



**Intermountain Valley View Medical Center
Community Health Needs Assessment
and Implementation Strategy
September 2013**

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Intermountain Valley View Medical Center Community Health Needs Assessment and Implementation Strategy September 2013

**Intermountain Valley View Medical Center
1303 North Main Street
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Executive Summary

Intermountain Valley View Medical Center 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.

Valley View Medical Center 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 Valley View Medical Center 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 Valley View Medical Center's Community Stewardship goals.

Valley View Medical Center'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 Valley View Medical Center's implementation strategy are part of Intermountain's system-wide initiatives to address chronic disease, access to care, and access to behavioral health services.

Valley View Medical Center 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 Valley View Medical Center Community

Valley View Medical Center is located in rural Cedar City, Utah, the only hospital in Iron County. The hospital has 48 staffed beds and offers a spectrum of inpatient and outpatient medical services. In 2012, VVMC provided more than \$3.4 million¹ in charity care in over 4,900 cases.

Based on 2012 estimates, approximately 46,750 individuals live in Iron County which encompasses 3,297 square miles with 14 people per square mile, compared to 33.6 for the state of Utah and 87.4 people per square mile in the U.S.²

US Census Quickfacts ³	Iron County	Utah	US
Persons under 18 years	29.4%	31.1%	23.7%
Persons 65 years and over	10.2%	9.5%	13.3%
Median household income	\$42,226	\$57,783	\$52,762
Persons below poverty level	20.7%	11.4%	14.3%
High school graduate or higher, percent of persons age 25+	91.5%	90.6%	85.4%
Bachelor's degree or higher, percent of persons age 25+	27.1%	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 \$2.7 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

Valley View Medical Center 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 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 the 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

¹⁵ Lee IM, Shiroma, EJ, Lobelo F, et al; Lancet Physical Activity Series Working Group. Effect of physical inactivity on

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

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

Valley View Medical Center 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. Terri Draper, Intermountain Southwest Region Public Relations Director, facilitated the meeting on April 19, 2012. A recorder was assigned for the meeting to capture the comments and details.

Representatives included the following:

- Family Healthcare Clinic – Nancy Neff, Executive Director and Eddie Ramirez
- Financial Aid Counselor – Sherri Evans
- Healthy Iron County and Iron County Parent Teach Association – Sherene Carter
- Intermountain Community Benefit – Terry Foust, AuD, Director
- Iron County Care & Share – April Phillips, Case Manager of Emergency Shelter
- Iron County School District – Lindsey Finch and Brenda Killian
- Southwest Behavioral Health – Brody Johnson
- Southwest Utah Public Health – Cambree Johnson, Injury Prevention
- Southern Utah University – Bryn Wood and Cynthia Wright, Professor of Nutrition
- Valley View Medical Center Governing Board – Linda Wilson

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:

- Social media is having an impact; social interactions are less active and people are not outside; we have a new media culture.
- We drive everywhere, not walking; activities of daily living are not getting us out.
- We have programs that show success but they are mostly self-selected and those most likely to need don't join the programs or participate.
- How do we get people who we know have a big problem and get their permission to help?

- Problems stem from home; teaching at school is a good thing but when they take physical education out, the school environment is not conducive to moving, no access to healthy food, then home is where intervention needs to happen and it is not.
- Communities are not designed to be healthy, they are not walkable. We introduce fear of strangers. Fast food is easy; whole environment has gone south in terms of ability to generate healthy living.
- People with low incomes don't have money for activities; there's a cost to do things that are healthy.
- Education is an issue; many people don't know enough about what obesity is doing to their health.
- Adult leadership is a challenge. I have a staff member that is a scout leader frustrated because he got these kids and they can't do anything. He wonders why he should even try to introduce healthy living when they will go home and go back to their routine; they hate walking, they hate everything.
- We live in a "want it now" society where things are offered by the media now. Instant weight loss, drugs, surgery, brides using feeding tubes to get to where they can fit into their wedding dress. Why work at it? We want a quick fix.
- Lack of money keeps the poor out. Look at the HCG diet, intelligent people don't see what is wrong with 500 calories a day.
- We're "over busy," won't or can't fit it in. Tired after work; don't have a priority of putting it first.
- Perception that healthy eating and exercise is hard and it really is not; we need to change our perceptions.
- Healthy food is more expensive and harder to prepare; we need cheaper good foods and easier access.
- Research shows that it is actually cheaper to eat healthy but not as convenient; just a perception that bad food is cheaper.

Strategies discussed:

- We altered desks so we could stand up and work at easier; don't have to sit as much. We also encourage bike riding to work even if one to two times a month and people did it.
- Research shows that if the doctor tells you that you are overweight and need to drop down people are more likely to do it; we're using this in our clinics but the doctors are reluctant to do it many times.
- We educate our patients to eat better. We found if our male patients' wives are in the room they tell us what kind of foods they cook for them. We tell what kinds of foods to fix for all of them and try to educate.
- Community supported agriculture helps people get good food free or low cost.
- We need to look at the design of our community to include community gardens. We provide a garden space for \$20 for a season and water for them.

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:

- We need a bigger clinic here and need the money to operate it. We have an increase of 30 percent a year (Family Healthcare Clinic).
- We lack the manpower and people with expertise to do what we need to have done.
- Many people say they don't know there is a clinic in town.
- We offer a lot to people in way of free services and people don't come take advantage of them at the health department. How do I make them? What is the best way?
- Until people need a service they don't take a look at it.
- Language is sometimes reported as a barrier but we provide bi-lingual services at the clinic.
- Maybe transportation is a barrier.
- We're able to get people where they need to go; people are not asking for transportation help like they used to.
- I worry that people won't seek care because they can't pay, that deductibles are too high.

Strategies discussed:

- At the (hospital) Emergency Department (ED) we refer people to the clinic to help with appropriate use.
- Southern Utah University (SUU) students helping with providing language support has been successful.
- We send all the SUU students to the clinic and that works well.
- Increased hours at the clinic have helped as well as 24 hour call.
- Our trail systems are very successful; part of our community master plan.
- Weight Watchers is successful.
- Family Healthcare Clinic provides access and wellness.
- Many web sites/aps have fitness programs.
- SUU had an internet fitness program.

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:

- We have a larger population of people with mental health disorders than the Utah Department of Health data shows.
- People come in for treatment but it is the other things, housing needs, employment etc. that are the barriers; if you have nothing else in your life the therapy is just fluff.
- Not enough properly trained people but it's hard when there are just not enough of the disorder present to justify a specialist; frustrating for us though when we are not trained.
- Maybe having religious leaders not having appropriate training; they need to know how to help. I hear all the time from Bishops and Priests "I'm in a situation and I'm not properly trained to help these people."

- Lack of services is a barrier. We had a student try to commit suicide. We knew earlier she was at-risk but could not get her to services; her mental health challenge also prevented her from seeing she needed help.
- We can train people to deal with them but we can't make them go to therapy. We just need people to take advantage of the services we have available.

Strategies discussed:

- We have \$20 visit co-pay for university students; also provide PHQ9 (screening for depression). If the PHQ9 is positive then we help them get help.
- A lot of companies have employee assistance programs.
- Crisis Intervention Team (CIT) program with police officers works well; they trained us to deal with people with mental health disabilities. Have seen less negative interaction with police and fewer ED transports since. Schools can request a CIT officer; it's a successful strategy that does not cost money.
- ED project in St. George has been successful; patients are assessed at the hospital but go right into our clinic scheduling system and get an appointment now or in a few days for primary care and mental health.
- We're starting a school based mental health program where we're getting therapists into schools; trying to get one into every school hoping as it goes along reluctant principals will see the light and be more open.

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. Valley View Medical Center 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 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 Valley View Medical Center 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 Valley View Medical Center community was defined by its primary market zip codes, which were used to assemble available data for health indicators:

84714 Beryl	84719 Brian Head	84720 Cedar City
84721 Cedar City	84742 Kanarrville	84753 Modena
84756 Newcastle	84760 Paragona	84761 Parawan
84772 Summit		

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

#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*	VVMC Community	Utah	US
Overweight/obese	10	58.4%	57.8%	64.5%
High blood pressure	4	17.8%	21.4%	28.7%
High cholesterol	5	19%	23.2%	37.5%
Last cholesterol screening 5 years ago or more	20	42.1%	33.1%	23%
Diabetes	5	4.7%	6.2%	8.7%
Asthma	15	8.7%	8.5%	9.1%
Arthritis	9	20.8%	21.6%	26%
Less than 2 servings of fruit daily	15	70.5%	68.8%	NA
Less than 3 servings of vegetables daily	18	79.7%	74.6%	NA
Not meeting recommended physical activity	10	37.3%	42%	49.5%
Current cigarette smoking	15	11.3%	9.4%	17.3%
Binge drinking	16	10.7%	8.6%	15.1%
Chronic drinking	18	5.6%	2.8%	5%
No routine medical checkup in past 12 months	1	35.3%	43%	NA
Adult watch more than 2 hours TV weekdays	20	68.3%	51.7%	NA
Child watch more than 2 hours TV weekdays	18	[76.5%]	66.5%	NA
Adult more than 1 soft drink/week	19	17.3%	13.7%	NA
Child more than 1 soft drink/week	6	2.3%	2.9%	NA
No colonoscopy after age 50	17	33.3%	29.6%	34.8%
Heart disease deaths (per 100K)	12	119.6	104.4	195.2
Stroke deaths (per 100K)	14	33	27.3	54.6
All cancer deaths (per 100K)	9	89.5	96.7	184.9
Prostate cancer deaths (males, per 100K)	15	17.7	14.5	22.8
Breast cancer deaths (females per 100K)	1	8.7	17.5	22.5
Colon cancer deaths (per 100K)	3	5.9	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

#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	UVRMC Community	Utah	US	
No healthcare coverage					
Overall	9	14.6%	15.1%	17.8%	
Hispanic	13	[59%]	44.6%	NA	
Non-Hispanic	10	12.3%	12.3%	NA	
Unable to get care due to cost					
Overall	8	11.6%	13.3%	14.6%	
Hispanic	NA	NA	26.1%	NA	
Non-Hispanic	7	10.5%	11.6%	NA	
No medical home					
Overall	11	21.4%	23.1%	18.2%	
Hispanic	10	[48.6%]	44.2%	NA	
Non-Hispanic	11	20.1%	20.8%	NA	
No routine medical checkup in past 12 months					
Overall	1	35.3%	43%	32.6%	
Hispanic	NA	NA	51%	NA	
Non-Hispanic	2	39.8%	43.6%	NA	
No healthcare coverage for child	8	[4.3%]	5.5%	8.2%	
No prenatal care until 3 rd trimester	12	3.7%	3.7%	NA	
Low birth weight	11	7.1%	7%	8.2%	
Last dentist visit 1 year ago or more	15	33.1	28.7%	30.3%	

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

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	VVMC Community	Utah	US	
Mental health not good 7 or more of past 30 days	18	18.1%	14.7%	NA	
Suicide rate (per 100K)	13	17.6	15.8	12	
Rx opioid deaths (per 100K)	5	10.3	14.5	4.8	
Ever diagnosed with depression	3	16%	22%	9.1%	

Implementation Strategy

Results of the two-part CHNA were used to develop a three-year implementation strategy with Valley View Medical Center 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 Valley View Medical Center 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. Valley View Medical Center'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, Valley View Medical Center identified the following focus and strategy:

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

Strategy: Develop a prescription for exercise program with community partner safety net clinics and track outcomes for physical activity improvements.

Valley View Medical Center'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 hospital staff member accountable for the plan; 2) Valley View Medical Center administrator (also accountable for achieving the goals over the next three years); and 3) the governing board chair.

Valley View Medical Center's Response to Additional Community Healthy Needs

Valley View Medical Center'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

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'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 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 Valley View Medical Center on the above health issues include but are not limited to:

- Cedar City Clinic
- Family Healthcare

³⁰ Ibid

Conclusion

Valley View Medical Center 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.

Valley View Medical Center will update its assessment of community health needs in 2016 and looks forward to continued partnership to improve the health of our community.

The Valley View Medical Center CHNA was completed by Intermountain Community Benefit and Strategic Planning and Research Departments.