

Intermountain Health | Delta Community Hospital

2026 Implementation Strategy

Table of Contents

Executive Summary.....	3
Intermountain Health	4
Hospital Background.....	6
 Community Profile	 6
Service Area	6
Community Demographics.....	7
Area of Deprivation Index.....	7
 CHNA Process	 8
Health Needs Being Addressed.....	9
Health Needs Not Being Addressed.....	9
 Evaluation	 10
 Community Health Implementation Strategies	 11
Improve Behavioral Health	11
Invest in Social Drivers of Health.....	12
Increase Access to Care.....	13
Prevent Childhood Injury and Illness	14
 Appendices.....	 15
Community Resources to Address Significant Health Needs.....	15
Intermountain Glossary	16

Executive Summary

In accordance with the Patient Protection and Affordable Care Act (ACA), Intermountain Health conducted a Community Health Needs Assessment (CHNA) in 2025 to identify data-driven health needs in the hospital service area. By regularly assessing and prioritizing health needs, the hospital can work collaboratively to address health disparities and improve the overall health of the community.

This Implementation Strategy guides efforts to address the health needs identified in the CHNA. It outlines programs and activities that align with

public health entities and community collaborators, defines data-identified needs, and provides an inventory of resources.

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

The CHNA and Implementation Strategy are publicly available on [Intermountain’s website](#).

2025 Significant Health Needs



Health Equity and Community Health

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

Our Community Health Needs Assessment process is driven by data. We look carefully at public health data to understand the prevalence of health issues in our communities and where those issues create the greatest disparities or differences in health outcomes. We talk with residents, community-based organizations, and

local leaders to understand how health disparities connect and how they affect individuals and families across the lifespan. With an understanding of the needs our communities face, we develop a Community Health Implementation Strategy that directs our resources to remove barriers and invest resources where they will have the greatest impact. Using data and community input to identify the greatest needs and targeting our approach to meeting those needs is health equity in action.

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

Intermountain Health

Headquartered in Utah with locations in six primary states and additional operations across the western U.S., Intermountain Health is a nonprofit system of 33 hospitals, 409 clinics, a medical group of nearly 5,000 employed physicians and advanced care providers, a health plan division called Select Health with more than one million members, and other health services.

With more than 68,000 caregivers on a mission to help people live the healthiest lives possible, Intermountain is committed to improving community health and is widely recognized as a leader in transforming healthcare. We strive to be the model health system by taking full clinical and financial accountability for the health of more people, partnering to proactively keep people well, and coordinating and providing the best possible care.

Our Mission

Helping People Live the
Healthiest Lives Possible®

Our Values





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

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

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

Intermountain Health by the Numbers



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



33 Hospitals
Including One Virtual
Hospital



4,700+
Licensed Beds



1.1 Million
Select Health
Members



409
Clinics



68,000+
Caregivers



\$17.15 Billion¹
Total Revenue



4,800+
Employed Physicians
& APPs

Delta Community Hospital

Delta Community Hospital in Delta, Utah, has been providing advanced urgent medical care to residents and visitors in rural central Utah since 1962. It is designated as Level IV Trauma Center and certified stroke center. A recent expansion of services included the addition of an emergency room, lab, and radiology department, and utilization of telehealth technology to offer specialty services. The hospital was recognized as a Becker’s Hospital Review’s 67 Critical Access Hospital to Know and Top 20 in Patient Satisfaction.

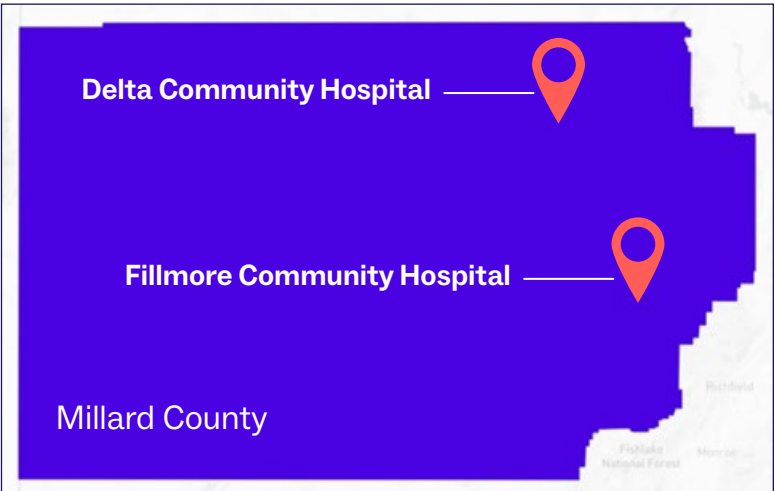


Community Profile

Service Area

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

County	Zip Code
Millard	84624, 84631, 84635, 84636, 84637, 84638, 84640, 84644, 84649, 84654, 84656, 84728



Community Demographics

Demographic Factors	Service Area	Utah	United States
Population	13,179	3,331,187	332,387,540
Persons Under 18 Years	31.4%	28.3%	22.2%
Persons 65 Years and Over	17.1%	11.6%	16.8%
Female Persons	48.4%	49.4%	50.5%
High School Graduate or Higher (age 25 years+)	91.3%	93.3%	89.4%
Persons in Poverty (100% Federal Poverty Level)	8.8%	8.6%	12.4%
Median Household Income (2022 dollars)	\$70,877	\$91,750	\$78,538
Persons without Health Insurance (under age 65)	11.5%	8.7%	8.6%
White, not Hispanic or Latino	82.0%	75.7%	58.2%
Hispanic or Latino	13.3%	15.4%	19.0%
Black or African American	0.2%	1.0%	12.0%
Asian	1.7%	2.3%	5.8%
American Indian and Alaska Native	1.4%	0.7%	0.5%
Native Hawaiian and Other Pacific Islander	0.1%	0.9%	0.2%
Two or More Races	1.2%	3.6%	3.9%
Households Where Spanish is Primary Language	10.3%	12.1%	13.0%

A demographic snapshot of the service area compared to Utah and the United States (Source: U.S. Census Bureau: American Community Survey, 2019-2023)

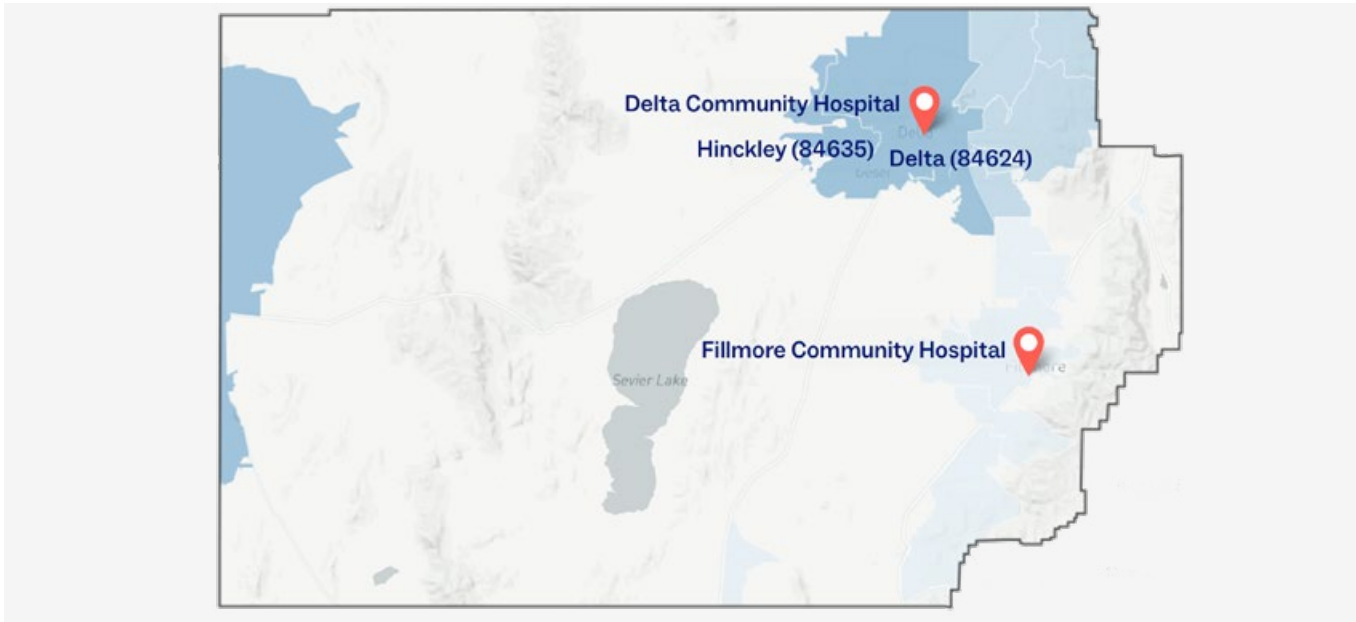
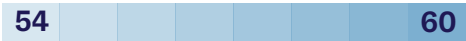
Area of Deprivation Index (ADI)

The Area of Deprivation Index (ADI) is a ranking of neighborhoods by socioeconomic disadvantage. It includes factors of income, education, employment, and housing quality. ADI compares each ZIP code in the state on a scale from 0 to 100 and higher values represent more

health disadvantages. The Implementation Strategy will focus on high ADI communities, when possible, to invest resources and improve community health.

In the service area, the overall ADI is 57 and ranges from 54 to 60. This compares to an ADI of 30 in Utah and 48 in the U.S. The following communities have the highest ADI: Hinckley and Delta.

2023 Millard County | 57 Average ADI



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

CHNA Process

The CHNA prioritization methodology began with analyzing secondary data while gathering primary data through public and stakeholder surveys. These findings were presented at community input

meetings to inform the prioritization process, including input from community members representing diverse backgrounds and experiences.

PRELIMINARY HEALTH NEEDS

Childhood injury Injuries are the leading cause of death and disability in children (ages 0 to 18 years).	Chronic diseases Heart disease, cancer, stroke, and respiratory disease are leading causes of death in the service area.	Financial security The median income is almost \$21,000 lower in the service area than the median income in Utah.	Food security 36% of students in the service area are eligible for free school lunch, compared to 25% in the state.
Healthcare access There are only 265 mental health providers per 100,000 residents compared to 979 per capita in Utah.	Housing stability 12% of residents in the service area are experiencing housing insecurity, compared to 10% in Utah.	Mental health 27% of adults in the service area were diagnosed with depression, which is higher than Utah at 26% and the U.S. at 23%.	Substance use and addiction Smoking among adults and deaths due to lung cancer are higher in the service area than in Utah.

The CHNA concluded with the application of validated analysis and scoring models that produced the final significant health needs. There were instances when additional health needs were

identified, unified under one heading, or prioritized. The CHNA report was reviewed and approved by Intermountain Regional Board in November 2025.

SIGNIFICANT HEALTH NEEDS



Health Needs Being Addressed

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

Childhood injury	Prioritized as a significant health need as part of childhood injury and illness
Financial security	Prioritized as a significant health need as part of social drivers of health
Food security	Prioritized as a significant health need as part of social drivers of health
Healthcare access	Prioritized as a significant health need as part of access to care
Housing stability	Prioritized as a significant health need as part of social drivers of health
Mental health	Prioritized as a significant health need as part of behavioral health
Substance use and addiction	Prioritized as a significant health need as part of behavioral health

Health Needs Not Being Addressed

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

Chronic diseases	Intermountain Health offers comprehensive clinical services for diabetes and endocrinology, including nutritional education, preventive care, and treatment. Additionally, local health departments provide community-based interventions through Diabetes Prevention Programs.
Community safety	Intermountain Health continues to contribute to community safety through community benefit activities and ongoing engagement with local and state leaders committed to improving public health and safety, including injury and safety programing through Primary Children’s Hospital.
Health insurance costs	Intermountain Health works closely with community leaders and partner organizations to connect individuals with available resources, advocate for affordability, and promote health equity allowing individuals access to affordable healthcare regardless of insurance status.

Evaluation

Evaluation is an essential component of the Implementation Strategy process at Intermountain Health. It provides insight into the effectiveness of each strategy, identifies areas for improvement, and ensures there is a measurable and meaningful impact on the significant health needs in communities.

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



Implementation Strategy: Improve Behavioral Health

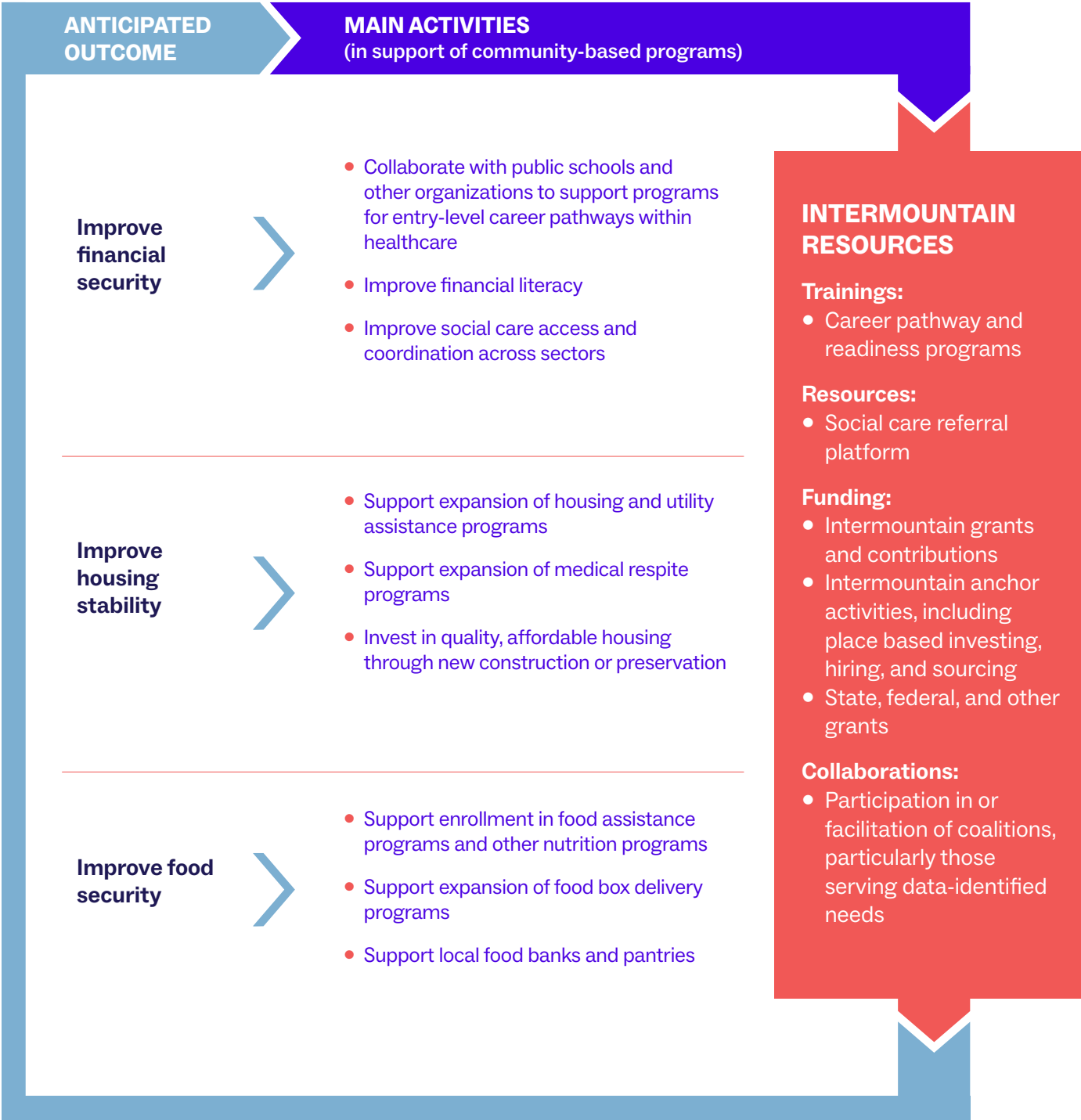
AIM STATEMENT: By the end of 2028, improve behavioral health at the individual, household, and community levels with measurable outcomes to increase awareness, improve help-seeking behaviors, improve access to community-based resources, and strengthen support networks. CHNA data will be used to direct resources and programs to reduce health disparities across the lifespan.



APPENDIX: COMMUNITY RESOURCES TO ADDRESS SIGNIFICANT HEALTH NEEDS

Implementation Strategy: Invest in Social Drivers of Health

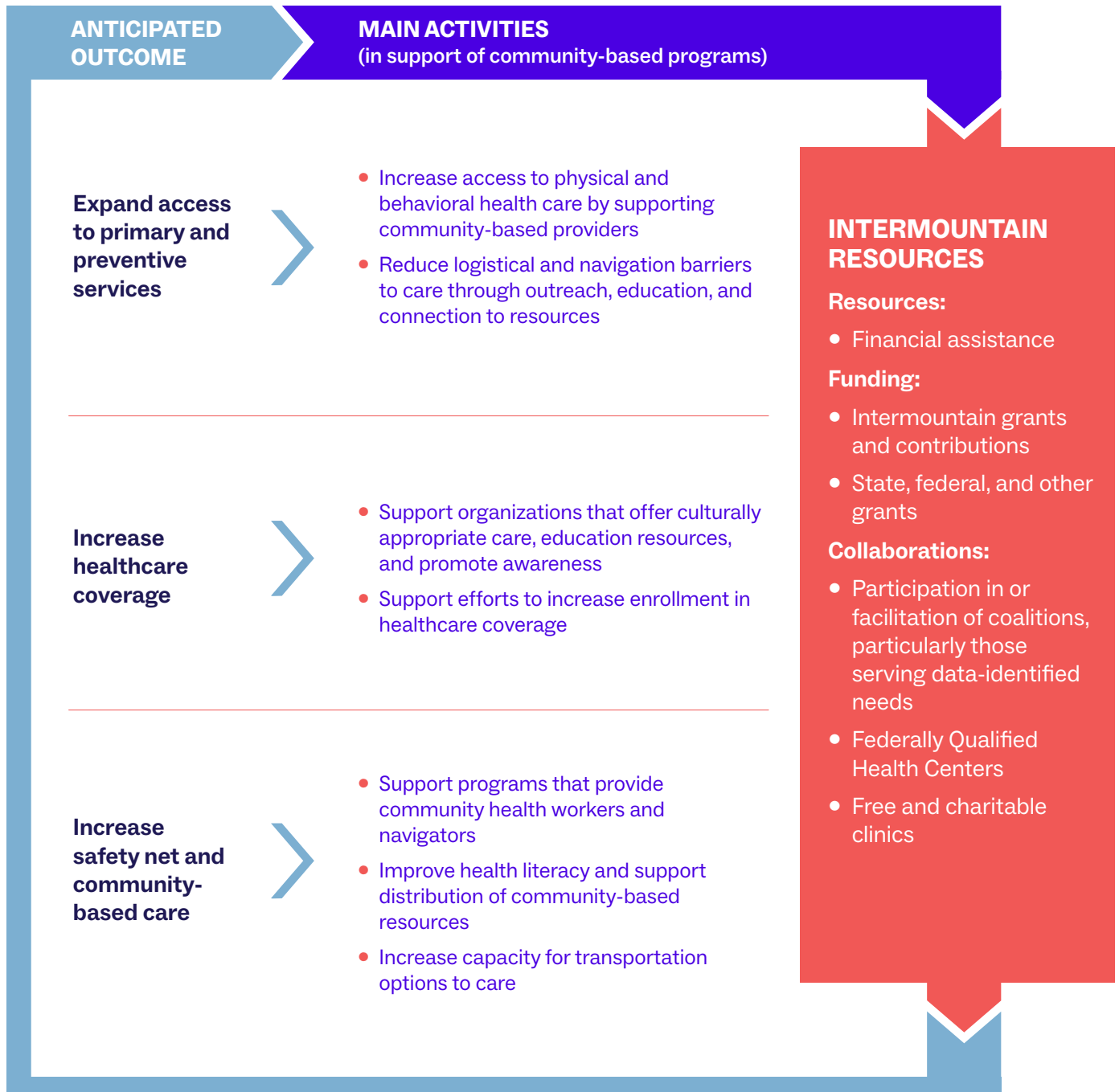
AIM STATEMENT: By the end of 2028, invest in social drivers of health at the individual, household, and community levels with measurable outcomes to increase utilization of community-based programs, strengthen network of resources, and improve self-efficacy and behaviors. CHNA data will be used to direct resources and programs to reduce health disparities across the lifespan.



APPENDIX: COMMUNITY RESOURCES TO ADDRESS SIGNIFICANT HEALTH NEEDS

Implementation Strategy: Increase Access to Care

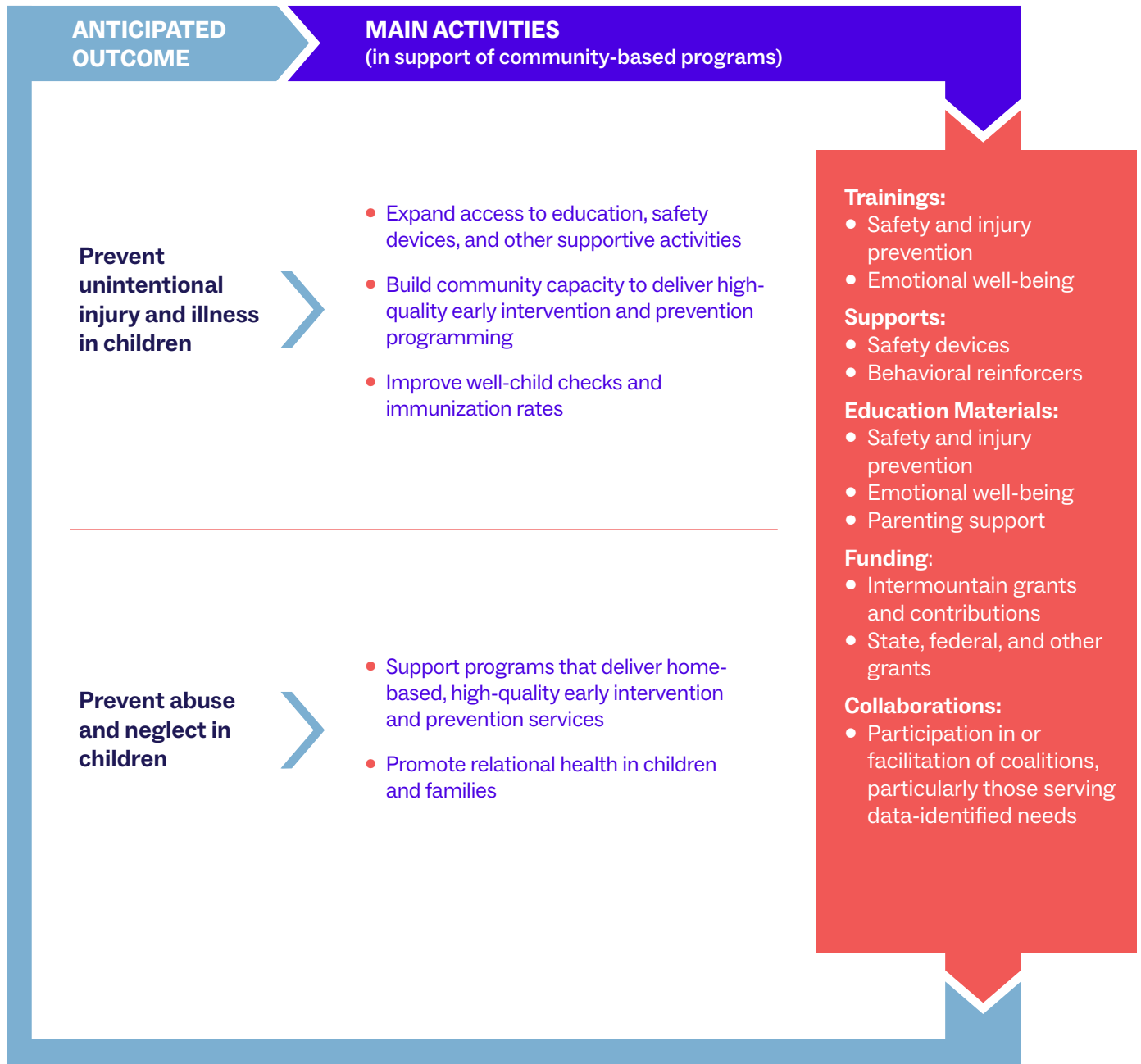
AIM STATEMENT: By the end of 2028, increase access to care at the individual, household, and community levels with measurable outcomes to expand provider capacity, increase outreach, strengthen community collaborations, and improve health knowledge and self-efficacy. CHNA data will be used to direct resources and programs to reduce health disparities across the lifespan.



APPENDIX: COMMUNITY RESOURCES TO ADDRESS SIGNIFICANT HEALTH NEEDS

Implementation Strategy: Prevent Childhood Injury and Illness

AIM STATEMENT: By the end of 2028, prevent childhood injury and illness at the individual, family, and community levels with measurable outcomes to strengthen protective factors, increase awareness, improve safety behaviors, and strengthen community collaborations. CHNA data will be used to direct resources and programs to reduce health disparities.



APPENDIX: COMMUNITY RESOURCES TO ADDRESS SIGNIFICANT HEALTH NEEDS

Appendices

Community Resources

Community Resources to Address Significant Health Needs

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

Intermountain Health

CHNA Glossary

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

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

For additional information about the CHNA or Implementation Strategy, contact:

Anne Cazier

Director of Community Health - Utah/Idaho
Anne.Cazier@imail.org

Lisa Nichols

Vice President of Community Health
Lisa.Nichols@imail.org

