



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

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

**Intermountain Cassia Regional Medical Center
1501 Hiland Avenue
Burley, Idaho 83318**

Executive Summary

Intermountain Cassia 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.

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Cassia 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 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 the 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 Cassia 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 the hospital's Community Stewardship goals.

Cassia 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 Cassia Regional 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.

Cassia Regional Medical Center 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 Cassia Regional Medical Center Community

Cassia Regional Medical Center is one of 21 Intermountain owned and operated hospitals in Utah and southeast Idaho. Located in rural Burley, Idaho, the hospital is on the border of Cassia and Minidoka counties. The hospital has 25 staffed beds and offers a spectrum of inpatient and outpatient medical services. In 2012, Cassia Regional Medical Center provided more than \$2 million¹ in charity care in over 5,000 cases.

Based on 2012 estimates, approximately 43,286 individuals live in Cassia and Minidoka counties. Cassia County encompasses 2,565, square miles with 8.9 people per square mile; Minidoka County encompasses 757 square miles with 26.5 people per square mile, compared to 19 people per square mile for the state of Idaho, and 87.4 people per square mile in the United States.²

US Census Quickfact ³	Cassia County	Minidoka County	Idaho	Utah	US
Persons under 18 years	32.1%	28.8%	27%	31.1%	23.7%
Persons 65 years and over	13.3%	14.9%	13.3%	9.2%	13.3%
Median household income	\$39,551	\$43,194	\$46,890	\$57,783	\$52,762
Persons below poverty level	18.0%	15.5%	14.3%	11.4%	14.3%
High school graduate or higher, percent of persons age 25+	77.3%	75.8%	88.5%	90.6%	85.4%
Bachelor's degree or higher, percent of persons age 25+	15.8%	10.0%	24.6%	29.6%	28.2%

(Compared to Utah because Intermountain's other 20 hospitals are in Utah.)

In 2012, approximately 14 percent of the Idaho population was enrolled in Medicaid; children make up 70 percent of the enrollment; 13 percent was enrolled in Medicare; 46 percent was enrolled in employer-sponsored health insurance; and eight percent were enrolled in individual plans. Approximately 18 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 (which 20 of Intermountain's 21 hospitals report) is approximately \$1.2 million.

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

³ Ibid

⁴ www.healthandwelfare.idaho.gov

Community Health Needs Assessment Background

Cassia 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 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 the 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; health indicators were selected for the health priority categories. These priorities were also used to elicit perceptions of invited participants in Cassia 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 Idaho⁸ are:

American Indian/Alaska Native	Non-Hispanic White
1. Heart disease	1. Cancer
2. Cancer	2. Heart disease
3. Unintentional injury	3. Chronic lower respiratory disease
4. Liver disease	4. Stroke
5. Diabetes	5. Unintentional injury

Several of the causes are associated with weight and unhealthy behaviors.⁹ 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.¹⁰

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.¹¹ In Idaho, 62 percent of adults are considered overweight and over 26 percent were obese.¹² 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.¹³ Strong evidence shows that physical inactivity increases the risk of many adverse

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 Idaho Death Certificate File (Idaho Dept of Health and Welfare), 2006 - 2010

⁹ *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.

¹⁰ *Chronic Disease at a Glance*, 2009.

¹¹ Ibid

¹² Idaho State Nutrition, Physical Activity, and Obesity Profile, September 2012

¹³ Blair SN. Physical inactivity: the biggest public health problem of the 21st century. *Br J Sports Med.* 2009; 43(1): 1-2.

health conditions, and is a bigger independent contributor to cardiovascular and all-cause mortality than other risk factors such as obesity, smoking, and diabetes.^{14 15 16}

About 52 percent of Idaho 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 18 percent of Idaho 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 Idaho had the sixth highest suicide rate in 2010.²⁴ Suicide is the second leading

¹⁴ Ibid

¹⁵ 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

¹⁶ 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

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 Kaiser Family Foundation State Health Facts, 2013

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.

²⁴ CDC Suicide Rates, 2010

cause of death for Idahoans ages 15 to 34 years of age and the second leading cause of death for Idaho males ages 10 to 14.²⁵

²⁵ Suicide Prevention Action Network of Idaho, October, 2012.

2013 Community Health Needs Assessment Process

Cassia 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 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. Cynthia Boshard, Intermountain Community Benefit Director, facilitated the meeting on May 23, 2012. A recorder was assigned for the meeting to capture the comments and details.

Representatives included the following:

- Cassia Regional Medical Center – Rod Barton, Administrator
- Cassia Regional Medical Center Governing Board – Jeff Poulsen, Certified Public Accountant
- Cassia School District – Delia Valdez, elementary school principal*
- College of Southern Idaho Head Start – Laura Loya, Director Cassia Center, and Dena Villaneueva, Educator
- Family Health Services Clinic (Federally Qualified Health Center) – Lynn Hudgens, Executive Director
- Intermountain Community Benefit – Terry Foust, AuD, Director
- Private practice OB/GYN – Terry Jeppson, MD*
- Private practice attorney – Kelly Anthon*
- Small business owner – Clay Handy,* Handy Trucking
- South Central Public Health District – Karyn Goodale, Program Manager

**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:

- Biggest barrier is the difficulty getting people to change their behavior; we're seeing more people with obesity. We're trying to identify these people by checking BMI on all patients then we try to get education to them. If chronic disease is involved we get them in a collaborative personalized management plan.

- People don't understand the health and disease; can't understand instructions, medication issues, how to use the healthcare system, where to go for resources and follow-up.
- The cost of programs to support patients is hard; cities can't afford programs to help people with risk factors, wellness programs are great but they come at a cost and it is a tough time for local government.
- We see families that don't want our services (we do BMI on all our kids; do free consultation with dieticians at Women, Infants, and Children (WIC staff) because they compare to other children who seem "fatter" and don't think their children are obese or over weight.
- Literacy; we assume families can read but found many don't comprehend and we have to explain.
- We also see young parents watching TV, on the computer and not out playing with their kids; use it as a baby sitter for their kids.
- We have enough resources in Spanish and other languages and we work with the refugee center; we don't think language itself is an issue.
- In medical settings language is a barrier – or at least a cultural issue; BMI and obesity are not perceived as a big issue by some groups as it is by others.
- Immigrants may have a cultural bias.
- Access is barrier.
- In talking about language barriers, we are seeing generational challenges; in the same family we can influence the younger generation but it's harder to reach the older generation. The younger ones respect and follow the older generation.

Strategies discussed:

- Public health district focused on policy systems and environmental changes; for example, no smoking in public places, bike lanes for kids to ride to school instead of one-on-one programs.
- Schools are changing lunch menus and vending programs.

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:

- Access; Family Health Services (Community Health Center) can't see them all. Even educating on whom to follow up with is hard. We (hospital ED) are seeing the same people with chronic disease over and over, but if they'd been seen by primary care provider or seen earlier they would not have had to come in.
- The biggest challenge is capacity; we see 46 percent uninsured and 81 uninsured of patients are low income. We need funding to build capacity. (Family Health Services Clinic)
- We don't advertise; we enroll with increased demand but can't meet the need. If we advertise our services then we create demand we can't meet. Our challenge is capacity.
- We don't get federal funding in private practice so if people are referred we see them; hospital charity care will cover hospital costs but not our costs.
- Lack of affordable specialty care; only so much you can do and also keep your door open.

Strategies discussed:

- We help facilitate enrollment for Medicaid and CHIP (Family Health Services).

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 provide behavioral health as a community health center (Family Health Services); again the challenge is capacity; there aren't enough providers in the community.
- Not only do we not have enough providers but no resources at the state level. Example: a patient comes from California where they get good services by the state; Idaho does not have those services and we have to tell them to go back to California.
- We have problems with the process. A patient comes in with behavioral/mental health issue. We have to call the police, they come and see them. The officer does an evaluation and then contacts the judge. They get a faxed order – they are the ones that determine if they are potential harm to self after two to three hours of training – not our medical staff. Patients have to wait six to seven hours for this process sometimes.
- We have no suicide hotline in the county.
- Our staff (hospital) is not well versed in handling mental health patients; we're an acute care staff – we don't have training and don't know how to help.
- We used to have a local program funded by the county that had one provider who was the examiner and worked with the population we are talking about but had to drop it as it could not be sustained.
- There was a mental health program that was helping people stay on their medications; it was actually pretty effective.

Strategies discussed:

- We see young moms with postpartum depression who fall off medications too soon; we try to help them in conjunction with Family Health Services. St. Luke's has a foundation that has given us funding before.

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. Cassia 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 Idaho Health District Five and 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 Cassia 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 Idaho Department of Health District Five and 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 Cassia Regional Medical Center community was defined by the Cassia/Minidoka geographic area to assemble available data for health indicators.

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 US data are included as crude rates, as well as for informational purposes only, not for precise comparisons with particular hospital communities.

Data sources: Idaho Health District Five and 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: Idaho Health District 5 and Utah Department of Health Behavior Risk Factor Surveillance System)	Community Rank*	Cassia Community	Utah	US
Overweight/obese	20	67.3%	57.8%	64.5%
High blood pressure	18	26.1%	21.4%	28.7%
High cholesterol	20	41.5%	23.2%	37.5%
Last cholesterol screening 5 years ago or more	11	35.1%	33.1%	23%
Diabetes	21	11.4%	6.2%	8.7%
Asthma	12	8.4%	8.5%	9.1%
Arthritis	17	25.2%	21.6%	26%
Less than 2 servings of fruit daily	1	28.5%	68.8%	NA
Less than 3 servings of vegetables daily	1	10.9%	74.6%	NA
Not meeting recommended physical activity	2	27.2%	42%	49.5%
Current cigarette smoking	19	13.4%	9.4%	17.3%
Binge drinking	8	7.3%	8.6%	15.1%
Chronic drinking	6	1.8%	2.8%	5%
No routine medical checkup in past 12 months	18	49.5%	43%	NA
Adult watch more than 2 hours TV weekdays	NA	NA	51.7%	NA
Child watch more than 2 hours TV weekdays	NA	NA	66.5%	NA
Adult more than 1 soft drink/week	NA	NA	13.7%	NA
Child more than 1 soft drink/week	NA	NA	2.9%	NA
No colonoscopy after age 50	20	51.1%	29.6%	34.8%
Heart disease deaths (per 100K)	20	202.5	104.4	195.2
Stroke deaths (per 100K)	17	47.6	27.3	54.6
All cancer deaths (per 100K)	NA	NA	96.7	184.9
Prostate cancer deaths (males, per 100K)	19	36.8	14.5	22.8
Breast cancer deaths (females per 100K)	16	23.2	17.5	22.5
Colon cancer deaths (per 100K)	7	8.1	9.1	16.4

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

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: Idaho Health District 5 and Utah Department of Health Behavior Risk Factor Surveillance System)	Community Rank	Cassia Community	Utah	US	
No healthcare coverage					
Overall	17	20.2%	15.1%	17.8%	
Hispanic	NA	NA	44.6%	NA	
Non-Hispanic	NA	NA	12.3%	NA	
Unable to get care due to cost					
Overall	11	12.8%	13.3%	14.6%	
Hispanic	NA	NA	26.1%	NA	
Non-Hispanic	NA	NA	11.6%	NA	
No medical home					
Overall	3	15.2%	23.1%	18.2%	
Hispanic	NA	NA	44.2%	NA	
Non-Hispanic	NA	NA	20.8%	NA	
No routine medical checkup in past 12 months					
Overall	18	49.5%	43%	32.6%	
Hispanic	NA	NA	51%	NA	
Non-Hispanic	NA	NA	43.6%	NA	
No healthcare coverage for child	NA	NA	5.5%	8.2%	
No prenatal care until 3 rd trimester	18	5.7%	3.7%	NA	
Low birth weight	16	7.7%	7%	8.2%	
Last dentist visit 1 year ago or more	20	38.7%	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: Idaho Health District 5 and Utah Department of Health Behavior Risk Factor Surveillance System)	Community Rank	Cassia Community	Utah	US	
Mental health not good 7 or more of past 30 days	11	14.4%	14.7%	NA	
Suicide rate (per 100K)	8	14.5	15.8	12	
Rx opioid deaths (per 100K)	NA	NA	14.5	4.8	
Ever diagnosed with depression	7	19%	22%	9.1%	

Implementation Strategy

Results of the two-part CHNA were used to develop a three-year implementation strategy with Cassia 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 Cassia 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. Cassia 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, Cassia Regional 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: Implement Intermountain's diabetes education/lifestyle coaching program to help improve the health of people identified as at-risk for diabetes referred by Family Health Services Clinic; provide additional community education and diabetes education events to help promote awareness of diabetes in the Cassia community.

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

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

Cassia 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;
- Cassia Regional Medical Center will be leasing property on its campus to Family Health Services for their new Burley, Idaho clinic site at a highly discounted rate;
- 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 \$252.4²⁶ million of charity care to people who are either uninsured or under-insured in more than 239,000 cases in 2012.²⁷

²⁶ Total gross charges; the total adjusted charity care based on standards established by the Utah State Tax Commission is approximately \$158.4 million.

²⁷ 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 2012²⁸;
- 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.

Community partners continue to work with Cassia Regional Medical Center on the above health issues include but are not limited to:

- Cassia School District
- Family Health Services Clinic (six clinic locations)
- Idaho South Central Health District

²⁸ Ibid

Conclusion

Cassia 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.

Cassia 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 Cassia Regional Medical Center CHNA was completed by Intermountain Community Benefit and Strategic Planning and Research Departments.