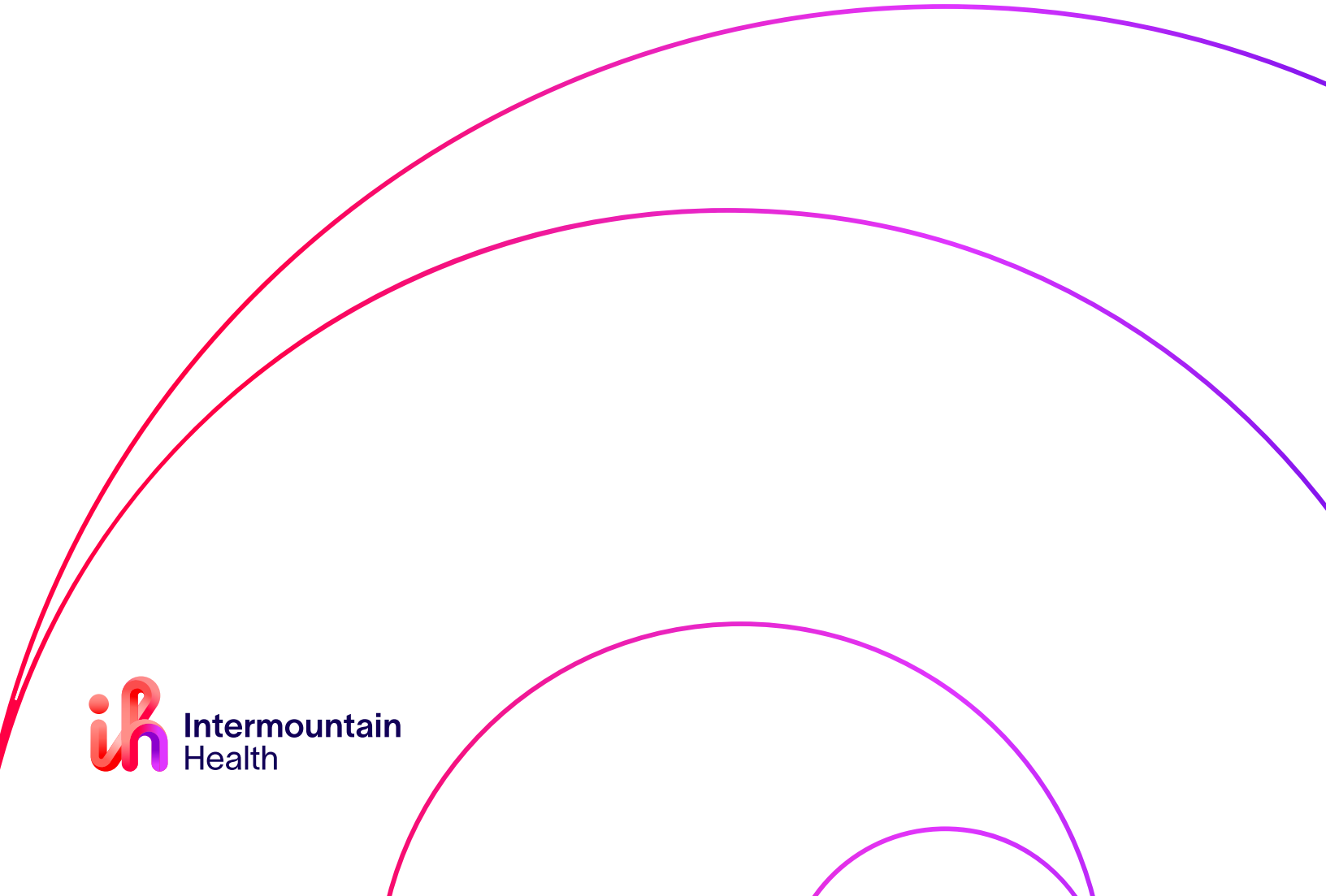
Intermountain Health | St. James Hospital

2026 Implementation Strategy



Intermountain Health

Table of Contents

Executive Summary **3**
Intermountain Health 4
Hospital Background 6

Community Profile **6**
Service Area 6
Community Demographics 7
Area of Deprivation Index 7

CHNA Process **8**
Health Needs Being Addressed 9
Health Needs Not Being Addressed 9

Evaluation **9**

Community Health Implementation Strategies **10**
Improve Behavioral Health 10
Invest in Social Drivers of Health 11
Increase Access to Care 12
Promote Childhood Wellness and Injury Prevention 13

Appendices **14**
Community Resources to Address Significant Health Needs 14
Intermountain Glossary 15

Executive Summary

In accordance with the Patient Protection and Affordable Care Act (ACA), Intermountain Health conducted a Community Health Needs Assessment (CHNA) in 2026 to identify data-driven health needs in the hospital service area. By regularly assessing and prioritizing health needs, the hospital can work collaboratively to address health disparities and improve the overall health of the community.

This Implementation Strategy guides efforts to address the health needs identified in the CHNA. It outlines programs and activities that align with public health entities and community collaborators, defines data-identified needs, and provides an inventory of resources.

Intermountain Health adheres to all applicable laws and continuously reviews regulatory requirements to ensure compliance. Accordingly, we may adjust our CHNA processes and Implementation Strategy as regulations change.

The CHNA and Implementation Strategy are publicly available on Intermountain's website.

2026 Significant Health Needs



Health Equity and Community Health

Intermountain Health's mission – helping people live the healthiest lives possible – includes everyone and requires valuing, understanding, and including the backgrounds and experiences of people in the communities we serve. Health equity is the principle of pursuing the highest possible standard of health by focusing on improving the well-being of our most vulnerable communities.

Our Community Health Needs Assessment process is driven by data. We look carefully at public health data to understand the prevalence of health issues in our communities and where those issues create the greatest disparities or differences in health outcomes. We talk with residents, community-based organizations, and local leaders to understand how health disparities connect and how they affect individuals and families across the lifespan. With an understanding of the needs our communities face, we develop a Community Health Implementation Strategy that directs our resources to remove barriers and invest resources where they will have the greatest impact. Using data and community input to identify the greatest needs and targeting our approach to meeting those needs is health equity in action.

As a healthcare system, employer, and community leader, Intermountain Health is committed to helping people live the healthiest lives possible.

Intermountain Health

Headquartered in Utah with locations in six primary states and additional operations across the western U.S., Intermountain Health is a nonprofit system of 34 hospitals, 400 clinics, a medical group of over 5,100 employed physicians and advanced care providers, a health plan division called Select Health with more than one million members, and other health services.

With more than 69,000 caregivers on a mission to help people live the healthiest lives possible, Intermountain is committed to improving community health and is widely recognized as a leader in transforming healthcare. We strive to be the model health system by taking full clinical and financial accountability for the health of more people, partnering to proactively keep people well, and coordinating and providing the best possible care.

Our Mission

Helping People Live the Healthiest Lives Possible®

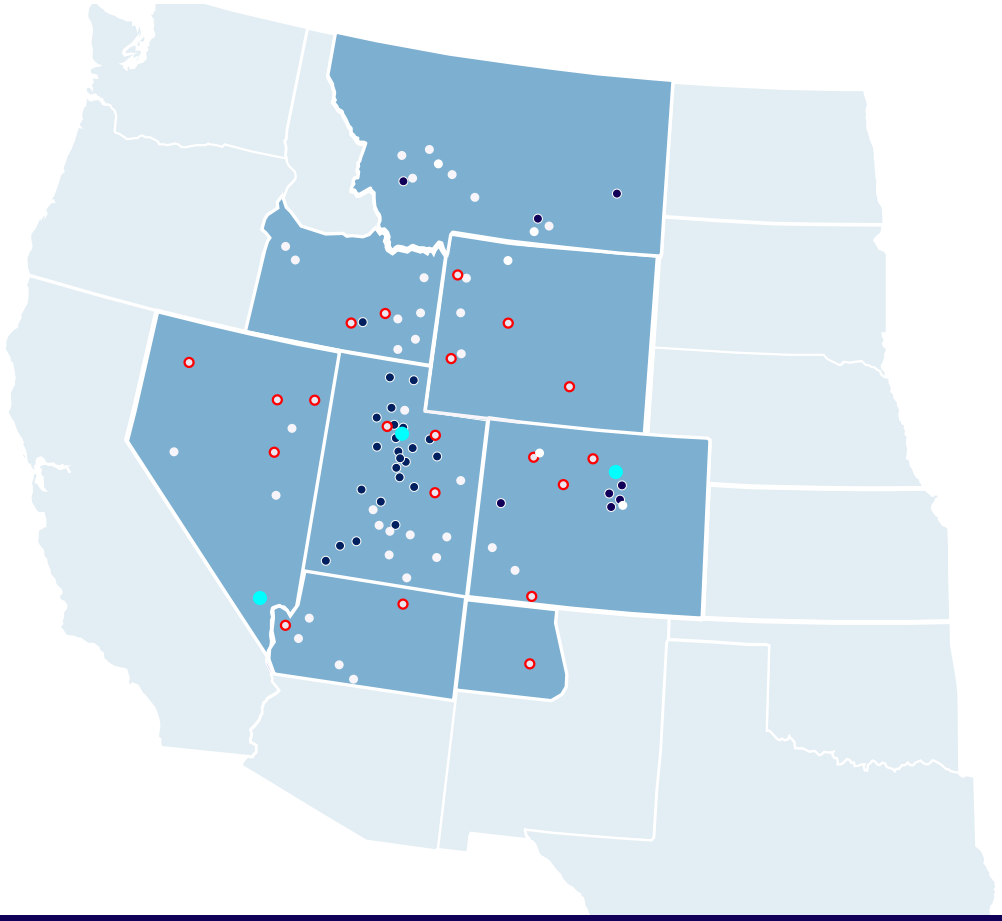
Our Catholic Mission

We reveal and foster God's healing love by improving the health of the people and communities we serve, especially those who are poor and vulnerable.

Our Values

Our Catholic health Ministry and Mission is entrusted to us to honor the sacred dignity of human life and the inherent worth of every person and are aligned with our common values.





Intermountain is headquartered in Salt Lake City, Utah, with regional offices in Broomfield, Colorado, and Las Vegas, Nevada.

- Hospitals
- Region Headquarter
- Affiliate/Outreach Partnerships
- Classic Air Medical Bases

Intermountain Health's 400+ clinics are not highlighted on the map

Intermountain Health by the Numbers

6 Primary States
(CO, ID, MT, NV, UT, WY)

34 Hospitals
Including One Virtual Hospital

4,700+
Licensed Beds

1.1 Million
Select Health Members

400
Clinics

69,000+
Caregivers

$18.51 Billion[1]
Total Revenue

5,100+
Employed Physicians & APPs

[1] Revenue for the year ended December 31, 2025

St. James Hospital

Founded by the Sisters of Charity of Leavenworth in 1881, St. James Hospital is located in Butte, Montana. St. James is a Level III Trauma Center and the only acute care hospital in the seven-county region of southwest Montana. It offers a comprehensive range of over 30 services, including a cancer center with radiation and medical oncology, orthopedics, women's services, heart services, and general surgery with robotics.



Community Profile

Service Area

The primary service area is determined geographically by the ZIP codes where most patient admissions originate. It is also defined by the populations served at the hospital including underrepresented, underserved, and low-income community members.

County	Zip Code
Silver Bow	59701
	59702
	59703
	59727
	59743
	59748
	59750



Community Demographics

Demographic Factors	Service Area	Montana	United States
Population	35,785	1,116,875	334,992,449
Persons Under 18 Years	20.2%	21.0%	22.0%
Persons 65 Years and Over	19.5%	20.1%	17.2%
Female Persons	48.4%	49.3%	50.5%
High School Graduate or Higher (age 25 years+)	94.0%	94.6%	89.6%
Persons in Poverty (150% Federal Poverty Level)	21.9%	20.9%	20.1%
Median Household Income (2024 dollars)	$61,754	$72,509	$80,734
Persons without Health Insurance (under age 65)	6.0%	8.6%	8.4%
White, not Hispanic or Latino	89.1%	83.6%	57.4%
Hispanic or Latino	4.6%	4.6%	19.3%
Black or African American	0.1%	0.4%	11.9%
Asian	0.4%	0.8%	5.9%
American Indian and Alaska Native	1.4%	5.3%	0.5%
Native Hawaiian and Other Pacific Islander	0.0%	0.0%	0.2%
Two or More Races	4.2%	4.7%	4.3%
Limited English Proficiency	0.6%	0.9%	8.6%

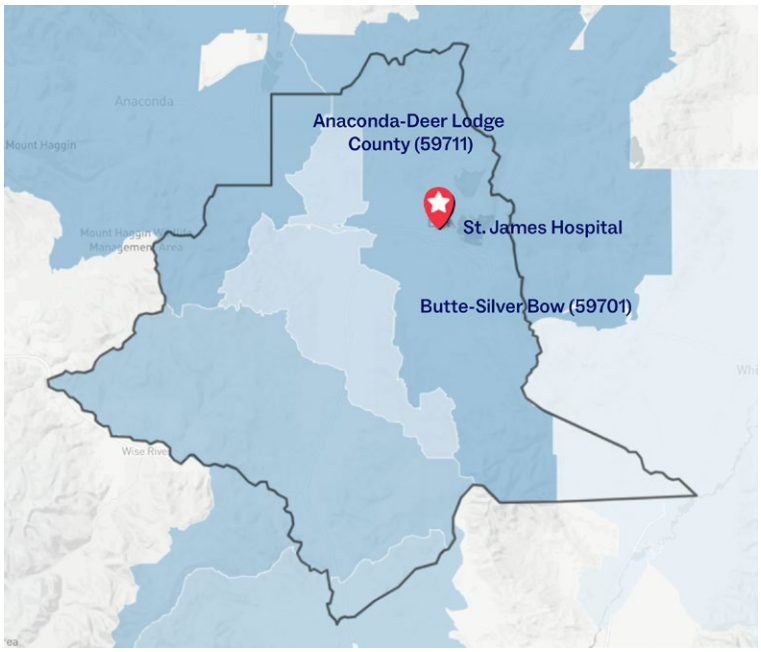
A demographic snapshot of the service area compared to Montana and the United States (Source: U.S. Census Bureau: American Community Survey, 2020-2024)

Area of Deprivation Index (ADI)

The Area of Deprivation Index (ADI) is a ranking of neighborhoods by socioeconomic disadvantage. It includes factors of income, education, employment, and housing quality. ADI compares each ZIP code in the state on a scale from 0 to 100 and higher values represent more health disadvantages. The Implementation Strategy will focus on high ADI communities, when possible, to invest resources and improve community health.

In the service area, the overall ADI is 65 and ranges from 38 to 70 across ZIP codes. This compares to an ADI of 46 in Montana and 48 in the U.S. The following communities have the highest ADI: Butte-Silver Bow and a portion of Anaconda-Deer Lodge County.

2023 Silver Bow County | 65 Average ADI



Metopio | Ties © Mapbox, Data source: University of Wisconsin - School of Medicine and Public Health: Neighborhood Atlas

38 — 70

CHNA Process

The CHNA prioritization methodology began with analyzing secondary data while gathering primary data through public and stakeholder surveys. These findings were presented at community input meetings to inform the prioritization process, including input from community members representing diverse backgrounds and experiences.

ST. JAMES HOSPITAL PRELIMINARY HEALTH NEEDS

Access to healthcare services

The uninsured rate in Silver Bow County is increasing and is about 13% lower than the national rate.

Childhood injury

Unintentional injury is the leading cause of death for children (ages 0 to 18 years) in Montana.

Heart disease and stroke

Silver Bow County has 352 heart disease-related deaths per 100,000 people, compared to 227 in Montana and 210 in the U.S.

Nutrition, physical activity, and weight

Low-income residents in Silver Bow County report higher rates of unhealthy weight, lack of physical activity, and difficulty buying fresh produce than the general population.

Mental health
Substance use and addiction

Depression rates are increasing and are highest among women and low-income residents.

Alcohol-induced deaths per capita are 80% higher in Silver Bow County than in the U.S.

Social drivers of health

The median household income for Silver Bow County is $61,754, which is 17% lower than Montana and 31% lower than the U.S.

The CHNA concluded with the application of validated analysis and scoring models that produced the final significant health needs. There were instances when additional health needs were identified, unified under one heading, or prioritized. The CHNA report was reviewed and approved by Intermountain Regional Board in November 2026.

SIGNIFICANT HEALTH NEEDS



Health Needs Being Addressed

The preliminary health needs that were prioritized as significant health needs:

Access to healthcare services	Prioritized as a significant health need as part of Increase Access to Care
Childhood injury	Prioritized as a significant health need as Promote Childhood Wellness and Injury Prevention
Mental health	Prioritized as a significant health need as part of Improve Behavioral Health
Social drivers of health	Prioritized as a significant health need as part of Invest in Social Drivers of Health
Substance use and addiction	Prioritized as a significant health need as part of Improve Behavioral Health

Health Needs Not Being Addressed

Intermountain Health is not addressing all the preliminary health needs identified during the CHNA in the Implementation Strategy. Heart disease and stroke, as well as nutrition, physical activity, and weight were not prioritized due to resource constraints, ability and expertise, existing efforts by other organizations, or lack of effective solutions; however, they remain important to the health of the community and are supported through clinical operations and programs, community benefit reportable activities, community outreach, and other collaborative efforts.

Evaluation

Evaluation is an essential component of the Implementation Strategy process at Intermountain Health. It provides measurable impact and identifies areas for improvement in each of the strategies to address significant health needs.

Intermountain continuously monitors performance on Implementation Strategies using the Intermountain Operating Model. This framework drives our culture of continuous improvement to maximize impact in the communities we serve. Successful performance will show the reach of activities and resources to communities with data-identified needs, changes in individual behaviors or attitudes, and removal of barriers to health. Additionally, we will use evidence-based and evidence-informed programs to ensure we improve anticipated health outcomes.



APPENDIX: INTERMOUNTAIN HEALTH CHNA GLOSSARY

Implementation Strategy: Improve Behavioral Health

AIM STATEMENT: By the end of 2029, improve behavioral health at the individual, household, and community levels with measurable outcomes to promote mental health and resilience, strengthen early interventions, and expand access to treatment and support services. CHNA data will be used to direct resources and programs to reduce health disparities across the lifespan.

ANTICIPATED OUTCOME	MAIN ACTIVITIES (in support of community-based programs)
Improve self-reported mental health in children and adults	• Support efforts to promote resilience, mental health, life skills, and behavioral health related outcomes • Strengthen capacity for evidence-based mental health care and resources • Expand and support mental health services and early intervention
Reduce the impact of substance misuse	• Support development and implementation of prevention and early intervention strategies • Expand behavioral health treatment and support services for individuals and families
Prevent suicide deaths and attempts	• Reduce access to lethal means • Increase help-seeking behaviors and resilience • Increase suicide prevention competencies and support services

INTERMOUNTAIN RESOURCES

Trainings:
- Evidence-based prevention trainings

Supports:
- Gunlocks and other safety devices

Education Materials:
- Child and adult mental well-being and suicide prevention
- Access to lethal means and safe firearm storage
- Substance misuse prevention

Funding:
- Intermountain grants and contributions
- State, federal, and other grants

Collaborations:
- Participation in coalitions, particularly those serving data-identified needs
- Community Mental Health Centers and other community service providers

APPENDIX: COMMUNITY RESOURCES TO ADDRESS SIGNIFICANT HEALTH NEEDS

Implementation Strategy: Invest in Social Drivers of Health

AIM STATEMENT: By the end of 2029, invest in social drivers of health at the individual, household, and community levels with measurable outcomes to expand safe and stable housing services, improve nutritious food access, and strengthen community collaborations. CHNA data will be used to direct resources and programs to reduce health disparities across the lifespan.

ANTICIPATED OUTCOME	MAIN ACTIVITIES (in support of community-based programs)
Improve housing stability	• Support expansion of housing and utility assistance programs • Strengthen the quality and capacity of the housing continuum • Explore place-based investment opportunities in affordable housing
Improve nutrition security	• Build community capacity for access to nutritious foods • Support local food banks and pantries

INTERMOUNTAIN RESOURCES

Resources:
- Social care referral platform

Funding:
- Intermountain grants and contributions
- Intermountain anchor activities, including place-based investing, hiring, and sourcing
- State, federal, and other grants

Collaborations:
- Participation in coalitions, particularly those serving data-identified needs
- Community-based organizations and other service providers

APPENDIX: COMMUNITY RESOURCES TO ADDRESS SIGNIFICANT HEALTH NEEDS

Implementation Strategy: Increase Access to Care

AIM STATEMENT: By the end of 2029, increase equitable access to care at the individual, household, and community levels with measurable outcomes to increase provider capacity, strengthen community resources, and address barriers to healthcare access. CHNA data will be used to direct resources and programs to reduce health disparities across the lifespan.

ANTICIPATED OUTCOME	MAIN ACTIVITIES (in support of community-based programs)
Expand access to health, behavioral health, and supportive services	• Increase access to physical and behavioral health care by supporting community-based providers • Improve community workforce capacity
Reduce logistical barriers to access care	• Increase care coordination and connection to community resources • Strengthen community capacity to address barriers to access

INTERMOUNTAIN RESOURCES

Resources:

- Financial assistance

Funding:

- Intermountain grants and contributions
- State, federal, and other grants

Collaborations:

- Participation in coalitions, particularly those serving data-identified needs
- Federally Qualified Health Centers, Community Mental Health Centers, and other community service providers

APPENDIX: COMMUNITY RESOURCES TO ADDRESS SIGNIFICANT HEALTH NEEDS

Implementation Strategy: Promote Childhood Wellness and Injury Prevention

AIM STATEMENT: By the end of 2029, promote childhood wellness and prevent childhood injury at the individual, household, and community levels with measurable outcomes in strengthening protective factors, promoting safe behaviors, and increasing community capacity to support children and families. CHNA data will be used to direct resources and programs to reduce health disparities.

ANTICIPATED OUTCOME	MAIN ACTIVITIES (in support of community-based programs)
Improve child and family wellness	• Strengthen community capacity to support youth well-being through training, partnerships, and coordinated resources • Promote protective factors, positive childhood experiences, and resilience among children and families • Strengthen family and caregiver capacity to support healthy child development and well-being
Prevent unintentional injury and accidental death in children	• Expand access to education, safety skills, protective equipment, and other supportive activities • Strengthen community capacity to promote child safety and injury prevention

Supports:
- Safety devices
- Behavioral reinforcers

Education Materials:
- Safety and injury prevention
- Emotional well-being

Funding:
- Intermountain grants and contributions
- State, federal, and other grants

Collaborations:
- Participation in coalitions, particularly those serving data-identified needs
- Community-based organizations and other community service providers

APPENDIX: COMMUNITY RESOURCES TO ADDRESS SIGNIFICANT HEALTH NEEDS

Appendices

Community Resources

Resources to Address Significant Health Needs

Significant Health Need	Organization	Summary of Resources
Improve Behavioral Health	Local Mental Health Organizations and Providers	Mental health therapy, case management, group therapy, and trainings. Individual and group services on a sliding fee scale that support access for low-income individuals.
	Substance Use Disorder Treatment Centers	Organizations that provide treatment programs for individuals with substance use disorder.
	County Public Health Departments	Provide prevention programming and harm reduction.
	Peer-Support Substance Use Organizations	Peer recovery coaching, family support services, and social supports.
Invest in Social Drivers of Health	Nonprofit Housing Organizations	Housing and utility assistance, emergency and respite shelter, case management, and workforce development.
	Housing Authorities	Affordable housing and support, case management, and transition services.
	County and State Government Agencies	Local workforce centers, government programs like Women, Infants and Children (WIC), and collaboration on economic stability strategies.
	Nonprofit Food Organizations	Community-based organizations that provide food assistance programs, local food banks, and pantries.
	Nonprofit Employment and Economic Stability Organizations	Community-based organizations that provide training programs leading to employment pathways, financial literacy education, and wrap-around support for people experiencing poverty.
Increase Access to Care	Federally Qualified Health Centers	Community-based organizations that provide comprehensive primary medical, dental, and behavioral healthcare regardless of ability to pay and insurance status.
	Safety Net Clinics	Community and school based primary care services including medical, behavioral health, and dental for low-income and uninsured residents.
	Nonprofit Community Organization	Navigation and application assistance for public programs, including government and other health insurance.
	Government Agencies	Enrollment assistance for numerous types of public benefits related to access, income, and insurance coverage.
	Law Enforcement and Corrections	Connection to medical, behavioral health, and social support services.
Promote Childhood Wellness and Injury Prevention	Early Childhood Government Agencies	In-home services, health and wellness support, and child protection.
	Nonprofit Community-Based Organizations	Assistance in connecting children and families experiencing poverty, abuse, neglect, or crisis to social services and other community resources. Supervision and programs for children focused on safety, health, learning, and development.
	Child Behavioral Health Organizations	Specialized pediatric behavioral health providers who serve children and youth.
	Education Organizations and Schools	Youth mental health resources, promotion of injury prevention and mental well-being, and career pathways leading to economic stability.

Intermountain Health

CHNA Glossary

Term	Definition
Activity or Program	Evidence-based actions to address each significant health need.
Community Health Needs Assessment (CHNA)	Triennial review and analysis of unmet or significant health needs in the communities served by Intermountain Health; it informs the development of the Implementation Strategy and all of Intermountain Health's Community Health work.
Evaluation	Assessment of results from actions taken to address significant health needs.
External Stakeholder	Organizations, government agencies, individuals, and other entities outside Intermountain Health that will be influential in the success of or impacted by the CHNA and Implementation Strategy.
Health Disparity	Data-identified and preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health experienced by communities.
Health Equity	Foundational and embedded across Intermountain Health's approach to health improvement is the principle of pursuing the highest possible standard of health by focusing on improving the well-being of our most vulnerable communities.
Health Needs	Unmet community health needs identified during the CHNA.
Health Indicators	Specific health discrepancies identified by data within the health needs (i.e., frequent mental distress as an indicator within behavioral health).
Health Outcome	Anticipated impact of strategies on significant health needs.
Implementation Strategies (IS)	A written plan to address health needs prioritized in the CHNA; it includes activities, collaborations, resources, funding, and the anticipated impact on data-driven needs.
Internal Stakeholder	Departments, teams, and other functions of Intermountain Health that will be influential in the success of or impacted by CHNA and Implementation Strategy.
Primary Data	Information gathered directly from sources including stakeholder and resident surveys, interviews, and community and stakeholder meetings.
Secondary Data	Information gathered by third parties, typically public health agencies, government agencies, or large studies.
Significant Health Needs	Community health needs prioritized during the CHNA that are addressed in the Implementation Strategy.

To submit written comments or request a paper copy, please email IH_CommunityHealth@imail.org

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Intermountain
Health