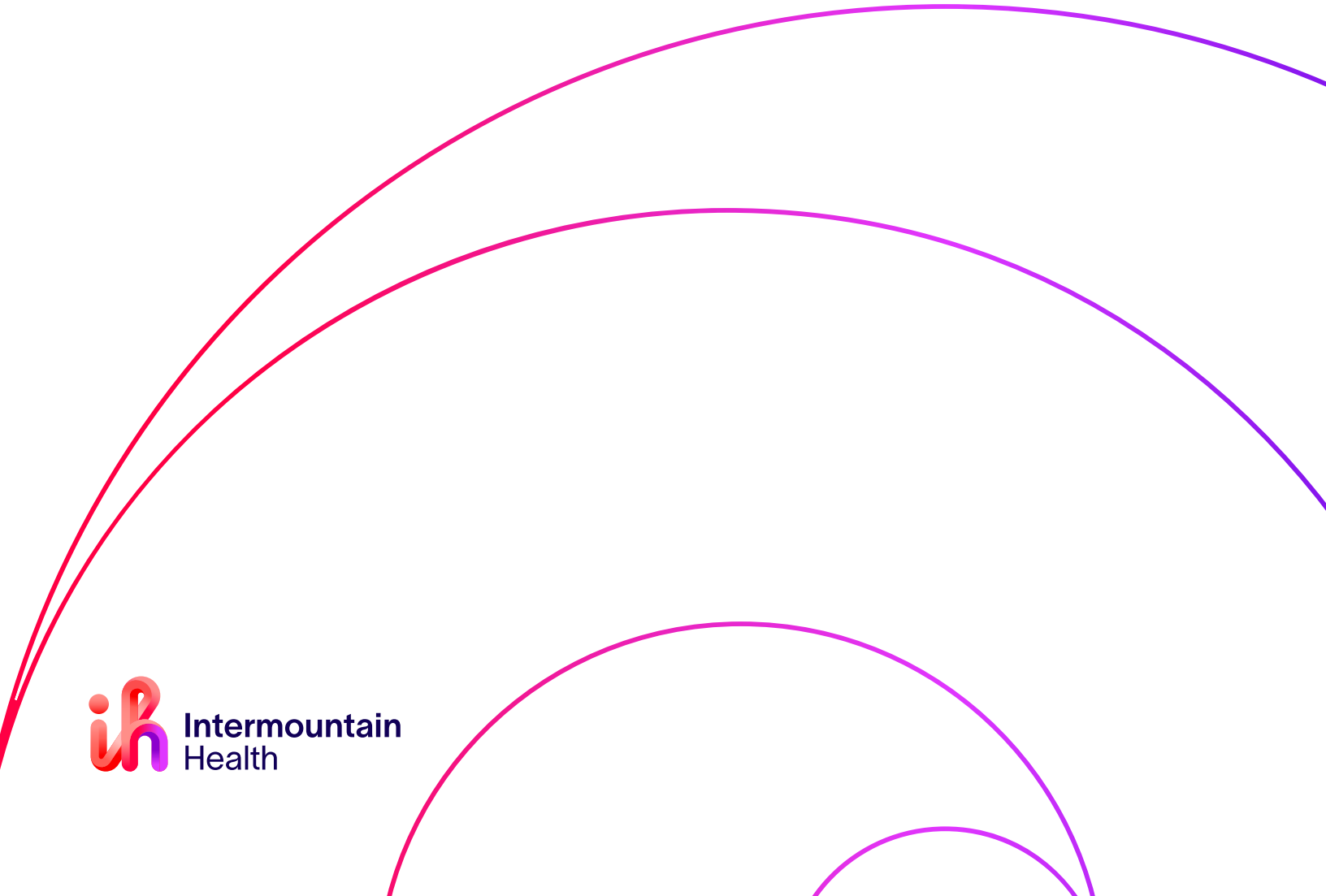
Intermountain Health | Southern Nevada

# 2026 Implementation Strategy



Intermountain Health

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# Executive Summary

The Patient Protection and Affordable Care Act (ACA) requires nonprofit hospitals to conduct a Community Health Needs Assessment (CHNA). While Intermountain Health does not operate a hospital in southern Nevada, we conducted a CHNA to identify significant health needs in the service area. By regularly assessing and prioritizing health needs, Intermountain 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

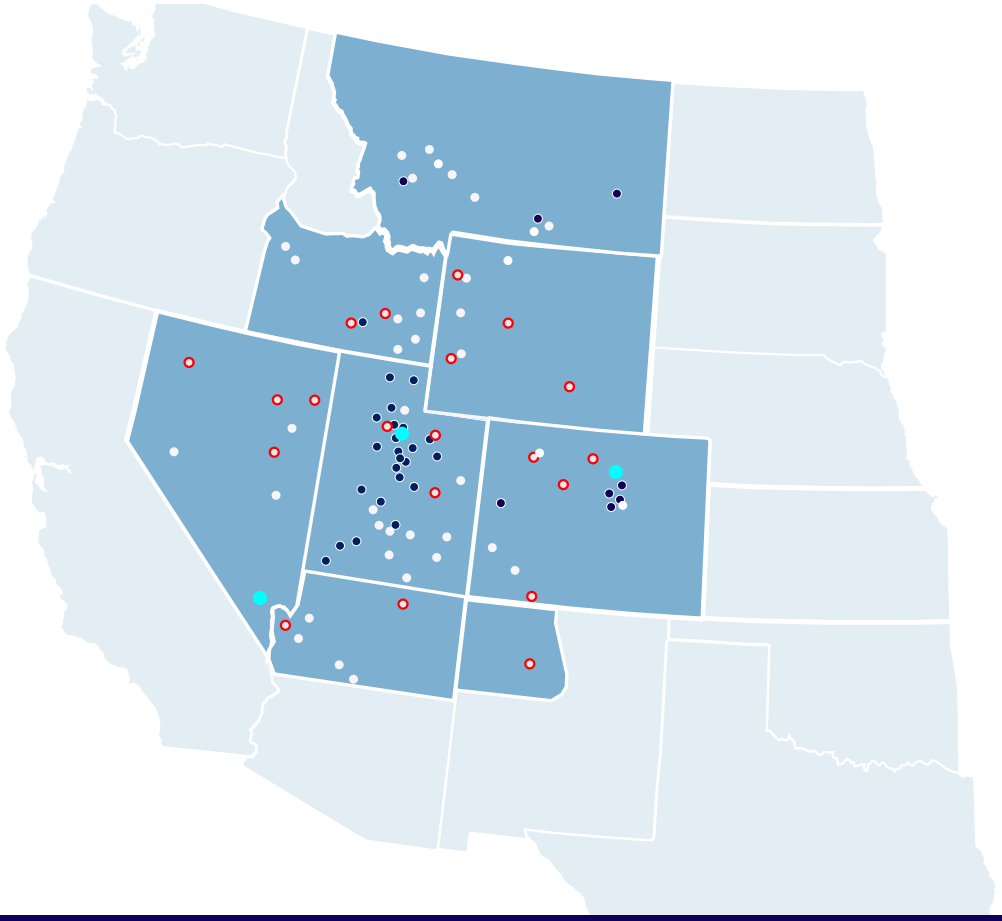
Headquartered in Utah with locations in six primary states and additional operations across the western U.S., Intermountain Health is a nonprofit system of 33 hospitals, 409 clinics, a medical group of nearly 5,000 employed physicians and advanced care providers, a health plan division called Select 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 Billion**[1]
Total Revenue

**4,800+**
Employed Physicians & APPs



[1] Revenue for the year ended December 31, 2024

## Southern Nevada Service Area

Intermountain Health offers more than 65 clinic locations in southern Nevada, 35 of which are award-winning senior primary care clinics recognized for providing exceptional healthcare for adults ages 65 and older. With an extended provider network, Intermountain delivers patient-centered primary, specialty, and urgent care services to approximately 350,000 Nevadans. In October 2024, Intermountain announced the Nevada Children's Hospital, the first comprehensive stand-alone children's hospital in the state. When the hospital opens, it will provide advanced specialty and subspecialty healthcare that increases access for children statewide.

# Community Profile

Intermountain Health provides care for people across southern Nevada. For purposes of the CHNA, the primary service area was Clark County, which is the most populous county in Nevada and where the majority of patients live. The primary service area includes underrepresented, underserved, and low-income community members.


## Service Area

| Clark County ZIP Codes | | | | | |
|---|---|---|---|---|---|
| 89002 | 89031 | 89086 | 89115 | 89130 | 89146 |
| 89004 | 89032 | 89101 | 89117 | 89131 | 89147 |
| 89005 | 89040 | 89102 | 89118 | 89134 | 89148 |
| 89011 | 89044 | 89103 | 89119 | 89135 | 89149 |
| 89012 | 89046 | 89104 | 89120 | 89138 | 89156 |
| 89014 | 89052 | 89106 | 89121 | 89139 | 89161 |
| 89015 | 89056 | 89107 | 89122 | 89141 | 89166 |
| 89018 | 89074 | 89108 | 89123 | 89142 | 89169 |
| 89019 | 89081 | 89109 | 89124 | 89143 | 89178 |
| 89025 | 89084 | 89110 | 89128 | 89144 | 89179 |
| 89030 | 89085 | 89113 | 89129 | 89145 | 89183 |

## Community Demographics

| Demographic Factors | Service Area | Nevada | United States |
|---|---|---|---|
| Population | 2,293,764 | 3,141,000 | 332,387,540 |
| Persons Under 18 Years | 22.5% | 22.1% | 22.2% |
| Persons 65 Years and Over | 15.6% | 16.6% | 16.8% |
| Female Persons | 50.0% | 50.0% | 50.5% |
| High School Graduate or Higher (age 25 years+) | 86.8% | 87.4% | 89.4% |
| Persons in Poverty (100% Federal Poverty Level) | 13.2% | 12.6% | 12.4% |
| Median Household Income (2023 dollars) | $73,845 | $75,561 | $78,538 |
| Persons without Health Insurance (under age 65) | 12.1% | 11.3% | 8.6% |
| White, not Hispanic or Latino | 39.4% | 46.0% | 58.2% |
| Hispanic or Latino | 31.5% | 29.2% | 19.0% |
| Black or African American | 11.7% | 9.1% | 12.0% |
| Asian | 10.3% | 8.5% | 5.8% |
| American Indian and Alaska Native | 0.3% | 0.6% | 0.5% |
| Native Hawaiian and Other Pacific Islander | 0.7% | 0.7% | 0.2% |
| Two or More Races | 5.6% | 5.4% | 3.9% |
| Limited English Proficiency | 13.0% | 11.1% | 8.4% |

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

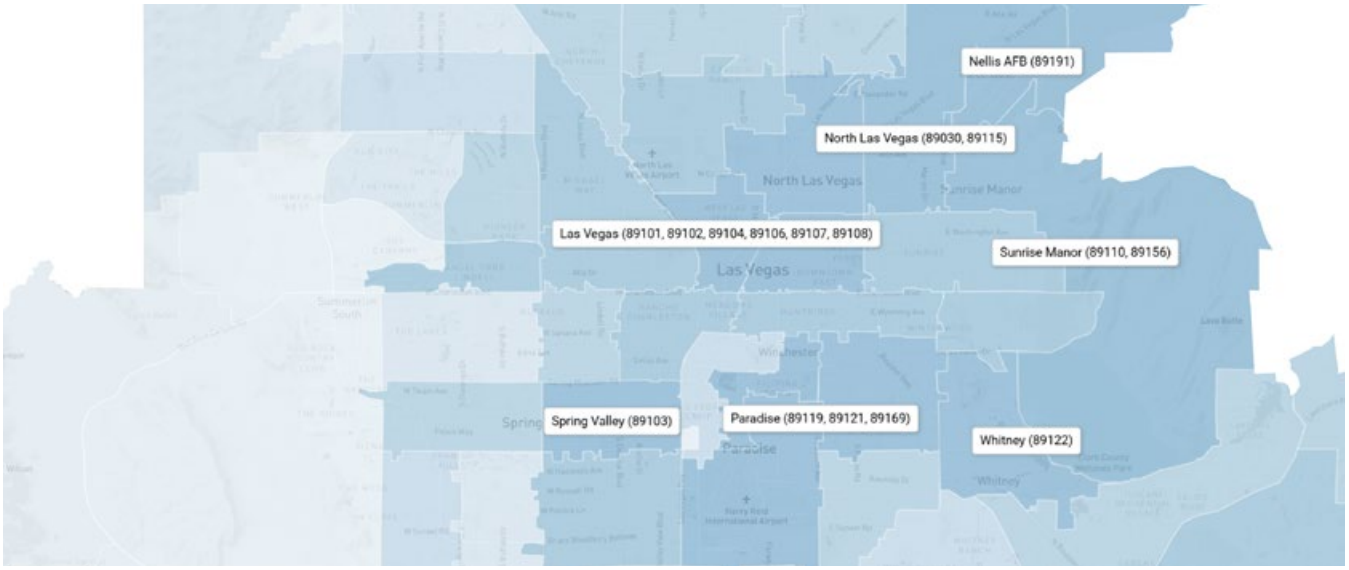
## Area of Deprivation Index (ADI)

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 40 and ranges from 11 to 69 across ZIP codes. This compares to an ADI of 39 in Nevada and 48 in the U.S. The following communities have the highest ADI: Las Vegas, Nellis Air Force Base, North Las Vegas, Paradise, Spring Valley, Sunrise Manor, and Whitney.

Clark County (Urban) - 2023 | 40 Average ADI

11 69




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

# CHNA Process

The collaborative CHNA prioritization methodology began with analyzing secondary data while gathering primary data through surveys and focus groups with community members and organizations. These findings resulted in health needs that were presented to community leaders representing diverse backgrounds and experiences. Intermountain Health prioritized eight preliminary health needs.

## INTERMOUNTAIN PRELIMINARY HEALTH NEEDS

**Access to care**

84% of Clark County adults have health insurance, compared to 89% in the U.S.

**Childhood injury**

Unintentional injury is the leading cause of death for children (ages 0 to 18 years) in Clark County.

**Chronic diseases**

Heart disease, cancer, COVID-19, chronic lower respiratory diseases, and stroke are leading causes of death among residents.

**Environmental factors**

Clark County heat-related deaths tripled since 2020.

Those at highest risk are elderly, pregnant, outdoor workers, and residents with chronic disease.

**Infectious diseases**

There is a higher incidence of tuberculosis, chlamydia, gonorrhea, syphilis, and Human Immunodeficiency Virus (HIV) in Clark County than in Nevada and the U.S.

**Mental health**

The percentage of Clark County adults reporting poor mental health has increased 38% over the past five years and remains higher than the national average.

**Substance Use**

Opioid overdose mortality nearly doubled to 20 deaths per 100,000 residents from 2019 to 2023.

**Social drivers of health**

87% of Clark County adults obtained a high school diploma, which is lower than the national rate.

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:

| | |
|---|---|
| **Access to care** | Prioritized as a significant health need |
| **Childhood injury** | Prioritized as a significant health need as part of childhood injury and illness |
| **Mental health** | Prioritized as a significant health need as part of behavioral health |
| **Social drivers of health** | Prioritized as a significant health need |
| **Substance use** | Prioritized as a significant health need as part of behavioral health |

## Health Needs Not Being Addressed

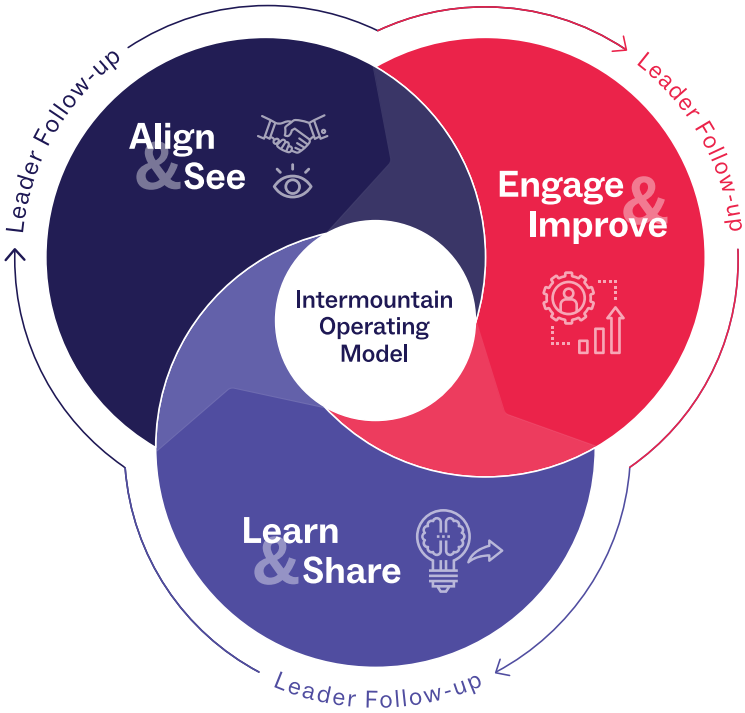
Intermountain Health is not addressing all the preliminary health needs identified during the CHNA in the Implementation Strategy. The following health needs were not prioritized due to resource constraints, ability and expertise, existing efforts by other organizations, or lack of effective solutions; 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** | The Southern Nevada Health District prioritized chronic disease prevention in its Community Health Improvement Plan, and Intermountain supports these efforts through clinical operations and care management programs that provide prevention, diagnosis, and treatment of chronic diseases. |
| **Environmental factors** | Environmental factors like air quality, heat exposure, and pollution are critical to community well-being. Intermountain addresses these conditions by supporting local efforts led by public health and governmental agencies, including advocacy, education, environmental policies and practices, and participation in community initiatives. |
| **Infectious diseases** | Infectious disease prevention and control remain essential to public health. The Southern Nevada Health District leads robust efforts in surveillance, education, and outbreak response. Intermountain supports these activities through clinical care, immunizations, and public health collaboration. |

# 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.




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

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**APPENDIX: INTERMOUNTAIN HEALTH CHNA GLOSSARY**

## 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.

| ANTICIPATED OUTCOME | MAIN ACTIVITIES (in support of community-based programs) |
|---|---|
| **Prevent suicide deaths and attempts** | • Reduce access to lethal means<br>• Increase help-seeking behaviors and resilience<br>• Expand community capacity for suicide prevention and support services |
| **Improve mental well-being and resilience across the lifespan** | • Promote resilience and mental well-being through school-based and family-focused programs<br>• Strengthen community capacity for high-quality behavioral health care and resources<br>• Expand and support mental health services and early intervention |
| **Reduce the impact of substance misuse and prevent overdose deaths** | • Build community capacity for high-quality, person-centered care for individuals and families affected by substance use<br>• Support development and implementation of local harm reduction and prevention strategies<br>• Expand access to prevention, treatment, and recovery supports for individuals at risk of substance misuse or overdose |

### INTERMOUNTAIN RESOURCES

**Trainings:**
- Evidence-based prevention trainings

**Supports:**
- Gun locks, naloxone, and other safety devices

**Education Materials:**
- Child and adult mental well-being and suicide prevention
- Access to lethal means and safe firearm storage
- Substance misuse prevention

**Funding:**
- Intermountain grants and contributions
- State, federal, and other grants

**Collaborations:**
- Participation in or facilitation of coalitions, particularly those serving data-identified needs

**APPENDIX: COMMUNITY RESOURCES TO ADDRESS SIGNIFCANT 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 health literacy and behaviors. CHNA data will be used to direct resources and programs to reduce health disparities across the lifespan.

| ANTICIPATED OUTCOME | MAIN ACTIVITIES (in support of community-based programs) |
|---|---|
| **Improve financial security** | • Support programs that build skills and create pathways to employment, shared ownership, and long-term economic mobility<br>• Support financial education and coaching programs that build financial literacy, improve budgeting skills, and increase economic resilience<br>• Expand utilization of financial assistance programs to reduce unmet needs and support household stability |
| **Increase housing stability and affordability** | • Provide flexible capital and gap funding through place based investments that expand affordable and supportive housing<br>• Support programs that prevent eviction and help individuals and families maintain safe, stable housing<br>• Strengthen collaborations and community capacity to increase the supply of affordable and supportive housing |
| **Improve food security** | • Expand access to nutritious food, including efforts that address logistical barriers<br>• Increase nutrition support through enrollment in government-supported programs, food-as-medicine, and other nutrition programs<br>• Promote nutrition literacy and healthy eating behaviors |

### INTERMOUNTAIN RESOURCES

**Trainings:**
- Career pathway and readiness programs

**Resources:**
- Social care referral platform

**Funding:**
- Intermountain grants and contributions
- Intermountain anchor activities, including place based investing, hiring, and sourcing
- State, federal, and other grants

**Collaborations:**
- Participation in or facilitation of coalitions, particularly those serving data-identified needs

**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 literacy. CHNA data will be used to direct resources and programs to reduce health disparities across the lifespan.

| ANTICIPATED OUTCOME | MAIN ACTIVITIES (in support of community-based programs) |
|---|---|
| **Expand access to primary and preventive services** | • Expand access to and capacity of primary, preventive, and behavioral health services<br>• Deliver awareness and education resources to improve utilization of insurance coverage<br>• Reduce barriers to care through outreach, education, and connection to resources |
| **Increase healthcare coverage** | • Support organizations to provide culturally responsive care<br>• Promote programs that strengthen the healthcare workforce to better reflect and meet the needs of the communities served<br>• Support efforts to increase enrollment in healthcare coverage and connect individuals to affordable care |
| **Increase safety net and community-based care** | • Support programs that provide community health workers and navigators<br>• Improve health literacy and support distribution of community-based resources<br>• Improve social care access and coordination across sectors |

### INTERMOUNTAIN RESOURCES

**Resources:**

- Financial assistance

**Funding:**

- Intermountain grants and contributions
- State, federal, and other grants

**Collaborations:**

- Participation in or facilitation of coalitions, particularly those serving data-identified needs
- Federally Qualified Health Centers
- Free and charitable clinics

**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.

| ANTICIPATED OUTCOME | MAIN ACTIVITIES (in support of community-based programs) |
|---|---|
| **Prevent injury and illness in children** | • Distribute educational materials, safety devices, and supportive resources to support child safety across homes, schools, and community spaces<br>• Advance injury prevention programs focused on safety, injury prevention, and mental well-being<br>• Increase childhood screenings, well-child checks, immunizations, and use of home visitation programs<br>• Strengthen local coalitions' capacity to implement community-wide prevention, harm reduction, and health promotion strategies |
| **Prevent abuse and neglect in children** | • Increase use of risk and protective screenings, well-child checks, immunizations, and home visitation programs<br>• Advance healthy birth and child outcomes by addressing data-identified needs through perinatal support programs and services<br>• Strengthen programs and protective measures that ensure families receive ongoing support and services |

**Trainings:**
- Safety and injury prevention
- Emotional well-being

**Supports:**
- Safety devices
- Behavioral reinforcers

**Education Materials:**
- Safety and injury prevention
- Emotional well-being
- Parenting support

**Funding**:
- Intermountain grants and contributions
- State, federal, and other grants

**Collaborations:**
- Participation in or facilitation of coalitions, particularly those serving data-identified needs

**APPENDIX: COMMUNITY RESOUCES TO ADDRESS SIGNIFICANT HEALTH NEEDS**

# Appendices

## 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. |

# 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