* • Run a marketing campaign advertising the availability of self-referral options to our behavioral health program *Strategy 3 – Community Stigma-Reduction Campaign* • Partner with the CARE Coalition to co-design a county-wide “Let’s Talk Mental Health” campaign. *Strategy 4 – Mental Health Awareness Walk* • Partner with Valley CARE Coalition & Valley County Health Department to organize an annual Mental Health Awareness Walk to engage the community in reducing stigma, promoting wellness, and highlighting local mental health resources. *Strategy 5 – Slash the Stigma Ice Hockey Tournament* • Partner with the Valley CARE Coalition to host the Slash the Stigma Hockey Tournament as a community-wide event that uses sports to foster mental health conversations and connect attendees with support services. *Strategy 6 – Stepping On – Falls Prevention Class* • Offer Stepping On classes to empower older adults with fall prevention education, while addressing the mental health impacts of fear, isolation, and loss of independence.

Priority Area #2: Heart Disease and Stroke	
Community Health Need	Reduce cardiovascular events through blood-pressure control, rapid emergency recognition, and strong rehabilitation support.
Goal(s)	• Increase detection and control of hypertension and other risk factors • Improve quality of acute cardiac and stroke care • Enhance adherence to cardiac-rehab and lifestyle-change programs
Target Population(s)	This strategy will focus on residents in Glasgow and other communities in Valley County as often as possible.
Partnering Organization(s)	Internal: Cardiac Rehabilitation, Primary Care, Community Integrated Health External: Valley CARE Coalition
Action Plan	*Strategy 1: Community Blood-Pressure Clinics* • Offer monthly clinics providing BP checks, tracker wallet cards, and laminated hypertension-stage cards • Distribute magnets listing heart-attack and stroke warning signs and emphasize calling 911 *Strategy 2: Weekly Core-Component Classes* • Hold classes every week for rehab patients and their support persons. • Cover rotating “core components”: BP management, stress management, medication adherence, smoking cessation, nutrition, diabetes management, and mental health. *Strategy 3: Support-Person Model in Cardiac Rehab* • Invite a patient’s support person to participate at no charge while insurance covers the acute patient. • Encourage support persons to assist with at-home exercise and reinforce diet changes. *Strategy 4: CCM Referral Review for Rehab Enrollment* • Audit Chronic Care Management (GCM/CIH/TCM) patient lists for cardiac or respiratory diagnoses (e.g., MI, CHF, COPD). • Flag eligible patients and issue automated referrals to Cardiopulmonary Rehab.

Priority Area #3: Diabetes	
Community Health Need	Prevent Type 2 diabetes and improve management among diagnosed patients through lifestyle change, education, and coordinated care.
Goal(s)	• Increase early identification of pre-diabetes and diabetes • Improve self-management and A1C control
Target Population(s)	This strategy will focus on residents in Glasgow and other communities in Valley County as often as possible.
Partnering Organization(s)	*Internal:* Primary Care, Nutrition Services, Cardiac Rehabilitation *External:* Valley CARE Coalition, Local Schools
Action Plan	*Strategy 1: Lifestyle & Nutrition Education* • Distribute diet pamphlets (heart-healthy, weight management) during clinic visits and community events • Refer interested patients to Nutrition Services and encourage SAIL (Stay Active & Independent for Life) participation for weight control and better sleep *Strategy 2: Weekly Core-Component Classes* • Hold classes every week for rehab patients and their support persons. • Cover rotating "core components": BP management, stress management, medication adherence, smoking cessation, nutrition, diabetes management, and mental health. *Strategy 3: School & Youth Prevention Initiative* • Support a Fresh Fruit & Veggie Snack Program that supplies seasonal produce to classrooms, exposing students to foods they may not get at home.

Implementation Strategy Adoption

On Wednesday, May 28 the Board of Frances Mahon Deaconess Hospital approved this Implementation Strategy to undertake the outlined measures to better address the significant health needs of the community.

This Implementation Strategy document is posted on the hospital's website.