



**Intermountain Dixie Regional Medical Center
Community Health Needs Assessment
and Implementation Strategy
September 2013**

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Intermountain Dixie Regional Medical Center Community Health Needs Assessment and Implementation Strategy September 2013

**Intermountain Dixie Regional Medical Center
1380 East Medical Center Drive
St. George, Utah 84790**

Executive Summary

Intermountain Dixie Regional 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.

Dixie Regional 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 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 Dixie Regional 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 Dixie Regional Medical Center's Community Stewardship goals.

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

Dixie Regional Medical Center (DRMC) 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 Dixie Regional Medical Center Community

Dixie Regional Medical Center is located in urban St. George, Utah, the only hospital in Washington County. The hospital has 245 staffed beds and offers a full spectrum of inpatient and outpatient medical services. In 2012, DRMC provided more than \$23 million¹ in charity care in over 17,000 cases.

Based on 2012 estimates, approximately 144,809 individuals live in Washington County which encompasses 2,426 square miles with 56.9 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	Washington County	Utah	US
Persons under 18 years	29.7%	31.1%	23.7%
Persons 65 years and over	18.3%	9.5%	13.3%
Median household income	\$50,307	\$57,783	\$52,762
Persons below poverty level	11.9%	11.4%	14.3%
High school graduate or higher, percent of persons age 25+	91.1%	90.6%	85.4%
Bachelor's degree or higher, percent of persons age 25+	24.9%	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.⁴

¹ Total gross charges; the total adjusted charity care based on standards established by the Utah State Tax Commission is approximately \$15.9 million thousand.

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

Dixie Regional 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 initiative.

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 Dixie Regional Medical Center'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*

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

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 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.

a combined total of about 102,130 individuals needing but not receiving mental health 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

Dixie Regional 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, Southwest Region Public Relations Director, facilitated the meeting on April 26 2012. A recorder was assigned for the meeting to capture the comments and details.

Representatives included the following:

- Community advocates – Jane Lambert and Gloria Shakespeare
- City of Hurricane – Arthur Brown, and Toni Foran, Planning & Zoning Director
- Dixie Regional Medical Center – Locke Ettinger, Director of LiVe Well Center
- Dixie State College – Phyllis Swift, Nursing Faculty
- Doctors' Volunteer Clinic – Clint Dalley, Community Mental Health Coordinator
- Head Start – Xochitl Cuara, Executive Director
- Intermountain Community Benefit – Cynthia Boshard, Director
- Senior Games – Nancy Colarossi*
- Southwest Utah Public Health Department – Shalyce Oman, Health Educator
- St. George City – Steven Bingham, City Planner

**Also on Governing Board*

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

Issues identified:

- It isn't safe to bike in some areas of the community; infrastructure is an issue.
- People are busy; don't want responsibility of our health, we want programs that meet our personal needs.
- We need to help people see their health issues; start with kids in schools.

- Current medical system has taken accountability for health; people are not accountable for their own health. Healthcare needs to relinquish it back. We can provide tools for people to be successful; the hardest thing is changing lifestyle.
- Lack of accurate nutrition information; people don't understand nutrition and use energy drinks, want a quick fix.
- People have to look hard to find healthy food options.
- Money is an issue; the cost of healthy eating, buying a bike, joining the gym or participating in summer programs requires money. We (Head Start) promote walking with our kids and families.
- Cheap food is easy, convenient. What information do people have who use food stamps to choose healthy food?
- To be successful with youth, we need connections with schools in order to promote activities, schools can promote health.

Strategies discussed:

- Worked with Gold Medal School program, it had a good effect, the program lost funding.
- There was a change in elementary school lunches.
- Dixie State College is a smoke-free campus.
- Terminology is changing from obese to “aerobic, cardiovascular fit” in the literature. Obesity is so passive, the real issue is activity; weight isn't the only indicator.
- Have been saying obesity is a label, we should talk about healthy lifestyles.
- We need to engage the end user, need to go to the low-income population and ask them what will work.
- The I Am Learning/I Am Moving initiative that promotes physical exercise has been successful.
- We encourage sidewalks in city planning; have paved trail in Hurricane so more kids are walking and biking.

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

Issues identified:

- Transportation is a barrier for people getting to healthcare providers.
- Letting people know about options; do people have awareness about services?
- Transportation; busses don't stop at Doctors' Volunteer Clinic. If patients don't have a ride, it puts their treatment behind.
- Other than the senior bus, people have no way to get to safety net clinics.
- Hours of transportation services are limited.
- People need access to sports physicals provided by doctors to kids that don't have insurance.
- Hardly any school nurses in Washington County.
- Dental checks are important.
- At hospital health fairs we gave vouchers that weren't used.
- If schools require physicals can the schools provide volunteers for screenings?

- Hard to balance transportation, time, other stresses.
- Access to healthcare is an issue because of no money, no insurance.
- Language barriers are a reality.
- Transportation is an issue if the hours don't fit the needs of the people. Late at night people choose the Emergency Department, they can't take time off work during the day.

Strategies discussed:

- Started the health clinic at Dixie State College for students and staff in October.
- The Doctors' Volunteer Clinic sees about 12,000 people a year; one third are mental health-related.
- Family Healthcare Clinic is open until 7, two locations; we send families there because of extended hours.
- Family Healthcare and Doctors' Volunteer Clinic are known in the community; they're safe.
- The hospital, Family Healthcare, and Doctor's Volunteer Clinic are good but the community lacks a personal contact for vulnerable, low-income, and uninsured people.
- This doesn't exist in our community, but there are portable, mobile clinics that serve pockets of the population.
- Mobile clinic could be helpful to provide physicals for low-income populations.
- People need access to sports physicals provided by doctors to kids that don't have insurance. School screenings exams in Ogden work with all volunteers.
- Southwest Utah Health Department programs such as immunizations, Women, Infants, and Children (WIC).
- Easy for us all to say what will work, but we need the ideas of the low-income, uninsured people to know what will work for them.
- Need for increased awareness, using the right medium; knowledge is the first step.
- We provide screenings through the senior games; seniors participate there and in their communities. Are schools a good focus for annual exams, can the school nurses conduct screenings?

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:

- Having enough providers and time to treat patients is an issue; students from the college help provide some hours, but we don't have volunteer mental health providers at Doctors' Volunteer Clinic, don't know why. We're booked out four to five weeks, difficult to treat people as they need to be seen in a timely way. We need more dollars or more volunteers.
- There are cultural beliefs "we don't deal with mental health." As long as the need is physical health, that's okay, mental health is not addressed; could be helped if there were more services in town.
- Language barriers at Doctors' Volunteer Clinic because we have few Spanish-speaking providers.
- What about how people deal with anxiety and stress? Those things that exercise can help with?
- We always suggest exercise and a lot of time, people don't need medications.

- Physicians don't suggest exercise as treatment option, they prescribe medication first.
- We can connect people to recreation centers; address challenges of giving information, help people experience the value of exercise. We need to figure out how.
- Encourage exercise from businesses.
- Is there a way to combine young people to work with others to start to "friend" people with mental health issues, someone to show how?
- People have damaged social networks, they're isolated, depressed.
- Not having networks puts people at greater risk, more isolation.
- Church-based groups could extend to provide support to people with mental health issues.
- There's value of an anxiety/depression group, think about exercise support groups. We have doctors that volunteer at the clinic, maybe they could go into the schools to provide exams.
- Should we re-align support groups to have exercise instead of donuts in a meeting room?
- Has the Doctors' Volunteer Clinic thought about going to pockets in the community, maybe using the Dixie State College van?

Strategies discussed:

- Ogden has a deal with schools to screen for health issues; they found health problems with doctors going in to the schools and spending five to 10 minutes with each kid.
- What we do at the College helps with mental health, acute care in collaboration with Family Healthcare and Intermountain.
- Any issue can be helped with an increase in exercise.

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

84722 Central	84725 Enterprise	84733 Gunlock
84737 Hurricane	84738 Ivins	84745 La Verkin
84746 Leeds	84757 New Harmony	84763 Rockville
84765 Springdale	84770 St. George	84771 St. George
84774 Toquerville	84779 Virgin	84780 Washington
84781 Pine Valley	84782 Veyo	84783 Dammeron Valley
84754 Hildale	84790 St. George	84791 St. George

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*	DRMC Community	Utah	US
Overweight/obese	6	55.1%	57.8%	64.5%
High blood pressure	19	27.7%	21.4%	28.7%
High cholesterol	17	27.1%	23.2%	37.5%
Last cholesterol screening 5 years ago or more	3	29%	33.1%	23%
Diabetes	14	6.4%	6.2%	8.7%
Asthma	3	6.1%	8.5%	9.1%
Arthritis	18	26.1%	21.6%	26%
Less than 2 servings of fruit daily	7	67%	68.8%	NA
Less than 3 servings of vegetables daily	7	72.1%	74.6%	NA
Not meeting recommended physical activity	19	49%	42%	49.5%
Current cigarette smoking	7	8%	9.4%	17.3%
Binge drinking	6	5.2%	8.6%	15.1%
Chronic drinking	10	2.2%	2.8%	5%
No routine medical checkup in past 12 months	5	41%	43%	NA
Adult watch more than 2 hours TV weekdays	19	62.6%	51.7%	NA
Child watch more than 2 hours TV weekdays	15	67.6%	66.5%	NA
Adult more than 1 soft drink/week	13	14.5%	13.7%	NA
Child more than 1 soft drink/week	9	2.7%	2.9%	NA
No colonoscopy after age 50	6	26.1%	29.6%	34.8%
Heart disease deaths (per 100K)	15	130.8	104.4	195.2
Stroke deaths (per 100K)	13	31.4	27.3	54.6
All cancer deaths (per 100K)	17	147	96.7	184.9
Prostate cancer deaths (males, per 100K)	18	34.9	14.5	22.8
Breast cancer deaths (females per 100K)	17	24.5	17.5	22.5
Colon cancer deaths (per 100K)	14	10.7	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

#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	DRMC Community	Utah	US	
No healthcare coverage					
Overall	19	23.1%	15.1%	17.8%	
Hispanic	17	76.7%	44.6%	NA	
Non-Hispanic	17	19.2%	12.3%	NA	
Unable to get care due to cost					
Overall	20	16.9%	13.3%	14.6%	
Hispanic	14	43.8%	26.1%	NA	
Non-Hispanic	16	13.4%	11.6%	NA	
No medical home					
Overall	12	21.7%	23.1%	18.2%	
Hispanic	14	65.6%	44.2%	NA	
Non-Hispanic	8	18.7%	20.8%	NA	
No routine medical checkup in past 12 months					
Overall	5	41%	43%	32.6%	
Hispanic	11	60.6%	51%	NA	
Non-Hispanic	1	39.6%	43.6%	NA	
No healthcare coverage for child	7	4.1%	5.5%	8.2%	
No prenatal care until 3 rd trimester	8	3.6%	3.7%	NA	
Low birth weight	5	6.3%	7%	8.2%	
Last dentist visit 1 year ago or more	16	33.6%	28.7%	30.3%	

Table 3 Access to behavioral health services

#3 Health Priority: Improve access to appropriate behavioral health services for low-income populations.					
Health indicator (Source: Utah Department of Health Behavior Risk Factor Surveillance System)	Community Rank	DRMC Community	Utah	US	
Mental health not good 7 or more of past 30 days	6	12.9%	14.7%	NA	
Suicide rate (per 100K)	10	16.3	15.8	12	
Rx opioid deaths (per 100K)	9	12.6	14.5	4.8	
Ever diagnosed with depression	6	18%	22%	9.1%	

Implementation Strategy

Results of the two-part CHNA were used to develop a three-year implementation strategy with Dixie Regional 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 Dixie Regional 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. Dixie Regional 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, Dixie Regional Medical Center 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: Develop a prescription for exercise program with community partnerships and track outcomes for physical activity improvements.

Dixie Regional 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) Dixie Regional Medical Center administrator (also accountable for achieving the goals over the next three years); and 3) the governing board chair.

Dixie Regional Medical Center's Response to Additional Community Healthy Needs

Dixie Regional 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 Dixie Regional Medical Center on the above health issues include but are not limited to:

- Doctor's Volunteer Clinic
- Family Healthcare Clinic

³⁰ Ibid

Conclusion

Dixie Regional 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.

Dixie Regional 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 Dixie Regional Medical Center CHNA was completed by Intermountain Community Benefit and Planning/Research Departments.