healthy by design

2026 – 2029

COMMUNITY HEALTH IMPROVEMENT PLAN

YELLOWSTONE COUNTY, MONTANA

Billings Clinic

Intermountain Health

RiverStone® Health

Acknowledgements

Healthy By Design would like to thank the following organizations for participating in the community health improvement planning process, including but not limited to:

Allies in Aging
AWARE Early Head Start
Best Beginnings Yellowstone County
Big Sky Economic Development
Billings Arts Association
Billings Chamber of Commerce
Billings City Council
Billings Clinic & Billings Clinic Foundation
Billings Family YMCA
Billings Industrial Revitalization District
Billings Community Foundation
Billings Schools
Billings TrailNet
Billings Urban Indian Health and Wellness Center
CASA of Yellowstone County
Chamber of Commerce
City of Billings
Community Crisis Center
Community Leadership & Development, Inc.
Continuum of Care
DOWL
Head Start, Inc.
HomeFront
HRDC
Intermountain Health St. Vincent Regional Hospital
Living Independently For Today and Tomorrow
MET Transit
Montana Office of Rural Health and Area Health Education Center
Montana Public Health Institute
Montana State University Billings
National Endowment for the Arts
North Park Neighborhood Task Force
Native American Development Corporation
Rimrock Foundation
Rimrock Neighborhood Task Force
RiverStone Health
Rocky Mountain College
Rocky Mountain Health Network
Rocky Mountain Tribal Leaders Council
South Side Neighborhood Task Force
Suicide Prevention Coalition of Yellowstone Valley
St. John's United
United Way of Yellowstone County
University of Montana Center for Children, Families and Workforce Development
Veterans Navigation Network
Yellowstone County Behavioral Health Coalition

The Community Health Needs Assessment (CHNA), Community Health Improvement Plan (CHIP), and Healthy By Design Coalition are sponsored by the healthcare Alliance of Billings Clinic, Intermountain Health St. Vincent Regional Hospital, and RiverStone Health. These initiatives are intended as a resource for Yellowstone County residents, organizations, and leaders.

To learn more, please visit www.hbdyc.org.

This report was prepared by Amanda Zimmerman-Murter, Healthy By Design; April Ennis Keippel, Intermountain Health St. Vincent Regional Hospital; Emma Lamson, Healthy By Design; Melissa Henderson, RiverStone Health; and Zach Benoit, Billings Clinic; and published on June 30, 2026.

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Community health workers train on basic disaster response skills and become Community Emergency Response Team certified.

A vendor shares produce with a community member at the Gardeners' Market.

Overview

Community Health Improvement Plan (CHIP)

The Healthy By Design (HBD) Coalition, consisting of diverse representatives from public health, healthcare, business, education, social services, government, faith and community groups, collaboratively develops the 2026 – 2029 Yellowstone County Community Health Improvement Plan (CHIP). This strategic roadmap aims to address the health needs and concerns of area residents and improve the overall health and well-being of the community. Each healthcare Alliance member (Alliance), including Billings Clinic, Intermountain Health St. Vincent Regional Hospital, and RiverStone Health, formally adopts the community-informed and owned CHIP.

The purpose of the CHIP is to develop targeted strategies and interventions to address the health issues and priorities identified in the 2026 Yellowstone County Community Health Needs Assessment (CHNA) and establish measurable goals and objectives for improvement. The plan considers various factors influencing health, such as the social drivers of health (SDOH), economic conditions, and cultural factors. Proposed initiatives adhere to evidence-based practices, utilize a policy, system, and built environment (PSE) approach, and leverage multi-sectoral partnerships.

The process of conducting the CHNA and developing the CHIP follows the nine-step Community Health Assessment Toolkit provided by the Association for Community Health Improvement (ACHI) (Figure 1). The toolkit emphasizes community collaboration and supports hospitals and health systems to strategically partner with the local community to address disparities in health outcomes. A detailed explanation of compliance with IRS Form 990, Schedule H and National Public Health Accreditation Board standards is available in Appendix D.

Community Health Needs Assessment (CHNA)

Professional Research Consultants, Inc. (PRC) conducted the 2026 Yellowstone County CHNA on behalf of the Alliance in partnership with The Rehabilitation Hospital of Montana, a joint venture of Billings Clinic and Intermountain Health St. Vincent Regional Hospital. The 2026 CHNA was conducted in late 2025 and published in February 2026.

The assessment aimed to comprehensively evaluate the health status of Yellowstone County by collecting and analyzing data concerning health status, behaviors, needs, and the social and environmental factors impacting health. The analysis of the data identified existing disparities within the community. A detailed list of steps taken is available in Appendix B.

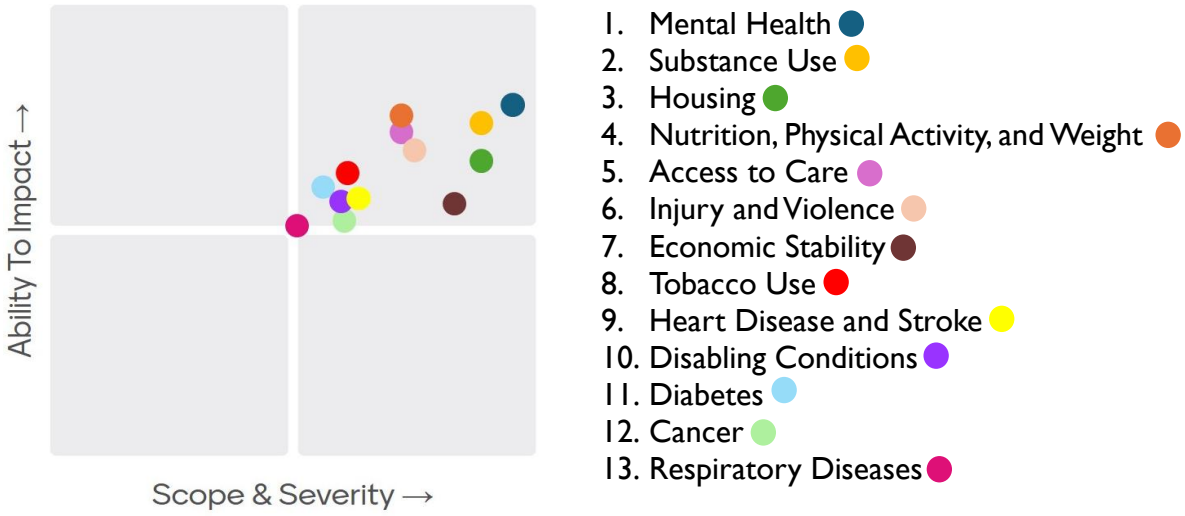
Figure 1. Association for Community Health Improvement (ACHI) Process, ACHI

CHIP Development

Priority Setting

On November 21, 2025, community leaders, public health officials, healthcare professionals, and residents were invited to attend a CHNA public forum. PRC and the CHNA work team, which consisted of key representatives from the Alliance and The Rehabilitation Hospital of Montana, presented a snapshot of the data and participants engaged in a collaborative exercise to prioritize the identified areas of opportunity in the CHNA. Nearly 80 individuals attended and participated in prioritization. Priorities were evaluated based on the community's capacity to address the issues and the severity of the issues within Yellowstone County (Figure 2).

Figure 2. Public Forum Prioritization Results, November 21, 2025



Communication of CHNA Results and Health Priorities

On January 12 and February 24, 2026, Alliance representatives and HBD staff reviewed the community prioritization results to ensure transparency and validity of the process. The purpose of this was to provide feedback and confirm the top health priorities or areas of opportunity for the 2026 – 2029 CHIP. The following health priorities were affirmed:

2026 – 2029 Health Priorities

- **Mental Health**
- **Substance Use**
- **Nutrition, Physical Activity, and Weight**
- **Access to Care**
- **Injury and Violence**
- **Social Drivers of Health (i.e., Housing, Economic Stability)**

Additionally, Alliance representatives affirmed crosscutting strategies for HBD. The 2026 – 2029 CHIP includes the following crosscutting strategies, which focus on evidence-based, upstream policy, systems, built environment opportunities, and collective action to address root causes of health outcomes. The following Strategy Areas were affirmed:

1. Healthy Neighborhoods
2. Strengthening Partnerships

The selection of these strategies for the CHIP was based on the shared recognition among the representatives that community health issues are not isolated incidents but rather deeply entrenched generational challenges that require crosscutting approaches addressing SDOH and root causes of health. These challenges require sustained and comprehensive interventions that gather momentum from one CHIP to the next.

Priority health indicators help determine areas of opportunity, progress, and successes over the course of the CHIP cycle and into the next. The following priority indicators are 2026 CHNA indicators that the Healthy By Design Coalition aims to address in the 2026 – 2029 CHIP:

Priority Health Indicators		
Mental Health 25.6% of residents report their overall mental health is "fair" or "poor"	**Substance Use** 54.9% of residents report their life has been negatively affected by substance use (self or other's)	**Access to Care** 49.2% of residents report experiencing difficulties accessing health care
Injury and Violence 18.7% of residents report not feeling safe walking alone in the neighborhood	**Economic Stability** 23.3% of residents would not be able to afford a $400 expense without going into debt	**Access to Produce** 23.8% of residents report difficulties accessing affordable, fresh produce
Nutrition, Physical Activity, and Weight 32.3% of residents report meeting physical activity guidelines		

As the landscape for community health improvement continuously evolves, various sectors are taking the lead in addressing community health issues. The increasing recognition of the crucial role played by social drivers of health and their complex interactions at the local level provides a unique opportunity to ignite fresh momentum, forge new partnerships, and mobilize additional resources for Coalition members. Many members have dedicated themselves to this vital work for over a decade.

Strategy Planning

In May and June 2026, HBD connected with various external partners and community stakeholders and shared a series of proposed tactics. These meetings aimed to review the 2026 CHNA priorities, the proposed CHIP framework, process and initial 6-month tactics, and aimed to gather stakeholder direction on the 2026 – 2029 CHIP. Staff asked stakeholders and external partners to 1) Identify any ongoing efforts within their respective organizations that align with the goals of the CHIP, 2) Suggest initiatives that have the potential to enhance community health but require collective action, and 3) Express their interest in joining future strategic CHIP working groups. Throughout this process, staff considered the potential impact of the proposed interventions on different populations, particularly those who face the greatest disparities.

CHIP Approach and Strategies

CHIP Approach

HBD's comprehensive and community-driven approach to community health improvement considers several key elements including exploring upstream policy, systems, and built environment opportunities, embracing a collective approach, relying on evidence-based practices, and actively engaging the community (see Appendix B for additional details). Coalition members aim to create sustainable and equitable improvements in community health outcomes.

Social drivers of health are the non-medical factors that affect health (Figure 3). Strategy Areas aim to improve these conditions and factors in daily life that significantly impact individuals' well-being and health outcomes. SDOH examples include:

- Access to care
- Access to nutritious foods
- Access to physical activity opportunities
- Education, job opportunities, and income
- Language and literacy skills
- Polluted air and water
- Racism, discrimination, and violence
- Safe housing, transportation, and neighborhoods

Figure 3. Social Drivers of Health (SDOH) Centers for Disease Control and Prevention (CDC), 2024

Additionally, to ensure the CHIP process is data-driven and community-informed, HBD evaluates the community identified health priorities and determines where there are some of the greatest disparities or gaps in health outcomes. With support and leadership from the community, HBD adopts the community-informed and -owned CHIP by working closely with leaders, partners, stakeholders, and those with lived experience to try and impact some of the greatest health gaps. Using the CHNA and community input, some disparities in health outcomes include:

- 15.8% of residents aged 40 to 64 report "often" experiencing feelings of isolation.
- 26.5% of women report "not feeling safe" walking alone in the neighborhood.
- 81.6% of residents who live below the federal poverty level report that they do not meet physical activity recommendations.
- 55.5% of women report experiencing difficulties accessing health care.
- 54.2% of residents who live below the federal poverty level report difficulties accessing affordable, fresh produce.

The crosscutting nature of HBD's approach and its strategies recognizes that SDOH and health outcomes do not exist in isolation, but even one or two SDOH barriers can have a ripple effect on health and well-being. HBD's Strategy Area of Healthy Neighborhoods focuses on addressing the root causes of health needs as they relate to neighborhood and built environment, social and community context, and economic stability. The Strategy Area of Strengthening Partnerships prioritizes working together as a community to leverage collective expertise, resources, and shared responsibility to improve health outcomes for all residents.

Each of the following Strategy Areas includes an overview of the approach, vision of the work, the implementation strategy, and action steps to complete by the end of December 2026. Additionally, the Coalition will be working closely with the community and partners over the next 6 months to identify SMART objectives, initiatives, and additional tactics to work on together.

2026 – 2029 Yellowstone County Community Health Improvement Plan Overview

Vision

A vibrant Yellowstone County where the healthy choice is the easy choice.

Overall Goal

By 2029, increase the proportion of Yellowstone County residents who self-report good or better overall health from 85.7% to 89.9%.

Health Priorities

Mental Health
Substance Use
Nutrition, Physical Activity, and Weight
Access to Care
Injury and Violence
Social Drivers of Health (i.e., Housing, Economic Stability)

Priority Health Objectives

- Increase the proportion of Yellowstone County residents reporting good or better **mental health** from 74.4% to 78.1%
- Decrease the proportion of Yellowstone County residents whose lives have been negatively affected by **substance use** from 54.9% to 52.2%
- Decrease the proportion of Yellowstone County residents who experience difficulty **accessing health care** from 49.2% to 46.7%
- Decrease the proportion of Yellowstone County residents who find it very/somewhat difficult to buy **fresh produce** from 23.8% to 22.6%
- Increase the proportion of Yellowstone County residents who are meeting **physical activity** guidelines from 32.3% to 33.9%
- Increase the proportion of Yellowstone County residents who **perceive neighborhood as safe** from 81.3% to 85.4%
- Decrease the proportion of Yellowstone County residents who would not be able to **afford an unexpected $400 expense** from 23.3% to 22.1%

Strategies

Healthy Neighborhoods

Built Environment
Economic Stability
Social Connection

Strengthening Partnerships

Approach

Policy, Systems, Built Environment • Collective Impact • Evidence-Based
Community-Informed and Community-Driven

Strategy Area #1: Healthy Neighborhoods

Overview

A healthy neighborhood supports and promotes physical, mental, economic, and social well-being among residents and consists of easy, affordable access to essential resources and services, fosters social connectedness, and facilitates healthy choices. Place-based efforts within neighborhoods and the community, focusing on social drivers of health, help promote vibrant spaces that are welcoming, accessible, and foster health and well-being for all residents.

Vision

All Yellowstone County residents have access to vibrant neighborhoods that are welcoming, accessible, foster health, have the social or emotional support to integrate into the community in a way that is relevant, accessible, and fulfilling across all life stages, and investments and the development of policies, systems, and infrastructure positively impact the health and well-being of area residents.

Implementation Strategy

Health Priority Goals	Main Activities	Coalition Efforts
Improve **mental health** outcomes Reduce the impact of **substance use** Improve **access to care** Improve **physical activity, nutrition, and food security** Reduce **injury and violence** Improve and support **social drivers of health**	**Built Environment** - Activate safe, outdoor, public spaces - Improve walkability and food access **Social Connection** - Enhance social and community conditions to support community and neighborhood connection **Economic Stability** - Support investments in, access to, and the affordability of key quality-of-life resources	**Initiatives** - Gardeners' Market - Trauma-Informed Care - Community building and connection opportunities - Creative placemaking and public art - Walkability and food access initiatives **Trainings** - Trauma-Informed Care 101 **Collaborations** - Local coalitions and groups - Community champions - Coalition partners

Healthy Neighborhoods Tactics to be Completed by December 2026

Over the next 6 months, the Coalition will work closely with community members and partners to identify opportunities and initiatives to support the Healthy Neighborhoods Strategy and will work together to complete the following tactics by the end of December 2026. These tactics include:

- Engage with Gardeners' Market producers and partners to increase vendor recruitment and retention during the 2026 Gardeners' Market season to support food systems and improve access to healthy, affordable produce in Yellowstone County.

- Engage neighborhoods and community members to identify community building and connection opportunities, such as hosting neighborhood block parties using the Good Neighbor Toolkit.

- Explore expanding initiatives with community members and partners that prioritize built environment conditions, such as walkability and/or food access in Yellowstone County.

- Engage partners and the community to launch a local, community-driven social marketing campaign that aims to address stereotypes and negative perceptions on aging and enhance the sense of community well-being and connection.

- Coordinate with Mobilize the MAGIC City leaders, partners, and community stakeholders to support and expand public art and creative placemaking efforts in Yellowstone County, such as supporting the establishment of a central funding mechanism for artists.

- Coordinate with the Trauma-Informed Care workgroup to strengthen the community's capacity by advancing a trauma-informed care understanding and approach in Yellowstone County and training a new cohort of community TIC Super Trainers.

- Use a health- and connection-in-all-policies approach across sectors to support, guide, and inform opportunities that advance health and social connection for all, such as working with the community and partners to examine and promote existing infrastructure, policies, and systems that allow individuals to connect more easily.

- Examine population specific health needs in the 2026 CHNA in collaboration with community partners to identify potential opportunities and initiatives.

Josiah Hugs provides the invocation and Amskapi Piikani (Blackfeet) artist, Maria Gladstone, describes the significance of "Eternal Presence".

Trauma-Informed Care trainer, DeeDe Baker of Dog Tag Buddies, presents to training participants.

Strategy Area #2: Strengthening Partnerships

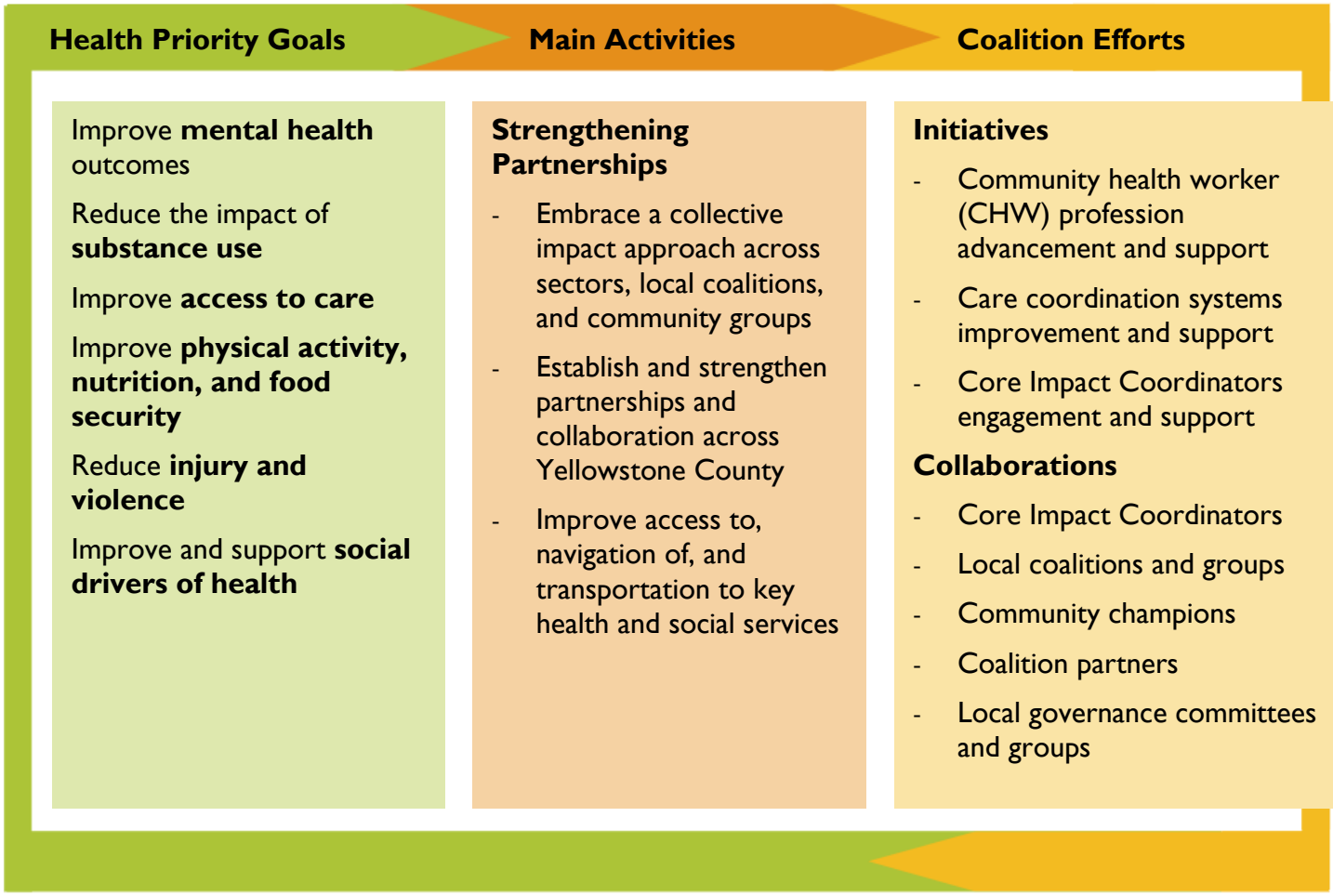
Overview

Yellowstone County is confronted with several intricate and long-standing health challenges, including mental health concerns, substance use, public safety, or health conditions related to limited access to care, safe physical activity or affordable, healthy foods. By strengthening partnerships, the community can leverage collective expertise, resources, and shared responsibility to improve health outcomes for residents. On behalf of the Alliance, and as Yellowstone County's longest standing community health coalition, Healthy By Design strives to bring community partners, community champions, and residents together to enhance the effectiveness of interventions, foster innovation, and promote a comprehensive approach to addressing community health needs.

Vision

Advance collective action to make Yellowstone County a healthier, more vibrant community.

Implementation Strategy



Strengthening Partnerships Tactics to be Completed by December 2026

Over the next 6 months, the Coalition will work closely with community members and partners to identify opportunities and initiatives to support the Strengthening Partnerships Strategy and will work together to complete the following tactics by the end of December 2026. These tactics include:

- Explore the improvement of care coordination systems with community-based organizations and CHWs, including piloting an outcomes-based care coordination model with CHWs in non-clinical roles who address health and social needs of community members.
- Guide and inform future investments in the CHW profession in partnership with local and statewide groups and efforts.
- Convene core backbone coalition leaders and community leaders in Yellowstone County to explore and identify collective impact practices and opportunities, such as engaging in nested collective impact mapping and training with backbone staff of local coalitions to support alignment and collaboration.
- Convene and support partners and community leaders to identify collaboration opportunities through a collective impact approach.
- Participate in local governance committees and groups to provide community health guidance and support.
- Examine population specific health needs in the 2026 CHNA to identify and expand collaboration opportunities with community partners.

Community health workers in Yellowstone County host a program share out for the community.

Impact Coordinators host Coffee Connect for community members and local leaders to explore ways to collaborate as a community using the collective impact framework.

2026 – 2029 Yellowstone CHIP Logic Model

Inputs	Strategies	Outputs	Short/Intermediate Outcomes (1 – 3 Years, CHNA Data)	Long-Term Outcomes (3+ Years, CHNA Data)
Healthy By Design Operations Team **Healthy By Design Coalition Backbone Staff** **Healthy By Design Members** **Strategy Area Workgroups** **Community Health Needs Assessment Priorities**	**Healthy Neighborhoods** - Built environment and walkability - Healthy food access - Neighborhood and social connection opportunities - Safe, public, outdoor spaces - Economic stability **Strengthening Partnerships** - Collaboration and partnerships across Yellowstone County - Access to care through partnerships and the support and advancement of the CHW profession	- Initiatives that prioritize walkability, built environment, and access to produce and/or services - Improved opportunities to get physical activity - New partnerships with local producers who provide fresh produce - Enhanced social conditions to support community connection - Enhanced community conditions to support safe, public, outdoor spaces - Number of health and social needs addressed by CHWs - Number of community members reached through CHWs - Improved systems to support care coordination - New partnerships formed	Increase the % of residents who get the **social and emotional support** needed from 88.7% to 93.1% Decrease the % of residents who **perceive they have no impact in the community** from 11.6% to 11.0% Increase the % of residents who self-report good or better **mental health** from 74.4% to 78.1% Decrease the % of residents whose lives have been negatively affected by **substance abuse** (their own or someone else's) from 54.9% to 52.2% Decrease the % of residents who experience difficulty **accessing health care** from 49.2% to 46.7% Decrease the % of residents who find it very/somewhat difficult to buy **fresh produce** from 23.8% to 22.6% Increase the % of residents who are meeting **physical activity guidelines** from 32.3% to 33.9% Increase the % of residents who **perceive neighborhood as safe** from 81.3% to 85.4% Decrease the % of residents who would **not be able to afford an unexpected $400 expense** without going into debt from 23.3% to 22.1%	Increase the % of residents who self-report good or better **mental health** from 74.4% to 81.8% Decrease the % of residents whose lives have been negatively affected by **substance abuse** (their own or someone else's) from 54.9% to 49.4% Decrease the % of residents who experience difficulty **accessing health care** from 49.2% to 44.2% Decrease the % of residents who find it very/somewhat difficult to buy **fresh produce** from 23.8% to 21.4% Increase the % of residents who are meeting **physical activity guidelines** from 32.3% to 35.5% Increase the % of residents who **perceive neighborhood as safe** from 81.3% to 89.4% Decrease the % of residents who would **not be able to afford an unexpected $400 expense** without going into debt from 23.3% to 21.0%

Implementation and Next Steps

The CHIP is designed to be adaptable to the changing needs and opportunities within Yellowstone County between now and June 2029. The CHIP will undergo continuous monitoring and evaluation of needs, data, and workgroup feedback. This monitoring will be captured via strategy progress reports shared every 6 months via the Healthy By Design website and communication channels. This initial CHIP outlines the core strategic approaches of the Coalition. Over the next 6 months, SMART objectives and additional tactics will be set by the community, Coalition members, and the HBD Operations Team. For more information on the Coalition structure and membership, please see Appendix C.

You are Invited to a CHIP Community Forum!

We want to hear from you! Help inform, guide, and lead initiatives and opportunities for collaboration based on the core strategies identified in the CHIP. Healthy By Design will be hosting a CHIP Community Forum in August 2026. Stay tuned for more information and let us know if you are interested in joining the Coalition by checking out the different ways you can get involved below.

Community Involvement

Community residents, leaders, and organizations can engage in community health improvement through various means. Here are some ways you can get involved:

- ✓ **Join a strategy working group.** Take the initiative to become part of a strategy working group. To get involved as an individual or organization, reach out to us at info@hbdyc.org or call 247-3276.

- ✓ **Connect with us.** If you have an idea for a new initiative or are working on something that we could partner on, please contact us at info@hbdyc.org.

- ✓ **Share your feedback and experiences.** We value community input, especially from those with firsthand experience. Your feedback is crucial to our work. We will regularly provide opportunities for community members to contribute their perspectives to ongoing projects over the next three years.

- ✓ **Advocate for policies or programs that improve health.** Support community health initiatives by advocating for policies, plans, and investments that improve health. Subscribe to our newsletter for advocacy opportunities or email us at info@hbdyc.org.

- ✓ **Use community health data in your grant-writing, decision-making, and evaluation.** Familiarize yourself with the Yellowstone County CHNA and other local data sources. This information, and corresponding resources, are a community tool that anyone can use and cite.

- ✓ **Stay informed.** Subscribe to our newsletter, follow us on Facebook (@HBDYellowstone) or Instagram (@hbdyellowstone) and read the bi-annual CHIP Progress Reports to stay up to date with progress.

- ✓ **Make the healthy choice, the easy choice where you live, work, learn, or play.** Here are several ways you can promote community health:
    - Model healthy behaviors, encourage social connections with a friend or neighbor, cook a healthy meal together, and explore your community's assets such as parks and walking paths.
    - Stay tuned for upcoming HBD opportunities and resources for ideas to implement initiatives in your business, worksite, local schools, or during events.
    - Ask for healthier options at restaurants, food trucks, or events.

Appendices

Appendix A: CHIP Approach and Definitions

Proposed HBD initiatives adhere to evidence-based practices, leverage collective action, are community informed, and utilize a policy, system, and built environment (PSE) approach. Below are brief descriptions of these criteria. Please visit the HBD website at https://www.hbdyc.org for more information.

1. **Evidence-Based Strategies:** Each strategy uses reliable and validated evidence to achieve desired outcomes or goals that are proven to impact health priorities. The list below includes reputable sources from public health and community health improvement sectors. Each strategy proposed for this CHIP are derived from one or more of these sources.
    a. Build Healthy Places Network – https://buildhealthyplaces.org
    b. ChangeLab Solutions – https://www.changelabsolutions.org/
        i. Healthy Planning Guide
    c. CDC (various pages) – www.cdc.gov
        i. A Public Health Approach to Community Violence Prevention
        ii. Promising Approaches to Promote Social Connection
        iii. Built Environment Assessment Tool and Manual | Physical Activity
    d. Healthy People 2030 (various pages) – https://odphp.health.gov/healthypeople/tools-action/use-healthy-people-2030-evidence-based-resources-your-work
        i. Neighborhood and Built Environment — Evidence-Based Resources
        ii. Social and Community Context
        iii. Community Health & Economic Prosperity
    e. Saamuhika Shakti - https://www.saamuhikashakti.org/
        i. Nested Theory of Change
    f. Local Initiatives Support Corporation – https://www.lisc.org
    g. Pathways Community HUB Institute – https://www.pchi-hub.org
    h. National League of Cities – https://www.nlc.org/
        i. 5 Proven Ways to Build Social Connections in Your Community
    i. ULI Americas – https://americas.uli.org
        i. Building Healthy Places Toolkit
    j. US Surgeon General's Office (various pages) – https://www.hhs.gov/
        i. Reports and Publications
        ii. Social Connection Advisory

2. **Collective Impact:** Multisector partnerships bring people together to make a collective impact on community health issues.

Five Conditions of Collective Impact
1. Common Agenda
2. Shared Measurement
3. Mutually Reinforcing Activities
4. Continuous Communication
5. Backbone Support

Healthy By Design Graphic
More information: Collective Impact, Collective Impact Forum, 2023

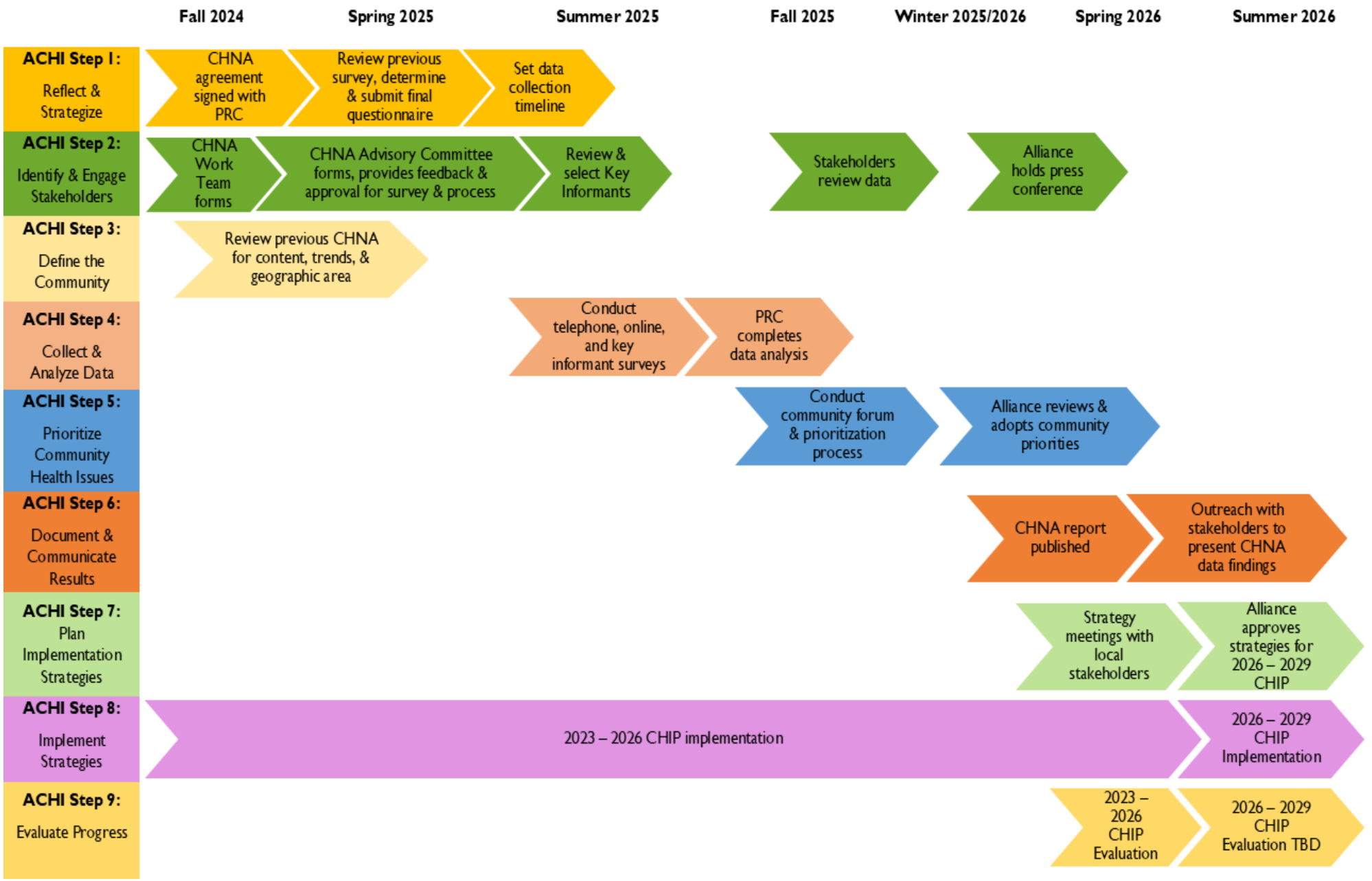
3. **Policy, Systems, and Built Environment (PSE):** PSE approaches aim to change the context to make healthy choices easier and address root causes of health.

Health Impact Pyramid
Source: Cobb 2020

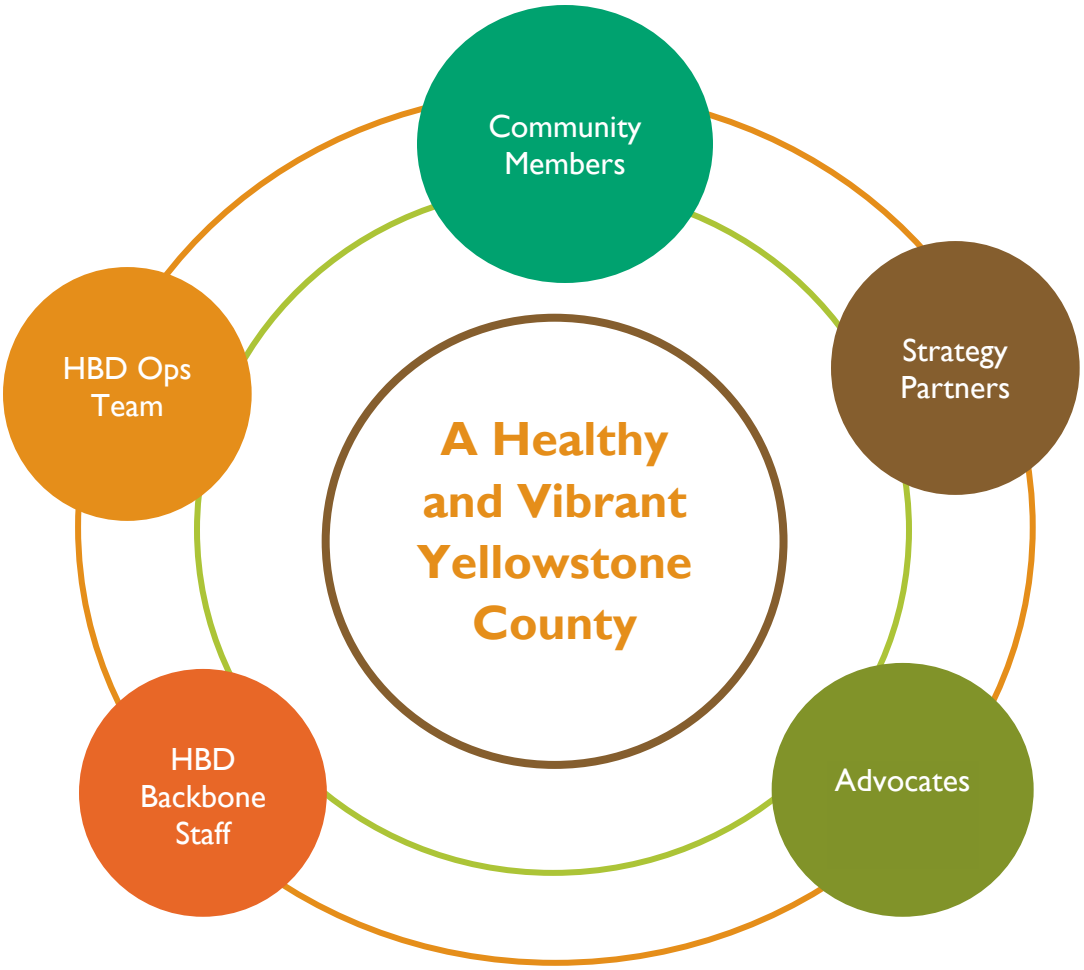
4. **Community-Informed and Community-Driven:** Initiatives involve and prioritize the input, needs, and preferences of community members in the planning, implementation, and evaluation process and prioritizes an approach where everyone gets a fair opportunity to achieve their highest level of health possible by understanding community barriers, circumstances and conditions.

Appendix B: CHNA and CHIP Planning and Implementation Timeline

Yellowstone County Community Health Needs Assessment & Community Health Improvement Plan Process
Model: Association for Community Health Improvement (ACHI)



Appendix C: Coalition Structure



Contributor	Contribution
Strategy Partners *Individuals and organizations committed to the CHIP*	• Advocate for HBD's shared vision for community health • Commit to shared measurement, mutually reinforcing activities, and consistent communication • Participate in monthly strategy workgroup meetings • Provide leadership and capacity to initiatives as appropriate
HBD Backbone Staff *Community Health Improvement Manager and Specialist*	• Coordinate meetings, resources, partners, and data • Provide technical assistance • Build momentum and resources for Coalition work
Operations Team *HBD staff and representatives from sponsoring organizations*	• Provide resources/funding and guidance to support Coalition and CHIP decisions and operations • Attend monthly meetings
Advocates *Interested residents or organizations that may be called upon as needed*	• Keep up with HBD communications, share as appropriate • Respond to calls for action and expertise as needed
Community Members *Individuals or groups with lived experience at the heart of our efforts*	• Provide input on Coalition initiatives by participating in community engagement opportunities

Appendix D: Compliance for IRS Form 990, Schedule H and Public Health Accreditation Board (PHAB) Standards

Schedule H Compliance: For non-profit hospitals, a CHNA satisfies certain requirements of tax reporting, pursuant to provisions of the Patient Protection & Affordable Care Act of 2010. The following table aligns CHIP report components with Form 990 Schedule H reporting requirements for hospitals.

Public Health Accreditation Board Standards: The CHNA addresses the public health accreditation domains listed below. By its nature, the CHNA is a cooperative venture sponsored by the Alliance to examine Yellowstone County trends, including comparisons to stage and national data and benchmarks (Youth Behavioral Risk Survey, Healthy People 2030, etc.). Through this instrument and the associated community conversations, the Alliance identifies barriers to positive community health outcomes and seeks to understand community service gaps and assets. Ultimately, community health improvement plans, and institutional strategic plans result from the CHNA and the community's response.

IRS Form 990 Schedule H Component	Reference
Part V Section B Line 3a. Definition of the community served by the hospital facility	CHNA Page 7
Part V Section B Line 3b. Demographics of the community	CHNA Page 29
Part V Section B Line 3c. Existing healthcare facilities and resources within the community that are available to respond to the health needs of the community	CHNA Page
Part V Section B Line 3d. Description of the process and how the data was obtained	CHNA Page 175
Part V Section B Line 3e. The significant health needs of the community	CHNA Page 15
Part V Section B Line 3f. The process for identifying and prioritizing community health needs and services to meet the community health needs	Throughout the CHNA
Part V Section B Line 3g. Primary and chronic disease needs and other health issues of uninsured persons	CHNA Page 16
Part V Section B Line 3h. The process of consulting with persons who represent the community's interests	CHNA Page 9
Part V Section B Line 3i. The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA	CHNA Page 185
Part V Section B Line 6a and 6b. Was the hospital facility's CHNA conducted with one or more other hospital facilities?	Yes

Adherence to Public Health Reaccreditation Standards and Measures (version 2022)		
Foundational Capability	**Measure Description**	**Measure Reference**
Accountability & Performance Management	Base programs and interventions on the best available evidence.	Measure 9.2.1 A
Assessment & Surveillance	Develop a community health assessment.	Measure 1.1.1 A
	Collect non-surveillance data.	Measure 1.2.1 A
	Participate in data sharing with other entities.	Measure 1.2.2 T/L
	Engage in data sharing and data exchange with other entities.	Measure 1.2.2 S
	Analyze data and draw public health conclusions.	Measure 1.3.1 A
Communications	Implement health communication strategies to encourage actions to promote health.	Measure 3.2.2 A
Community Partnership	Participate actively in a community health coalition to promote health equity.	Measure 4.1.2 A
	Adopt a community health improvement plan.	Measure 5.2.1 A
	Collaborate with other sectors to improve access to social services.	Measure 7.2.1 A
Equity	Address factors that contribute to specific populations' higher health risks and poorer health outcomes.	Measure 5.2.3 A
	Manage operational policies including those related to equity.	Measure 10.2.1 A
Policy Development	Examine and contribute to improving policies and laws.	Measure 5.1.1 A

Contact Us

For more information on the 2026 Community Health Needs Assessment, the 2026 – 2029 Community Health Improvement Plan, or the Healthy By Design Coalition, please contact us.

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Mayor Cole and Mobilize the MAGIC City dignitaries participate in the first of two ribbon cutting celebrations. Photo courtesy of Shan Cousrouf.

Community members enjoy a summer afternoon at the Gardeners' Market at South Park.