



**Intermountain LDS Hospital
Community Health Needs Assessment
and Implementation Strategy
September 2013**

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Intermountain LDS Hospital Community Health Needs Assessment and Implementation Strategy September 2013

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Executive Summary

Intermountain LDS Hospital conducted a Community Health Needs Assessment (CHNA) to identify its local area healthcare needs and develop an implementation strategy to address a significant health priority. The Patient Protection and Affordable Care Act (ACA) signed into law in March 2010 requires each nonprofit hospital to perform a CHNA every three years and develop a three-year implementation strategy to address an identified community health need.

This document fulfills the requirement to make results of the CHNA publicly available.

LDS Hospital is one of Intermountain Healthcare's 21 hospitals located in Utah and southeastern Idaho. Intermountain's Community Benefit Department created a system-wide process to be used by each of its 21 hospitals in conducting components of the CHNA: 1) asking for community input regarding local healthcare needs; 2) quantitative data collection; 3) developing an implementation strategy; and 4) making the CHNA results publicly available.

Intermountain clinical staff determined to use similar health priorities identified in a previous health status report for the 2013 quantitative data collection in order to identify any changes in the health indicators over the past few years. The broad categories remain significant health issues for communities served by Intermountain hospitals. Community input meetings included open-ended questions about local health needs as well as discussion on the health priorities:

1. Improve the prevention, detection, and treatment of chronic diseases associated with weight and unhealthy behaviors;
2. Improve access to comprehensive, high-quality healthcare services for low-income populations; and
3. Improve access to appropriate behavioral health services for low-income populations.

The 2013 CHNA combined a review of the data describing the health needs with input from members of the community representing the broad interests of the residents, including healthcare needs of medically underserved and low income populations.

Results of the two-part CHNA were used to develop a three-year implementation strategy for LDS Hospital using an evidence-based program to address a significant health need. Outcome measures for the implementation strategy were defined and will be tracked quarterly over three years. The implementation strategy is also one of LDS Hospital's Community Stewardship goals.

LDS Hospital's implementation strategy was reviewed by the hospital governing board and signed by: 1) the person accountable for the plan; 2) the hospital administrator (also accountable for achieving the goals over the next three years; and 3) the governing board chair.

Additional community health needs identified in the CHNA not addressed in LDS Hospital's implementation strategy are part of Intermountain's system-wide initiatives to address chronic disease, access to care, and access to behavioral health services.

LDS Hospital conducted a Community Health Needs Assessment (CHNA) in 2013. This report addresses the specific requirements outlined in the Patient Protection and Affordable Care Act (ACA) to describe the CHNA process. This document is provided in fulfillment of the requirement to make results of the CHNA publicly available.

The LDS Hospital Community

LDS Hospital is one of 21 Intermountain Healthcare owned and operated hospitals in Utah and southeast Idaho. Located in Salt Lake City, LDS Hospital has 222 staffed beds and offers a complete range of high-quality wellness, diagnostic, and treatment services. In 2012, LDS Hospital provided more than \$30 million¹ in charity care to patients in over 25,000 cases.

Salt Lake County has 12 hospitals including Intermountain Primary Children’s Hospital and Shriners Hospital for Children, both pediatric specialty hospitals, University of Utah Hospital, and the Veterans Administration Hospital. Intermountain owns and operates four additional hospitals in Salt Lake County.

Based on 2012 estimates, approximately 1.1 million individuals live in Salt Lake County which encompasses 742 square miles with 1,390 people per square mile, compared to 33.6 for the state of Utah and 87.4 people per square mile in the United States.²

US Census Quickfacts ³	Salt Lake County	Utah	US
Persons under 18 years	29.0%	31.1%	23.7%
Persons 65 years and over	8.9%	9.5%	13.3%
Median household income	\$59,168	\$57,783	\$52,762
Persons below poverty level	11.1%	11.4%	14.3%
High school graduate or higher, percent of persons age 25+	88.7%	90.6%	85.4%
Bachelor’s degree or higher, percent of persons age 25+	30.2%	29.6%	28.2%

In 2012, approximately nine percent of the Utah population was enrolled in Medicaid (over half of which were children); 10 percent was enrolled in Medicare; and 59 percent was enrolled in employer-sponsored health insurance. Approximately 15 percent of the population did not have health insurance.⁴

¹ Total gross charges; the total adjusted charity care based on standards established by the Utah State Tax Commission is approximately \$16.8 million.

² United States Census, <http://quickfacts.census.gov>; revised June 27, 2013

³ Ibid

⁴ Behavioral Risk Factor Surveillance Survey, Utah, 2007, 2008, 2009, and 2010

Community Health Needs Assessment Background

LDS Hospital was part of Intermountain's 2009 health status study (conducted prior to the ACA-required CHNA) to identify significant community health needs, especially for low-income residents in Utah and southern Idaho communities. From data gathered and in consultation with nonprofit and government partners, Intermountain's Community Benefit Department established health priorities dealing with these main issues:

1. Chronic disease associated with weight and unhealthy behaviors;
2. Access to healthcare for low income populations; and
3. Access to behavioral health services for low income populations.

These priorities met Intermountain objectives to improve healthcare for low-income populations, reduce the cost of healthcare for Intermountain and the community, and assure Intermountain meets the hospital healthcare needs of each community where its hospitals are located. The health priorities aligned with *Healthy People 2010*⁵ goals and Intermountain clinical goals. Intermountain hospital leaders used the health priorities to identify health improvement strategies and develop Community Benefit programs and the community health goals of its individual hospitals, clinics, and other initiatives.

The Patient Protection and Affordable Care Act (ACA) signed into law in March 2010 requires each nonprofit hospital to perform a CHNA every three years and use the findings to develop three-year implementation strategies to address identified community needs. The ACA requires that each nonprofit hospital solicit input from individuals with broad community representation to discuss health needs within the community, gather quantitative data on significant health needs, make the CHNA results public, and report how it conducted the CHNA and developed a three-year implementation strategy on the IRS Form 990 Schedule H Section V.

Intermountain's Community Benefit Department created a system-wide process to be used by each of its 21 hospitals in conducting components of the CHNA: 1) asking for community input regarding local healthcare needs; 2) quantitative data collection; 3) developing an implementation strategy; and 4) making the CHNA results publicly available.

Intermountain clinical staff determined to use the health priorities identified in the previous health status report for the 2013 quantitative data collection and in order to identify any changes in the health indicators over the past few years; 37 health indicators were selected for the health priority categories. These priorities were also used to elicit perceptions of invited participants in LDS Hospital's community input meeting. The broad categories identified in 2009 remain significant health issues for communities served by Intermountain hospitals. Following is additional information to illustrate how each priority remains an area of focus:

⁵ www.healthypeople.gov/2010/

Health Priorities for 2013 CHNA

Health Priority #1: Improve the prevention, detection, and treatment of chronic diseases associated with weight and unhealthy behaviors.

Almost one in two adults in the United States has at least one chronic disease.⁶ Moreover, chronic diseases account for 70 percent of all deaths in the United States and cause major limitations in daily living for almost one out of 10 Americans.⁷ The five most common causes of death in Utah are:

1. Heart disease
2. Cancer
3. Chronic lower respiratory disease
4. Stroke
5. Accidents

Several of the causes are associated with weight and unhealthy behaviors.⁸ Furthermore, there is a high correlation between socioeconomic standing and prevalence of chronic disease.

While chronic diseases are some of the most common of all health problems, they are also the most preventable. Chronic disease places an enormous burden on healthcare resources. More than 75 percent of healthcare costs in the United States are due to chronic conditions.⁹

Four common behaviors—tobacco use, poor eating habits, inadequate physical activity, and excessive alcohol use—are responsible for much of the illness, disability, and premature death related to chronic disease.¹⁰ In Utah, almost 60 percent of adults are considered overweight or obese.¹¹ Individuals who are obese are at increased risk of morbidity from hypertension, high LDL cholesterol, type 2 diabetes, coronary heart disease, stroke, and osteoarthritis.

Physical inactivity has been called the biggest public health problem of the 21st century.¹² Strong evidence shows that physical inactivity increases the risk of many adverse health conditions, and is a bigger independent contributor to cardiovascular and all-cause mortality than other risk factors such as obesity, smoking, and diabetes.^{13 14 15}

⁶ *Chronic Diseases at a Glance*, National Center for Chronic Disease Prevention and Health Promotion, Center for Disease Control and Prevention, U.S. Department of Health and Human Services, 2009.

⁷ *Ibid*

⁸ *Utah Burden of Chronic Disease*, National Center for Chronic Disease Prevention and Health Promotion, Center for Disease Control and Prevention, U.S. Department of Health and Human Services, 2008.

⁹ *Chronic Disease at a Glance*, 2009.

¹⁰ *Ibid*

¹¹ Behavioral Risk Factor Surveillance Survey, Utah, 2007, 2008, 2009, and 2010.

¹² Blair SN. Physical inactivity: the biggest public health problem of the 21st century. *Br J Sports Med.* 2009; 43(1): 1-2.

¹³ *Ibid*

¹⁴ Church, TS. Cardiorespiratory fitness and body mass index as predictors of cardiovascular disease mortality among men with diabetes. *Arch Intern Med.* 2005;165:2114-2120

Utah has the lowest adult smoking rate in the country and a lower adolescent smoking rate that has declined by five percent since 1999.¹⁶ In 2011, 56 percent of Utah adults reported getting the recommended amount of physical activity compared to 51 percent nationally.¹⁷

Health Priority #2: Improve access to comprehensive, high-quality healthcare services for low-income populations.

Healthcare access is “the timely use of personal health services to achieve the best possible health outcomes.”¹⁸ More than 40 million Americans do not have access to a particular doctor’s office, clinic, health center, or other place to seek health care.¹⁹ People without regular access to healthcare forgo preventative services that can reduce unnecessary morbidity and premature death.

Many barriers exist to access healthcare, including: lack of insurance, inability to pay, not knowing how or when to seek care, language and cultural obstacles, limited transportation options, and lack of primary or specialty care providers. Approximately 421,900 or 15 percent of Utah residents are uninsured.²⁰ People with lower household incomes and less formal education were more likely to report difficulties in accessing care.²¹

Health Priority #3: Improve access to appropriate behavioral health services for low-income populations.

Mental disorders are among the most common causes of disability. The resulting disease burden of mental illness is among the highest of all diseases. According to the National Institute of Mental Health (NIMH), in any given year, an estimated 13 million American adults (approximately one in 17) have a seriously debilitating mental illness.²²

Approximately 32 percent of the United States population is affected by mental illness in any given year.²³ The 2012 annual report of the Utah Department of Health Division of Substance Abuse and Mental Health reports that five percent of adults and 4.7 percent of youth under age 18 in Utah were classified as needing treatment for mental health issues, or a combined total of about 102,130 individuals needing but not receiving mental health

¹⁵ Lee IM, Shiroma, EJ, Lobelo F, et al; Lancet Physical Activity Series Working Group. Effect of physical inactivity on major non-communicable diseases worldwide: an analysis of burden of disease and life expectancy. *Lancet*. 2012;380(9838):219-229

¹⁶ Behavioral Risk Factor Surveillance Survey, Utah, 2007, 2008, 2009, and 2010.

¹⁷ Kaiser Family Foundation analysis of the Centers for Disease Control and Prevention’s Behavioral Risk Factor Surveillance System Survey Data (BRFSS), 2011.

¹⁸ *Access to Health Services, Healthy People 2020*, www.healthypeople.gov

¹⁹ Ibid

²⁰ Behavioral Risk Factor Surveillance Survey, Utah, 2007, 2008, 2009, and 2010

²¹ *Access to Health Services, Healthy People 2020*, www.healthypeople.gov

²² Kessler, R.C, Chiu W, Demler O., et al. Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*. 2005 Jun; 62(6):617-27.

²³ Utah Healthcare Access Survey. Population Estimates: UDOH Office of Public Health Assessment. Estimates are for 2007 year.

treatment. The public mental health treatment system served 44,611 individuals, which is less than 31 percent of the current need.²⁴

Utah has one of the highest age-adjusted suicide rates in the United States. Suicide is the second leading cause of death for Utahns ages 15 to 44 years of age and the third leading cause of death for Utahns ages 10 to 14.²⁵ Utah has a higher suicide rate than the average in the rest of the United States and it has increased since 2008.²⁶ Compared to other states, Utah has a similar percentage of adults who reported seven or more days of poor mental health in the last 30 days.²⁷

²⁴ Holzer, C.E., & Nguyen, H.T. (2008). Synthetic Estimates of Mental Health Needs for Utah (based on the Collaborative Psychiatric Epidemiological Surveys and the U.S. Census 2009 Population Estimate), from www.charles.holzer.com.

²⁵ *Utah Health Status Update, Teen and Adult Suicide*, Utah Department of Health, July 2008.

²⁶ *2012 Utah Statewide Health Status Report*, Utah Department of Health, January, 2013

²⁷ Ibid

2013 Community Health Needs Assessment Process

LDS Hospital conducted its 2013 CHNA in two parts: 1) inviting input from community members representing the broad interests of each hospital community; and 2) gathering health indicator data.

CHNA Part One: Community Input

Participants representing the broad interests of the community, including the healthcare needs of uninsured and low-income people, were invited to attend a meeting to share their perspectives on health needs in the hospital's community. The facilitator guided discussion to help hospital staff understand the issues and perceptions of residents. Meeting participants were asked open-ended questions as well as questions about the health priorities. Issues and needs that emerged from the open-ended questions were included in one of the three health priority categories. To help prompt thoughtful discussion, community information from the 2009 health status study was shared in the meeting. Meeting participants were also asked to identify successful health-related strategies in the hospital community. Erica Dahl, Urban Central Region Community Relations Director, facilitated the meeting on April 11, 2012. A recorder was assigned for the meeting to capture the comments and details.

Representatives included the following:

- Community Health Centers of Salt Lake – Dexter Pearce, Executive Director
- Greater Avenues Community Council – John K. Johnson
- Intermountain Community Benefit – Terry Foust, AuD, Director
- Intermountain Medical Group provider – Doug Kasteler, MD
- Intermountain Urban Central Region Governing Board – Robert Clark
- National Association on Mental Illness – Kimberly Myers, Prevention by Design Program Manager
- Neighborhood residents – Dave Midget and Pete Taylor
- Rape Recovery Center – Cindy Taylor, Director of Education
- Retired nurse – Paula Julander
- Salt Lake City Mayor's Office – Shawn McDonough, Community Liaison
- Tooele Transcript Bulletin – Keith Bird, Sales Representative
- United Way of Salt Lake, Summit, and Tooele counties – Bill Crim, Senior Vice President of Collective Impact and Public Policy
- Utah State Representative – Rebecca Chavez-Houck
- Voices for Utah Children – Karen Crompton, Executive Director

Health priority #1: From your perspective, what are the biggest challenges our community faces in trying to prevent, detect, and treat chronic diseases associated with weight and unhealthy behaviors?

Issues Identified:

- Access is the greatest challenge; lack of resources once something is detected, limited resources at community health centers for diabetes and hypertension treatment.
- High correlation of obesity and underlying root causes.

- Challenge to get providers to diagnose obesity.
- Providers see so much obesity – provide standard advice to lose weight and exercise.
- A lot of attention about obesity, but not a lot to address it.
- Poor guidance to schools regarding nutrition.
- Social determinants of health including living wage, environment, safe neighborhoods, number of jobs, etc.
- There aren't good low cost options for highly nutritious foods.
- Access is an issue, barriers still exist; Salt Lake City conducted focus groups on culture; we hear about the same issues over and over but we're not seeing change.
- Area of nutrition and physical activity; problems drives up costs.
- United Way has invited people to work with us in a coordinated way, not much going on even with Gold Medal Schools and health walks to "move the needle."
- A lot of good efforts, but not organized or aligned; need to get baseline measures on kids in schools then align goals and activities. Unless a partner says to United Way that they will work with us in targeted schools, we don't know the strategies to make an impact.
- People need "imbedded" behavior to reinforce behavior changes; very simple, peer support with others doing the same.

Strategies discussed:

- Intermountain's LiVe Well program helps; kids see the information.
- Positive promise of the medical home with a variety of experts to address challenge.
- Buzz words of accountable care; Intermountain is on its own with Shared Accountability. We're anticipating change in healthcare delivery with implementation of Shared Accountability.
- Parental support is critical to helping change/improve health of children.

Health Priority #2: From your perspective, what are the biggest challenges our community faces in providing access to comprehensive, high-quality healthcare for uninsured and low-income people?

Issues Identified:

- Clients express needs for information on community services; we provide information on Intermountain and other clinics, services, and use 211 Information and Referral phone resource.
- Just giving a list isn't enough; need to explore the patient navigator programs especially for mental illness.
- Having insurance doesn't guarantee access; Utah has the lowest participation rate of CHIP and Medicaid. The state can do more to increase access. SelectHealth and Molina are helping with enrollment.
- United Way hears that community health centers are full, services are not available; we're working with Utah Partners for Health mobile clinic but it isn't frequent enough with only one visit in six weeks.
- A lot of service providers seem to work in isolation; school staff doesn't facilitate getting kids into clinics.

Successful Strategies

- Active, targeted access for enrollment; don't let fear drive strategies.
- Availability of Utah Partners for Health mobile medical van to work with local agencies to provide primary care periodically in high need neighborhoods.

Health priority #3: From your perspective, what are the biggest challenges our community faces in providing access to appropriate behavioral health services for uninsured and low-income people?

Issues Identified:

- Low-level depression can be treated at clinics; Medicaid premium needs to be addressed for providers. Primary healthcare needs to bring behavioral health together.
- People with insurance don't necessarily have access to behavioral health because they may not have that benefit in their plan; co-location and integration are important, successful.
- Look at the suicide rate, there are things we can do; so many kids, school-based healthcare, school counselors maybe?
- The biggest challenge is how to educate the people who will have impact on the issue; work with the people that make decisions and address the stigma of mental health. Legislators and parents need education on mental health.
- As the state develops basic healthcare plans, we need to look at kids differently with screening, diagnosis, treatments, and address healthcare coverage differently to diagnose early and catch life-long risks early.
- In United Way partnerships, mental health for kids comes up with the need for general health and dental access.
- If you don't have Medicaid, there aren't resources for mental health.

CHNA Part Two: Indicators for Each Significant Health Priority

Intermountain clinical leaders identified potential health indicators for health issues to include in the 2013 CHNA. LDS Hospital Planning Department staff provided the zip codes that define the primary market area for the hospital to clearly delineate the hospital's "community." Strategic Planning and Research department staff collaborated with the Utah Department of Health to assemble available data on health indicators for the LDS Hospital community. Data were drawn from the Behavioral Risk Factor Surveillance System, Vital Records Statistics, and State Hospital Discharge Data. Two or three years of data were aggregated together for each indicator to achieve a large enough sample size to have a reliable estimate for each health indicator. A report containing scores on each health indicator for each community was presented to LDS Hospital Administration and Community Benefit staff; the report was used along with the summaries of the community input meetings for the next step; implementation strategy planning based on the CHNA results.

Intermountain staff identified two significant gaps in the quantitative analysis portion of the CHNA. First, significant health indicators were not available for recent depression, and other behavioral health diagnostic categories from the Utah Department of Health. Second, current Medicaid enrollment and eligibility data and information on the number of healthcare providers accepting Medicaid in local communities was unavailable to Intermountain.

The LDS Hospital community was defined by its primary market zip codes, which were used to assemble available data for health indicators:

84010 Bountiful	84011 Bountiful	84014 Centerville
84025 Farmington	84054 North Salt Lake	84087 Woods Cross
84101 Salt Lake City	84102 Salt Lake City	84103 Salt Lake City
84104 Salt Lake City	84105 Salt Lake City	84108 Salt Lake City
84110 Salt Lake City	84111 Salt Lake City	84116 Salt Lake City
84126 Salt Lake City	84127 Salt Lake City	84143 Salt Lake City
84147 Salt Lake City	84158 Salt Lake City	84151 Salt Lake City

Health indicator data are crude-rated (not age-adjusted) to show “actual burden” of an indicator for the population in a particular hospital community. State and United States data are included as crude rates, as well as for informational purposes only, not for precise comparisons with particular hospital communities.

Data sources: State of Utah Behavioral Risk Factor Surveillance System, (BRFSS), 2008, 2009, 2010, and 2011; Utah Department of Substance Abuse and Mental Health, 2012; Utah Vital Statistics, 2008, 2009, 2010, 2011; U.S. BRFSS, 2010; Centers for Disease Control, 2008 and 2009; U.S. Department of Substance Abuse and Mental Health, 2012.

Following is a summary of indicators within each of the three major health priorities:

Table 1 Chronic diseases associated with weight and unhealthy behaviors

#1 Health Priority: Improve the prevention, detection, and treatment of chronic diseases associated with weight and unhealthy behaviors.				
Health indicator (Source: Utah Department of Health Behavior Risk Factor Surveillance System)	Community Rank*	LDSH Community	Utah	US
Overweight/obese	8	57.3%	57.8%	64.5%
High blood pressure	15	22.8%	21.4%	28.7%
High cholesterol	16	25.8%	23.2%	37.5%
Last cholesterol screening 5 years ago or more	2	27.7%	33.1%	23%
Diabetes	9	6.1%	6.2%	8.7%
Asthma	9	8%	8.5%	9.1%
Arthritis	11	21.3%	21.6%	26%
Less than 2 servings of fruit daily	13	68.7%	68.8%	NA
Less than 3 servings of vegetables daily	8	72.2%	74.6%	NA
Not meeting recommended physical activity	16	45.6%	42%	49.5%
Current cigarette smoking	11	9.6%	9.4%	17.3%
Binge drinking	15	10.5%	8.6%	15.1%
Chronic drinking	13	3.4%	2.8%	5%
No routine medical checkup in past 12 months	6	41.5%	43%	NA
Adult watch more than 2 hours TV weekdays	9	49.6%	51.7%	NA
Child watch more than 2 hours TV weekdays	10	64.1%	66.5%	NA
Adult more than 1 soft drink/week	2	10.9%	13.7%	NA
Child more than 1 soft drink/week	5	2.1%	2.9%	NA
No colonoscopy after age 50	8	27.3%	29.6%	34.8%
Heart disease deaths (per 100K)	13	119.6	104.4	195.2
Stroke deaths (per 100K)	12	29.2	27.3	54.6
All cancer deaths (per 100K)	12	100.9	96.7	184.9
Prostate cancer deaths (males, per 100K)	11	13.9	14.5	22.8
Breast cancer deaths (females per 100K)	12	18.7	17.5	22.5
Colon cancer deaths (per 100K)	12	10	9.1	16.4

*Community rank represents a 1-21 ranking of geographic communities served by Intermountain

Table 2 Access to comprehensive healthcare services

#2 Health Priority: Improve access to comprehensive, high-quality healthcare services for low-income populations.					
Health indicator (Source: Utah Department of Health Behavior Risk Factor Surveillance System)	Community Rank	LDSH Community	Utah	US	
No healthcare coverage					
Overall	6	14%	15.1%	17.8%	
Hispanic	10	50.7%	44.6%	NA	
Non-Hispanic	5	10.5%	12.3%	NA	
Unable to get care due to cost					
Overall	7	11.4%	13.3%	14.6%	
Hispanic	11	27.5%	26.1%	NA	
Non-Hispanic	5	9.9%	11.6%	NA	
No medical home					
Overall	10	21.2%	23.1%	18.2%	
Hispanic	13	52%	44.2%	NA	
Non-Hispanic	7	18.6%	20.8%	NA	
No routine medical checkup in past 12 months					
Overall	6	41.5%	43%	32.6%	
Hispanic	6	54.8%	51%	NA	
Non-Hispanic	4	40.8%	43.6%	NA	
No healthcare coverage for child	12	5.2%	5.5%	8.2%	
No prenatal care until 3 rd trimester	6	3.5%	3.7%	NA	
Low birth weight	8	7%	7%	8.2%	
Last dentist visit 1 year ago or more	9	26.9%	28.7%	30.3%	

Table 3 Access to behavioral health services

#3 Health Priority: Improve access to appropriate behavioral health services for low-income populations.					
Health indicator (Source: Utah Department of Health Behavior Risk Factor Surveillance System)	Community Rank	LDSH Community	Utah	US	
Mental health not good 7 or more of past 30 days	9	13.8%	14.7%	NA	
Suicide rate (per 100K)	9	16.3	15.8	12	
Rx opioid deaths (per 100K)	17	18.8	14.5	4.8	
Ever diagnosed with depression	13	23%	22%	9.1%	

Implementation Strategy

Results of the two-part CHNA were used to develop a three-year implementation strategy with LDS Hospital Community Benefit staff, planners, administrators, governing board members, and community members with expertise in health including community health educators, county and state health department staff, and chronic disease experts. The hospital team identified a significant local health need where there was both an opportunity to make measurable health improvements over the next three years and align with LDS Hospital programs, resources, and priorities.

The hospital planning team identified potential collaborative partnerships with county and/or state health departments, schools, health coalitions, and other advocacy agencies that were already engaged in health initiatives. LDS Hospital's implementation strategy incorporates evidence-based approaches to address chronic disease and includes an outline of goals and outcome measures beginning 2013 through 2015.

Based on the results of the two-part CHNA, LDS Hospital identified the following focus and strategy:

Health Priority Focus: Improve the prevention, detection, and treatment of chronic diseases associated with weight and unhealthy behaviors.

Strategy: Define and understand the met and unmet health needs of the diabetic population served by the hospital; develop partnerships in the diabetes community to enhance care and access. Identify, develop, and implement an evidence-based program to address self-management of diabetes to improve health.

LDS Hospital's implementation strategy is not only an annual Community Benefit goal, but is also part of the hospital's Community Stewardship goal. Annual goals are tracked and reported quarterly; the status of each goal will be shared with hospital leadership, hospital governing boards, as well as with Intermountain senior leadership and Board of Trustees. The hospital implementation strategy was reviewed by the hospital governing board and signed by: 1) the LDS Hospital staff member accountable for the plan; 2) LDS Hospital administrator (also accountable for achieving the goals over the next three years); and 3) the governing board chair.

LDS Hospital's Response to Additional Community Health Needs

LDS Hospital's CHNA identified needs that the hospital determined were not the highest priority to address with an implementation strategy in the local community for several reasons including: limited community resources for providing solutions, ability of the hospital to create a meaningful impact without broader community support, or because the issue would be better addressed by Intermountain as a system. A summary of some of those activities is provided below.

Intermountain continues system-wide efforts to improve chronic disease detection and treatment:

- Cancer screening and referral events for low-income and underserved communities;
- LiVe Well education campaign for middle school students increase awareness of healthy activity levels and nutrition and LiVe Well family education for children, adolescents, and their parents;
- LiVe Well Centers in three of its hospitals provide health risk assessments, education, and coaching;
- Community health education courses on arthritis and diabetes self-management in collaboration with senior centers and safety net clinics; and
- Community support groups for cancer, breast cancer, and heart disease.

Intermountain continues to provide both access to its healthcare services for low-income and uninsured people in communities served by its hospitals and clinics and creates access by establishing clinics and partnerships to reach out to the most underserved communities to ensure they also have access to hospitals and clinics.

- Intermountain operates six community and school clinics located in geographic areas where there are no other health providers; fees are charged on a sliding scale based on Federal Poverty Guidelines;
- Intermountain provides Community Health Centers and free clinics with vouchers for diagnostic imaging and lab tests for patients;
- Intermountain provides grants through Intermountain Community Care Foundation to Community Health Centers and other safety net clinics in excess of \$2.3 million annually to create medical home access for low-income and uninsured people; and
- People presenting in Intermountain hospitals and clinics are eligible to receive medically necessary services regardless of ability to pay. In addition, community partners refer directly to Intermountain's specialty and diagnostic services using a voucher. In 2012, \$5.6 million in vouchers were used to directly access financial assistance. In total, Intermountain provided \$252.4²⁸ million of charity care to people who are either uninsured or under-insured in more than 239,000 cases in 2012.²⁹

Intermountain's CHNA identified access to behavioral services as a need in most communities served by its hospitals. Intermountain continues efforts to create access specifically for low-income, uninsured people. In addition to the charity care services Intermountain has provided since its inception to address this need, current efforts focus on creating access in community-based services.

²⁸ Total gross charges; the total adjusted charity care based on standards established by the Utah State Tax Commission is approximately \$158.4 million.

²⁹ Internal Case Mix Data, Intermountain, 2012

- Intermountain provided \$7.6 million in charity care for low-income mental health patients (defined as Medicaid/uninsured with mental disorders and / or substance abuse issues) in more than 2,700 cases in 2012³⁰;
- Collaborative partnerships exist in all urban communities to link uninsured people with community-based behavioral health providers;
- Intermountain is developing telehealth and community partnership solutions to address access issues in the rural healthcare setting and in pediatric populations;
- Intermountain leaders participate in county and state initiatives to address access challenges;
- Hospital and clinic staff provide community education on suicide prevention and depression; and
- Intermountain provides grants to Community Health Centers and safety net clinics of \$2.3 million annually for comprehensive health services inclusive of mental health.

Multiple community partners continue to work with LDS Hospital on the above health issues include but are not limited to:

- Family Counseling Center
- Four Salt Lake City Community Health Centers
- Fourth Street Homeless Clinic
- Hope and Maliheh clinics which provide primary care free to low-income and uninsured people
- Health Access Project, a referral/case management program for uninsured, low-income Salt Lake County residents
- National Alliance on Mental Illness
- Polizzi Clinic (behavioral health services) for low-income people
- Salt Lake Valley Health Department
- Utah Department of Health
- Utah Partners for Health provides referrals to primary and specialty care providers for low-income and uninsured people
- Utah Support and Advocates for Recovery Awareness (support for substance abuse recovery)
- Valley Mental Health
- Volunteers of America

³⁰ Ibid

Conclusion

LDS Hospital is grateful for the support of community members and agencies for their participation in the process of understanding local community healthcare needs. The implementation strategy developed in partnership with community leaders will require continued collaboration in order to be successful in addressing the identified community health priority.

LDS Hospital will update its assessment of community health needs in 2016 and looks forward to continued partnership to improve the health of our community.

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