



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

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

**Intermountain Orem Community Hospital  
331 North 400 West  
Orem, Utah 84057**

## **Executive Summary**

Intermountain Orem Community 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.

Orem Community 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 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 Orem Community 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 Orem Community Hospital's Community Stewardship goals.

Orem Community 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 Orem Community 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.

Orem Community 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 Orem Community Hospital Community

Orem Community Hospital is located in urban Orem, Utah, a suburb of Provo. The hospital has 18 staffed beds and offers a full spectrum of inpatient and outpatient medical services. In 2012, Orem Community Hospital provided more than \$1 million<sup>1</sup> in charity care in over 1,900 cases.

Utah County has five hospitals including three owned by Intermountain.

Based on 2012 estimates, approximately 540,504 individuals live in Utah County which encompasses 2,003 square miles with 257.8 people per square mile, compared to 33.6 for the state of Utah and 87.4 people per square mile in the United States.<sup>2</sup>

US Census Quickfacts <sup>3</sup>	Utah County	Utah	US
Persons under 18 years	34.8%	31.1%	23.7%
Persons 65 years and over	6.8%	9.5%	13.3%
Median household income	\$59,338	\$57,783	\$52,762
Persons below poverty level	12.9%	11.4%	14.3%
High school graduate or higher, percent of persons age 25+	93.6%	90.6%	85.4%
Bachelor's degree or higher, percent of persons age 25+	35.9%	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.<sup>4</sup>

<sup>1</sup> Total gross charges; the total adjusted charity care based on standards established by the Utah State Tax Commission is approximately \$741 thousand.

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

<sup>3</sup> Ibid

<sup>4</sup> Behavioral Risk Factor Surveillance Survey, Utah, 2007, 2008, 2009, and 2010

## Community Health Needs Assessment Background

Orem Community 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*<sup>5</sup> 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 representing broad interests of the community 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 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:

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<sup>5</sup> [www.healthypeople.gov/2010/](http://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.<sup>6</sup> 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.<sup>7</sup> 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 unhealthy weight and behaviors.<sup>8</sup> 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.<sup>9</sup>

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.<sup>10</sup> In Utah, almost 60 percent of adults are considered overweight or obese.<sup>11</sup> 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 21<sup>st</sup> century.<sup>12</sup> 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.<sup>13 14 15</sup>

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<sup>6</sup> *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.

<sup>7</sup> *Ibid*

<sup>8</sup> *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.

<sup>9</sup> *Chronic Disease at a Glance*, 2009.

<sup>10</sup> *Ibid*

<sup>11</sup> Behavioral Risk Factor Surveillance Survey, Utah, 2007, 2008, 2009, and 2010.

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

<sup>13</sup> *Ibid*

<sup>14</sup> 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.<sup>16</sup> In 2011, 56 percent of Utah adults reported getting the recommended amount of physical activity compared to 51 percent nationally.<sup>17</sup>

### **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.”<sup>18</sup> 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.<sup>19</sup> 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.<sup>20</sup> People with lower household incomes and less formal education were more likely to report difficulties in accessing care.<sup>21</sup>

### **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.<sup>22</sup>

Approximately 32 percent of the United States population is affected by mental illness in any given year.<sup>23</sup> 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

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<sup>15</sup> 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

<sup>16</sup> Behavioral Risk Factor Surveillance Survey, Utah, 2007, 2008, 2009, and 2010.

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

<sup>18</sup> *Access to Health Services, Healthy People 2020*, www.healthypeople.gov

<sup>19</sup> Ibid

<sup>20</sup> Behavioral Risk Factor Surveillance Survey, Utah, 2007, 2008, 2009, and 2010

<sup>21</sup> *Access to Health Services, Healthy People 2020*, www.healthypeople.gov

<sup>22</sup> 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.

<sup>23</sup> 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.<sup>24</sup>

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.<sup>25</sup> Utah has a higher suicide rate than the average in the rest of the United States and it has increased since 2008.<sup>26</sup> 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.<sup>27</sup>

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<sup>24</sup> 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](http://www.charles.holzer.com).

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

<sup>26</sup> *2012 Utah Statewide Health Status Report*, Utah Department of Health, January, 2013

<sup>27</sup> Ibid

## 2013 Community Health Needs Assessment Process

Orem Community 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 Orem Hospital 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. Kye Miner, Urban South Region Community Benefit Manager, facilitated the meeting on June 6, 2012. A recorder was assigned for the meeting to capture the comments and details.

#### Representatives included the following:

- Intermountain Community Benefit – Terry Foust, AuD, Director; and Debbie Hardy, Manager
- Kids on the Move – Eileen Chamberland, Director
- Local business person – A. Rock Boutler
- Mountainlands Community Health Center (CHC) – Todd Bailey, Executive Director
- Orem City Council – Karen McCandless
- Orem Community Hospital – Steven Badger, Administrator
- SCERA Center Arts – Linda Campbell, Director
- Utah County Health Department – Sarah Dahl and Steven Mickelson
- Utah Department of Substance Abuse – Kye Nordfelt
- Utah Valley Regional Medical Center – Ryan Lecheminant
- Utah Valley University – Gwen Anderson
- Wasatch Mental Health – Juergen Korbanka, Executive Director

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

#### Issues identified:

- Mountainlands Community Health Center (CHC) just needs to have enough access for our patients to reach us.
- This is an entitlement issue; people are entitled to healthcare; and who should pay for it.
- Maybe the best approach to prevention of these chronic diseases would be education.

- Weight and unhealthy behaviors shows higher incidence with lower education and lower income and poverty levels; better to focus some of the outreach on those populations.
- Would be important to have information available in different languages to help educate and overcome cultural differences.
- Seems that most health issues fall back into the fact that we aren't eating correctly.
- Big disconnect between what people believe and what they do and it doesn't always fall in the poverty lines. Once people get a chronic disease they feel like they need to be taken care of and don't understand that they have responsibility to make changes on their own.
- Wasatch Mental Health providers have seen that many low-income clients they see for mental health issues simply ignore their physical health, so they wait until it is an emergent situation and then the cost of the care is really high.
- Recently there were five deaths in the Pacific Islander population in Utah County where they had died of heart conditions; in every case, they did not realize they had those symptoms.
- Hispanic populations have certain propensities to health issues, so if we could get into the communities to help them learn how to prevent their diseases that might help.
- Cancer is an issue; encourage people to protect themselves.
- Address binge eating of teenagers.
- Look at the food banks and the kinds of food they provide to low income people; many clients are obese. Get the right kinds of foods and educate the people at food pantries.
- Poorer people tend to have more fat in their diet; the less income they have the less likely they are to participate because their priorities are different.

**Strategies discussed:**

- There was a success with a demonstration exercise to help people experience what it's like to be in a low-income, uninsured situation; it teaches that even though the participant knew it was important to be healthy, paying the bills and having food were a higher priority.
- Education and prevention is the best treatment, but once you have a chronic illness you have to manage it.
- At Mountainlands CHC, once staff identify someone with a chronic disease, they put them on a list to be contacted to encourage them to become better educated as to how to care for themselves and realize their responsibilities; see levels come down, education is an important piece of the strategy.
- Access to low cost pharmaceuticals is helpful.
- Intermountain's LiVe Well campaign.
- Hundred Day Heart Challenge education series provided several years ago was helpful.
- Prevention and changes in healthy eating is one strategy used at Wasatch Mental Health for clients with serious and persistent mental illness (SPMI); have had great success in smoking cessation and improving the overall health while improving mental health.
- Having a work competition to improve fitness and provide incentives of good prizes.
- County tobacco cessation program and lobbying for changes in laws.
- Booster seat laws have reduced child passenger injury; car seat events help make sure seats are in correctly.
- State of Utah had a program to visit every county in Utah; a passport, also a Utah county passport, to check off the activities completed.
- Utah Valley University has a "Biggest Loser" program which makes it fun to lose weight.

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

**Issues identified:**

- Knowledge is very important, knowing what's available and incorporating healthcare into our lives; important to know how to access care and where clinics that serve low-income people are located with easy accessibility to work within their work schedules.
- The cost is huge for some emergent problems because of under treatment.
- High deductible plans are inhibiting people from accessing care.
- Looked for clinic access information at the university and found information sheet that doesn't get distributed; students don't want to take the time to research where to access care.
- The way to get information to students and others is through the Internet.
- Number of primary care providers retiring will affect Utah in a few years; need to encourage schools to train family doctors.

**Strategies discussed:**

- Impressed with the investment by companies to benefit their employees such as Blendtec, Vivint; all have doctors on call and/or a clinic on-site.

**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:**

- Fewer clinical support groups that can address the needs of people with these issues.
- Don't have those lower cost alternatives available to the general low-income population; not aware of programs for people who don't need one-on-one therapy.
- There aren't enough options available such as innovative concepts that cost less than one-on-one treatment. The challenge is to provide enough access to make available to the broader population.
- Systematically behavioral health cannot use Medicaid efficiencies for non-Medicaid clients anymore, which has reduced access to care and increased costs to provide care.
- We need to expand on something to improve access to care.
- Suggested that Utah Legislators consider overturning legislation that stops schools from seeking care for those students in need of care; right now they're stopped from doing so.
- There's a growing heroin addiction in the valley and escalating violent levels of pornography.
- Mountainlands CHC has a huge waiting list for treatment; having those opportunities available and the education out there to say it is okay to go to a provider to get some help. Maybe if primary care providers can know where to refer if they come across a need like an emergent mental health issue that would help. Because of the low-income population they see, mental health provider sees more suicide issues than anything else.
- When looking at reducing physical healthcare costs, the root can be mental health related.
- The notion of whole health is a developing concept, but when people go to a counselor, they only address the mental health needs and avoid the overweight issues, etc., is becoming more obvious that these should be addressed as well.

- All the health issues are part of the same problem, need to be addressed together.

**Strategies discussed:**

- Alpine School District has been trying to deal with mental health issues with school children and using the schools to get information out to families, specifically getting information on suicide to the families, creating neighborhood gathering posts to help connect people.
- Wasatch Mental Health has been working with Mountainlands CHC to facilitate a physical health clinic to help address basic healthcare needs for clients who also have a mental health issue.
- Programs to get unused prescription medicine out of the homes and disposed of have been very successful.
- Police department collects so much unused prescription medication that it's overwhelming; great thing, but they have to keep them under watchful care.
- Physicians in Orem Community Hospital are being careful about what kinds of prescriptions they're writing. Emergency Department (ED) doctors meet regularly to discuss cases and doctors that are not careful; has helped change behaviors; many of their problems come from meds prescribed elsewhere.
- Department of Substance Abuse works with court system to get clients with mental health and substance abuse issues access to care; National Alliance on Mental Illness (NAMI) provides great help.
- Success with Utah Valley Regional Medical Center working on tobacco cessation and a smoke free campus.
- A lot of doctors are telling patients to quit smoking to improve their health; people more likely to quit if a healthcare provider tells them.

## 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. Orem Community 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 hospital's 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 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 Orem Community 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 Orem Community Hospital community was defined by its primary market zip codes, which were used to assemble available data for health indicators:

84057 Orem

84058 Orem

84097 Orem

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 U.S. 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**

<b>#1 Health Priority: Improve the prevention, detection, and treatment of chronic diseases associated with weight and unhealthy behaviors.</b>				
<b>Health indicator (Source: Utah Department of Health Behavior Risk Factor Surveillance System)</b>	<b>Community Rank*</b>	<b>Orem Hospital Community</b>	<b>Utah</b>	<b>US</b>
Overweight/obese	16	61.7%	57.8%	64.5%
High blood pressure	7	19.4%	21.4%	28.7%
High cholesterol	6	20.8%	23.2%	37.5%
Last cholesterol screening 5 years ago or more	13	36.4%	33.1%	23%
Diabetes	19	7.5%	6.2%	8.7%
Asthma	17	10%	8.5%	9.1%
Arthritis	3	17.2%	21.6%	26%
Less than 2 servings of fruit daily	3	63.9%	68.8%	NA
Less than 3 servings of vegetables daily	17	78%	74.6%	NA
Not meeting recommended physical activity	4	32.7%	42%	49.5%
Current cigarette smoking	3	4.7%	9.4%	17.3%
Binge drinking	4	4.1%	8.6%	15.1%
Chronic drinking	3	[0.6%]	2.8%	5%
No routine medical checkup in past 12 months	14	47.8%	43%	NA
Adult watch more than 2 hours TV weekdays	4	45.2%	51.7%	NA
Child watch more than 2 hours TV weekdays	5	60.9%	66.5%	NA
Adult more than 1 soft drink/week	12	14.4%	13.7%	NA
Child more than 1 soft drink/week	3	1.9%	2.9%	NA
No colonoscopy after age 50	15	29.2%	29.6%	34.8%
Heart disease deaths (per 100K)	7	101	104.4	195.2
Stroke deaths (per 100K)	8	26.3	27.3	54.6
All cancer deaths (per 100K)	6	84.3	96.7	184.9
Prostate cancer deaths (males, per 100K)	8	13.2	14.5	22.8
Breast cancer deaths (females per 100K)	13	19.3	17.5	22.5
Colon cancer deaths (per 100K)	6	7.7	9.1	16.4

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

Data with brackets [ ] indicates small sample size and possibly unreliable results

**Table 2 Access to comprehensive healthcare services**

<b>#2 Health Priority: Improve access to comprehensive, high-quality healthcare services for low-income populations.</b>					
<b>Health indicator (Source: Utah Department of Health Behavior Risk Factor Surveillance System)</b>	<b>Community Rank</b>	<b>Orem Hospital Community</b>	<b>Utah</b>	<b>US</b>	
<b>No healthcare coverage</b>					
Overall	1	9.9%	15.1%	17.8%	
Hispanic	4	[38%]	44.6%	NA	
Non-Hispanic	4	10.3%	12.3%	NA	
<b>Unable to get care due to cost</b>					
Overall	6	11.4%	13.3%	14.6%	
Hispanic	1	[11.8%]	26.1%	NA	
Non-Hispanic	13	12.1%	11.6%	NA	
<b>No medical home</b>					
Overall	6	19.7%	23.1%	18.2%	
Hispanic	3	[30.5%]	44.2%	NA	
Non-Hispanic	6	18.5%	20.8%	NA	
<b>No routine medical checkup in past 12 months</b>					
Overall	14	47.8%	43%	32.6%	
Hispanic	10	[59.9%]	51%	NA	
Non-Hispanic	17	49.2%	43.6%	NA	
No healthcare coverage for child	4	3.3%	5.5%	8.2%	
No prenatal care until 3 <sup>rd</sup> trimester	7	3.6%	3.7%	NA	
Low birth weight	6	6.5%	7%	8.2%	
Last dentist visit 1 year ago or more	7	26.1%	28.7%	30.3%	

Data with brackets [ ] indicates small sample size and possibly unreliable results

**Table 3 Access to behavioral health services**

<b>#3 Health Priority: Improve access to appropriate behavioral health services for low-income populations.</b>					
<b>Health indicator (Source: Utah Department of Health Behavior Risk Factor Surveillance System)</b>	<b>Community Rank</b>	<b>Orem Hospital Community</b>	<b>Utah</b>	<b>US</b>	
Mental health not good 7 or more of past 30 days	14	16.2%	14.7%	NA	
Suicide rate (per 100K)	2	9.3	15.8	12	
Rx opioid deaths (per 100K)	7	11.2	14.5	4.8	
Ever diagnosed with depression	5	17%	22%	9.1%	

## Implementation Strategy

Results of the two-part CHNA were used to develop a three-year implementation strategy with Orem Community 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 Orem Community 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. Orem Community 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, Orem Community 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: Implement the "100 Day Heart Challenge" chronic disease self-management program with select populations to develop skills and confidence to self-manage their condition and improve health.

Orem Community 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 Orem Community Hospital staff member accountable for the plan; 2) Orem Community Hospital administrator (also accountable for achieving the goals over the next three years); and 3) the governing board chair.

## Orem Community Hospital's Response to Additional Community Healthy Needs

Orem Community 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 \$252.4<sup>28</sup> million of charity care to people who are either uninsured or under-insured in more than 239,000 cases in 2012.<sup>29</sup>

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

<sup>29</sup> Internal Case Mix Data, Intermountain, 2012

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.

- 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 2012<sup>30</sup>;
- 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 Orem Community Hospital on the above health issues include but are not limited to:

- Community Health Centers (two in Utah County)
- Community Health Connect (a referral/case management program for uninsured, low-income Utah County residents)
- National Alliance on Mental Illness
- United Way of Utah County
- Utah County Health Department
- Utah Department of Health
- Volunteer Care Clinic

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<sup>30</sup> Ibid

## **Conclusion**

Orem Community 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.

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

The Orem Community Hospital CHNA was completed by Intermountain Community Benefit and Strategic Planning and Research Departments.