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EXECUTIVE SUMMARY

Intermountain Healthcare’s mission, helping people live the healthiest lives possible®, is best realized with a comprehensive understanding of the communities it serves. Since 2009, Intermountain Healthcare has engaged in a system-wide process for each of its hospitals to identify local area health needs through a community health needs assessments (CHNA). This local, community approach enhances the understanding of health of annually reviewed national benchmarking metrics. This community intelligence is comprised of:

- Soliciting community input regarding local health needs and health disparities
- Collecting quantitative data on health indicators
- Prioritizing data to identify significant needs
- Making the CHNA results publicly available
- Developing implementation strategies to address the significant priorities
- Making the implementation plan publicly available
- Report progress on the IRS Form 990 Schedule H

As a result of this extensive needs assessment and prioritization process, described in the following pages, Intermountain Healthcare and each of its hospitals identified the significant health needs as:

**Improve Mental Well-Being, Prevent Avoidable Disease & Injury, and Improve Air Quality**

This report focuses on the health needs in the services areas for Intermountain Healthcare with specific findings related to each hospital community. Intermountain’s 23 physical hospitals are located in Utah and southeastern Idaho. Child and adolescent health needs are included in this report and highlighted in the Intermountain Primary Children’s Hospital CHNA summary. Primary Children’s is Intermountain’s pediatric specialty and referral hospital located in Utah that serves more than 1 million children living in a 400,000 square-mile service area.

The 2019 CHNA report informs Intermountain leadership, public health partners, and community stakeholders of the significant health needs in our communities, allowing hospitals and their local partners to develop strategies that leverage Intermountain and community resources to address those needs throughout the Intermountain system.

The Patient Protection and Affordable Care Act (ACA) requires each not-for-profit hospital to conduct a CHNA every three years and to develop an implementation plan to address, measure, and report impact of significant health priorities. This report fulfills a key component of that requirement by documenting the process to collect reliable information through a community health needs assessment that allows the organization to develop meaningful implementation strategies. This report has been reviewed and approved by the Intermountain Boards of Trustees, who has final responsibility for Intermountain’s actions and is thus the authorized body for each of its hospitals.

DEFINING THE COMMUNITY

Intermountain Healthcare

Intermountain Healthcare is a Utah-based not-for-profit system of 23 hospitals (24 hospitals including a “virtual” hospital, which is not a licensed hospital), a medical group of 2,400 physicians and advance practice providers, 160 clinics and 38,000 employees, a health plans group under the name SelectHealth, and other medical services. As a not-for-profit health system, Intermountain Healthcare is committed to making healthcare more affordable and providing quality care regardless of a patient’s ability to pay. Intermountain strives to create an environment that is inclusive, non-discriminating, and provides meaningful and equal access to all programs, benefits, and activities.

![Service Area Map](image)

Intermountain Healthcare defines its community by geography and includes underserved, low-income, and minority populations. Using zip codes specific to each hospital community, Intermountain can understand the health needs of communities each hospital serves by neighborhood, county, and local health district in addition to a state as a whole. Each zip code and therefore specific hospital community aligned with public health geographic boundaries to encourage collaboration and more reliable data.

Hospitals in the Intermountain Healthcare service area

- Brigham City Community Hospital
- Cache Valley Hospital
- Davis Hospital
- Garfield Memorial Hospital
- Intermountain Alta View Hospital
- Intermountain American Fork Hospital
- Intermountain Bear River Valley Hospital
- Intermountain Cassia Regional Hospital
- Intermountain Cedar City Hospital
- Intermountain Delta Community Hospital
- Intermountain Dixie Regional Medical Center
- Intermountain Fillmore Community Hospital
- Intermountain Heber Valley Hospital
- Intermountain Layton Hospital
- Intermountain LDS Hospital
- Intermountain Logan Regional Hospital
- Intermountain McKay-Dee Hospital
- Intermountain Medical Center
- Intermountain Orem Community Hospital
- Intermountain Orthopedic Specialty Hospital (TOSH)
- Intermountain Park City Hospital
- Intermountain Primary Children’s Hospital
- Intermountain Revertor Hospital
- Intermountain Sampeta Valley Hospital
- Intermountain Sevier Valley Hospital
- Intermountain Utah Valley Regional Hospital
- Jordan Valley Medical Center
- Lakeview Hospital
- Lone Peak Hospital
- Minidoka Memorial Hospital (Rupert, Idaho)
- Mountain Point Medical Center
- Mountain View Hospital
- Ogden Regional Hospital
- Pioneer Valley Hospital
- Salt Lake Regional Medical Center
- Shriners Hospital for Children
- St. Mark’s Hospital
- Timpanogos Regional Hospital
- University of Utah Hospital
- Veterans Administration Salt Lake City Healthcare System

1 Intermountain owns and operates 22 hospitals in Utah and southeastern Idaho and manages Garfield Memorial Hospital, owned by Garfield County, in Panguitch, Utah. Intermountain included Garfield Memorial Hospital in its system-wide CHNA. For purposes of this report, reference will be made to 23 hospitals to include this hospital.
DEFINING THE COMMUNITY

The Patient Protection and Affordable Care Act (ACA) requires all not-for-profit hospitals to complete a community health needs assessment (CHNA) every three years.

Since 2009, Intermountain Healthcare has engaged in a system-wide process for each of its hospitals to identify local area health needs and better understand how to help people live the healthiest lives possible. This community intelligence is comprised of:

- Soliciting community input regarding local health needs
- Collecting quantitative data on health indicators
- Prioritizing data to identify significant needs
- Making the CHNA results publicly available
- Developing an implementation strategy to address the significant priority
- Making the implementation plan publicly available
- Report progress on the IRS Form 990 Schedule H

In the prior CHNA (published in 2016), this comprehensive process aimed to identify significant community health needs, especially for underserved, low-income, and minority populations in Utah and southeastern Idaho communities. From data review and consultation with public health, not-for-profit and government partners, Intermountain identified these health priorities:

- Prevention of prediabetes
- Prevention of high blood pressure
- Prevention of depression
- Prevention of prescription opioid misuse
- Prevention of suicide among youth

Intermountain addressed these priorities to improve healthcare for low-income populations, reduce the cost of healthcare for Intermountain and the community, and focused on the healthcare needs of each community where its hospitals are located. The health priorities aligned with Healthy People 2020 goals (a national program to attain high-quality, longer lives free of preventable disease, disability, injury, and premature death) and Intermountain clinical goals. The 2016 CHNA guided Intermountain’s community health improvement efforts and the community health goals of its hospitals, clinics, and programs.

Encouraged by the new regulations set forth by the ACA and public health accreditation standards, the Utah Department of Health, local health districts, hospitals (including but not limited to Intermountain hospitals), and other stakeholders across the state of Utah created a collaboration in 2018 aimed at successfully designing and implementing a needs assessment that meets each organization's objectives. The purpose of this collaboration is to reduce redundancy, better engage community stakeholders, and bring alignment to the needs assessment and implementation planning processes that will ultimately improve the health of our communities.
Intermountain’s mission of helping people live the healthiest lives possible is best realized with a comprehensive understanding of the health needs of the community served by its hospitals, clinics, and health plans. Intermountain is committed to routinely assessing the community’s health needs through a comprehensive assessment process that both engages members of the community and analyzes the most current health status information. Intermountain uses the assessment to inform its system-wide and local strategies to improve community health.

In 2017, Intermountain’s Executive Leadership Team adopted a Community Health Index aimed to help leaders understand health outcomes more broadly. Selection of this metric was based on the following criteria:
- National benchmark capabilities, but also reported at a state level
- Metrics align with CHNA
- Utilized by community partners
- Longitudinal data available for trend analysis

After careful consideration of several different metrics, America’s Health Rankings® (AHR) from the United Health Foundation was selected. Their yearly publication, the Annual Report, is the longest running annual assessment of the nation’s health on a state-by-state basis. This report aligns with the World Health Organization’s definition of health and analyzes a comprehensive set of behaviors, public health and healthcare policies, community and environmental conditions, and clinical care data to provide a holistic view of the health of the people in the nation.

World Health Organization definition of health: “Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.”

While this metric allows Intermountain leaders to quickly understand health in the communities served by the organization, it has some limitation in the scope of indicators it includes and its lack of community input. While Intermountain considers AHR to be the foundation of health indicators for Intermountain, the 2019 CHNA process, the CHNA allows Intermountain to better understand local needs and disparities in addition to including important indicators that are relevant to the communities served by Intermountain, such as suicide.

The 2019 CHNA process was designed by Intermountain and performed in collaboration with the Utah CHNA Collaboration. Representatives from Intermountain Healthcare currently co-chair this collaboration with the Utah Department of Health. This Collaboration is structured as a working coalition composed of representatives from all participating agencies. The common strategies of the Utah CHNA Collaboration include: (1) initiate relationships with important stakeholders; (2) create a community advisory panel and accountability structure complementary to internal leadership, guidance, and oversight; (3) organize and convene co-hosted community input meetings; (4) define shared health indicators for data collection and help improve the state query database; (5) prioritize health needs based on data; (6) integrate this collaboration of the community health needs assessment into implementation strategies that become the state- and system wide goals and hospital-based clinical programs. Current membership of the Utah CHNA Collaboration includes:
- Bear River Health Department
- Beaver Valley and Milford Hospitals
- Blue Mountain Hospital
- Central Utah Public Health Department
- Comagine Health
- Davis Behavioral Health
- Davis County Health Department
- Get Healthy Utah
- Intermountain Healthcare
- Kern C. Gardner Policy Institute
- MountainStar Healthcare
- Salt Lake County Health Department
- San Juan Health Department
- Shriner’s Hospital for Children
- Southeast Health Department
- Southwest Health Department
- Summit County Health Department
- Tooele County Health Department
- TriCounty Health Department
- Uintah Basin Healthcare
- University of Utah Health
- Utah County Health Department
- Utah Department of Health
- Utah Health Information Network
- Utah Hospital Association
- Weber Human Services
- Weber-Morgan Health Department
- Leadership from the Utah Hospital Association
- Representatives of Intermountain Community Health team, Strategic Research Department, and Medical Group Clinics

This Collaboration is directed by a Community Advisory Panel, which has a formal charter that provides guidance regarding the purpose and work of the Collaboration. The Community Advisory Panel is composed of local health officers and leaders in the state of Utah. While this formal charter provides some guidance, the Utah CHNA Collaboration follows an informal process for decision-making and implementation. The Community Advisory Panel was originally convened in 2015 to provide public health expertise and community guidance to Intermountain in its CHNA and to formalize collaborative partnerships with the local health departments where Intermountain facilities are located. Success of the collaborative CHNA with local and state health departments has resulted in the panel members committing to expand the membership to share information, leverage resources, and measure and evaluate community health improvement strategies together for the benefit of people throughout our service areas. Membership on the Community Advisory Panel includes:
- Executive directors from the following health departments: Davis County Health Department, Central Utah Health Department, Salt Lake County Health Department, Summit County Health Department, Utah County Health Department, Utah Department of Health, Wasatch County Health Department, and Weber-Morgan Health Department
- Leadership from the Association for Utah Community Health (Federally Qualified Health Centers)
- Leadership from Utah’s public behavioral health system, Davis Behavioral Health, Southwest Behavioral Health Center, Utah Division of Substance Abuse and Mental Health, Wasatch Mental Health, and Weber Human Services
- Leadership from the Utah Hospital Association

In addition to these partnerships, the Intermountain Community Health Leadership Team and Executive Leadership Team provide additional oversight to create alignment with internal strategies, manage resources, and support communication internally.

Final approval of the significant health priorities and CHNA report is given by the Intermountain governing Board of Trustees. The Affordable Care Act (ACA) requires the CHNA and Implementation Plans to be approved and adopted by “an authorized body of the hospital facility”. An “authorized body of the hospital facility” means (i) The governing body (that is, the board of directors, board of trustees, or equivalent controlling body) of the hospital organization that operates the hospital facility. Intermountain Healthcare is governed by a governing Board of Trustees which sets policy, creates goals, approves operating budgets, evaluates management’s performance, and ensures Intermountain operates in the best interest of the community. While each hospital has a local governing board who was engaged in the CHNA process, they do not approve or manage operations of the hospitals. The Intermountain Board of Trustees has final responsibility for Intermountain’s actions and is thus the authorized body for each of its hospitals.
Evaluation of 2016 CHNA
In early 2017, Intermountain’s Strategic Research team conducted an online evaluation survey to understand opportunities or gaps in the 2016 CHNA process. The general public was also encouraged to make comments through Intermountain’s website after the publication of the 2016 reports. Two primary recommendations were made through these evaluation efforts:

1. Engage internal partners and clinical leaders in the CHNA process earlier so that more alignment throughout the system can be made.
2. Gather public perceptions of health needs in addition to community stakeholder input meetings.
3. Include more data regarding the social determinants of health.

With these recommendations in mind, Intermountain implemented a system-wide approach in conducting its 2019 CHNA by:

- Asking for broader community input regarding local health needs, including needs of medically underserved and low-income, and minority populations
- Identifying a reliable, valid method for collecting general public perceptions
- Gathering quantitative data collection on health indicators
- Analysis and prioritization of health needs indicators to identify significant needs
- Making the CHNA results publicly available

Community Input
Through coordination with the Utah CHNA Collaboration, Intermountain Healthcare, the Utah Department of Health, and the local health districts co-hosted the community input meetings. Invitees included representatives of the following groups:

- Food pantries
- Health advocate groups
- Healthcare providers
- Human service agencies
- Law enforcement
- Local business
- Local government
- State and local health departments

These participants, representing a broad range of interests, including the health needs of underserved, low-income, and minority people, were invited to attend the meeting to share their perspectives on health needs in the hospital’s community. Staff from Intermountain facilitated 90-minute input meetings in fall 2018 in 20 different communities. These meetings focused on key health issues and the barriers that cause health needs to persist. Questions included:

1. How is [health issue] affecting the health of your community?
2. What barriers exist in your community that cause [health issue] to persist as a health priority?
3. What other health issues are affecting your community that we may not have discussed yet?

Health issues were identified from previous assessments, both from Intermountain and other organizations, and included:

- Mental health
- Substance misuse
- Chronic diseases associated with unhealthy weight and behaviors
- Air quality
- Social determinants of health
- Communicable diseases, specifically respiratory illness such as influenza and pneumonia

Input meetings took place in the following locations, but included participants for the surrounding communities of each location:

- Burley, ID
- Delta, UT
- Farmington, UT
- Heber, UT
- Logan, UT
- Mt. Pleasant, UT
- Murray, UT
- Ogden, UT
- Park City, UT
- Richfield, UT
- Riverton, UT
- Salt Lake City, UT
- Sandy, UT
- St. George, UT
- Tremonton, UT

An additional meeting was held at Primary Children’s Hospital to discuss the health needs specific to children and adolescents. As part of the Utah CHNA Collaboration, Intermountain also helped facilitate input meetings in Price, Moab, and Blanding, Utah. Although these communities are not directly within the organization’s service areas, understanding the health needs throughout the entire state allows Intermountain to better collaborate with key partners and understand resources available to address health needs and disparities.

Due to the recent collection of community input in the Provo, UT community by the local public health department, Intermountain collaborated with the Utah County Health Department to share and review previously collected input from that community to avoid duplication of a meeting with key partners.

An online survey was sent to people who could not attend the community input meeting to encourage more representative feedback and engage all who were invited. Not all the people who received the invitation or follow-up survey responded to the request. Transcripts of each meeting and the survey results were then reviewed for a qualitative, thematic analysis. Themes were analyzed by frequency (the number of times a topic is mentioned) and severity (weighted by notetakers as key comments that resulted in an empathetic response during the meeting).

Written comments from the 2016 CHNA and implementation plans were also reviewed for key themes and suggestions regarding significant health priorities.

General Public Survey
Under the guidance of the Utah CHNA Collaboration, best practices and recommendations for methods to capture the perceptions of the general public were reviewed and discussed. The primary objective of the general public survey was to capture a broader representation of individuals in addition to the community input meetings. Many organizations within the Collaboration had tried different methodologies (door-to-door surveys, social media polls, focus groups, etc.), but with varying success. All previously tried methodologies had limitations when considering how to implement on a state level and recruit a representative group of participants that included underserved, low-income, and minority populations.
A final recommendation was made to add a qualitative, open-ended question to the Behavioral Risk Factor Surveillance System survey. The Behavioral Risk Factor Surveillance System (BRFSS) is the nation’s leading system of health-related telephone surveys that collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. BRFSS has strong, validated methodology to capture representation across geography, race, ethnicity, income, sexual orientation, and other important demographics.

Prior to implementation, Intermountain conducted a pilot study to test versions on the qualitative question. 800 patients and community members participated in the pilot.

The final question “What would you say are the top three physical and mental health concerns facing you, your family, and/or your community right now” was implemented in January, 2019. The question will be included for one calendar year. While results for this general public survey are not yet available for Intermountain’s 2019 CHNA, the process and results will be invaluable as Intermountain continues to respond to community needs.

Health Indicators

The selection of reliable, meaningful health indicators was an important part of the 2019 CHNA. First, Intermountain created an inventory of health indicators used in the 2016 assessment and compared those indicators with published needs assessments and/or annual reports from the Utah Department of Health and local health departments. Second, an extensive literature review of national reporting metrics including AHR, and particularly those that allow for a better understanding of the social determinants of health, also contributed indicators to the inventory. Third, members of the Utah CHNA collaboration interviewed epidemiologists at the Utah Department of Health and local health departments to identify additional indicators important to their own needs assessments and specific measures that have good reliability and availability. The Utah CHNA Collaboration reviewed and approved the final list of indicators.

Intermountain collaborated with the Utah Department of Health Office of Public Health Assessment to assemble available data on health indicators for the community Intermountain and each hospital serves. The Utah Department of Health Office of Public Health Assessment has a web-based resource to support community health needs assessments and other data needs in the community called the Public Health Indicator Based Information System (IBIS). IBIS includes a large selection of community health indicators that allow users to understand what are the health outcomes from a national, state, local health district, and neighborhood level. This website allows users to view, map, and analyze these indicators as well as understand racial/ethnic, age, sex, and other disparities. Analysts aggregated two or three years of data for each indicator to achieve a large enough sample size to have a reliable estimate for each health indicator. Appendix A contains data for many of the indicators reviewed, specifically those part of AHR, but additional analysis took place through the IBIS query system to better understand disparity and significant health needs by demographics within each indicator.

As previously mentioned, Intermountain and each specific hospital defined its service area using zip codes. These zip codes also align with the Utah Department of Health “Small Areas”, which allows for the aggregation of publicly reported data through IBIS at a neighborhood level. Small area data is used frequently by public health and other partners to understand geographic disparities and communities with high needs. For details regarding all small areas in Utah and how each hospital community is defined, see Appendix B. Data for Cassia Regional Hospital was not available through this methodology. As a result, Cassia Regional Hospital defined its community using zip codes that align with local public health efforts and County Health Rankings & Roadmaps.

Several other secondary data sources were reviewed to understand health needs, including Mental Health America, America’s Health Ranking, Map the Meal Gap Hunger Study, the Autism and Developmental Disabilities Monitoring Network, and the CDC Modified Retail Food Environment Index.

Appendix C contains a list of all health indicators reviewed for the 2019 CHNA.

Prioritization

Intermountain engaged its internal and external partners in a rigorous prioritization process to identify significantly important health needs for Intermountain Healthcare and each of its hospital communities. Prioritization involved identifying dimensions by which to prioritize, analysis based on those dimensions, inviting key stakeholders to evaluate health issues based on those dimensions, and finally, calculating scores to identify the significant health needs.

Intermountain identified dimensions for prioritization using practices established by public health professionals. The dimensions reflect needs assessment best practices, ACA requirements, and Intermountain strategic goals.

Dimensions included:

- **Affordability**: the degree to which addressing this health issue can result in more affordable healthcare
- **Alignment**: the degree to which the health issue aligns with Intermountain Healthcare’s or stakeholder organization’s mission and strategic priorities
- **Community input**: the degree to which community input meetings highlighted it as a significant health issue
- **Feasibility**: the degree to which the health issue is feasible to change, taking into account resources, evidence based interventions, and existing groups working on it
- **Health equity**: the degree to which the health issue disproportionately affects population subgroups by race/ethnicity
- **Seriousness**: the degree to which the health issue is associated with severe outcomes such as mortality and morbidity, severe disability, or significant pain and suffering
- **Size**: the number of people affected by the health issue
- **Upstream**: the degree to which the health issue is upstream from and a root cause of other health issues


4 Association for Community Health Improvement (2007). ACHI Community Health Assessment Toolkit. Available at http://www.assocstoolkit.org/assocstoolkit/member/Priorities/index.jsp
Each dimension was weighted equally. The dimensions of Affordability, Community Input, Health Equity, and Size were calculated using the Hanlon Method, a validated objective method for reviewing and prioritizing baseline data. Following the Hanlon methods guidelines, analysts assigned ratings for each health indicator database on the following criteria:

- Affordability: reduction of costs associated with addressing the health issue being small (1), moderate (2), or large (3), provided by Intermountain’s Population Health Analytics team.
- Community input: not mentioned by the community as an issue (1); mentioned, but not a common theme (2); common theme mentioned by several community members (3).
- Health equity: calculated by creating a disparity score using race as the only indicator of disparity. The highest number in the race categories was subtracted from the lowest number, divided by the lowest number, and then multiplied by 100 to get a percentage (% disparity). 1 = 0-100% disparity; 2 = 101-300% disparity; 3 = >300% disparity. Further validated with the Utah Department of Health, Office of Health Disparities.
- Size: prevalence: 1 = 0 – 9%; 2 = 10 – 24%; 3 = ≥ 25%; incidence: 1 = 0-49 per 100k; 2 = 50-99 per 100k; 3 = 100+ per 100k. Scales reflect national metrics.

Key stakeholders were then asked to participate in a multi-voting technique to consider the dimensions of Alignment, Feasibility, Seriousness, and Upstream. Intermountain identified several key groups throughout the organization to participate in the prioritization process. After a presentation of the CHNA results and health needs identified through the Hanlon prioritization analysis, participants received an online survey to confidentially vote for the health priorities based on the previously mentioned dimensions. Participants included:

- Hospital Administration
- Administrator/Chief Executive, Financial, Medical, Nursing, and Operations Officers
- Clinical Services Leadership
- Clinical Programs Leadership
- Medical Group Chief Executive, Financial, Medical, Nursing, and Operations Officers
- SelectHealth Chief Executive, Financial, Medical, and Operations Officers
- Community Advisory Panel members
- Community Health Leadership Team
- Community Health team members

Comprehensive prioritization results were reviewed by Intermountain’s Executive Leadership Team, who approved the final significant health needs for the system.

**Significant Community Health Need:**

Intermountain Healthcare reviewed the final calculation of priority scores based on ratings across the eight dimensions and identified the priority health needs as:

1. **Improve Mental Well-Being**
   - Decreased frequent mental distress rates
   - Decreased depression rates
   - Decreased suicide rate
   - Decreased drug poisoning deaths

2. **Prevent Avoidable Disease & Injury**
   - Increased immunization rates
   - Decreased prediabetes rates
   - Decreased high blood pressure rates
   - Decrease unintentional injury deaths

3. **Improve Air Quality**
   - Decreased bad air days (PM2.5)

Understanding both the community input and quantitative data from health indicators is essential to prioritizing health needs and creating meaningful implementation plans. Though 20 individual community input meetings were held, themes and identified health needs were remarkably similar between the different hospital communities. The following summary reflects the overall themes from all community input meetings and includes the perspective of underserved, low-income, and minority populations and the organizations that advocate for them.

**Summary of key issues and ideas from community input meeting**

1. **Mental health continues to be a critical health need that affects all other aspects of health and well-being.**
   - a. Suicide is a concern among all ages, not isolated to youth.
   - b. Lack of providers and treatment options are barriers due to the high demand of those seeking mental health care.
   - c. Social isolation is another key barrier, as individuals spend more time engaged in screens/social media and believe their neighborhoods are unsafe.
   - d. Chronic stress is a growing concern as individuals are having to work longer hours, multiple jobs, and/or balance multiple activities in addition to parenting, caring for aging parents, and managing unaffordable housing costs.
   - e. There is a strong relationship between mental health and other chronic conditions.

2. **Substance use disorders, specifically opioid misuse, is a concern in many communities and is highly linked to mental health needs.**
   - a. However, opioid misuse is one area that many participants noted the positive results of community efforts.
   - b. Vaping, especially among adolescents, is a growing concern.

3. **Chronic diseases associated with unhealthy weight and behaviors (including prediabetes and high blood pressure) continue to be the result of sedentary lifestyles more than other contributing factors.**
   - a. Screen time and chronic stress are considered key barriers.
   - b. Lack of confidence in nutritional knowledge and access to healthy foods (either because of financial cost and/or time) is a barrier that affects all groups, regardless of demographics.
   - c. The financial cost associated with activities that promote physical activity are considered too high by most community members, especially the cost associated with youth recreation and sports.

4. **Air quality, both from inversions and wildfires, is a key emerging health need.**
   - a. Poor air quality day result in poor mental health, according to many participants.
   - b. Many communities are unpalatable and lack adequate public transit, which continues to exacerbate the issue the Wasatch Front.
A number of critical barriers were identified through the community input meetings that illustrate why significant health priorities persist, in spite of the number of partners working to address them. The social determinants of were a common barrier identifies. Some key quotes from participants that illustrate this are:

“Among folks who have gotten over that hurdle of seeking help, they’re seeking help, they recognize it, and they want to receive the help and maybe they’ve got access to a provider of sorts. And sometimes they can’t get there.”

“Mental health is a huge concern for us from an EMS perspective. We transport EMS patients with a mental health crisis almost daily. And when I say that, we’re transporting them from this facility to a mental health facility. I feel like it’s a broken system because they leave here, they go to a facility that insurance will only pay for a short time stay, that doesn’t give them the long-term help that they need. There’s no follow up after they leave. They leave there with a prescription. And then within a few weeks we pick them up again...there’s got to be a way to help these people overcome these challenges better.”

“If you don’t have a place to live, and you don’t even have water, and you don’t have food, you really don’t care about anything else, honestly. You really can’t care about it because you’re so driven by meeting your basic needs that you really don’t care what you eat. You would eat a Twinkie if there’s a Twinkie because it’s just something to eat.”

Prioritized Health Indicator Data
In addition to the qualitative information gathered through community input meetings, quantitative data was collected and analyzed. Using the IBIS system and County Health Rankings, among the previously mentioned secondary sources, an accurate understanding of disease burden is acquired. Though only select results of the significant health needs are shared in this report, additional details were collected and can be found again through the IBIS website.

Mental Well-being
Why we are focusing on mental well-being as a health priority
According to the World Health Organization, mental health refers to “a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community”.

Mental health and mental disorders can be influenced by numerous conditions including biologic and genetic vulnerabilities, acute or chronic physical health conditions, and environmental conditions and stresses. Of all mental illnesses, depression is the most common disorder. Major depression is defined as having severe symptoms that interfere with a person’s ability to work, sleep, study, eat, and enjoy life. Despite the availability of effective treatments for major depression, such as medications and/or psychotherapeutic techniques, it often goes unrecognized and untreated. Depression is a serious concern for children and adolescents as well, with 25.7 percent of adolescents reporting feeling sad or hopeless.

Utah and Idaho have some of the highest suicide rates in the country. Overall, suicide is the sixth-leading cause of death in Utah and eighth in Idaho. Suicide is the leading cause of death for Utahns ages 10 to 24. In Utah, it is the second leading cause of death for ages 25 to 44 and the fourth-leading cause of death for ages 45-64. In Idaho, suicide is the 2nd leading cause of death for Idahoans ages 15-34 and for males up to age 44. All suicide attempts should be taken seriously. More people are hospitalized or treated in an emergency room for suicide attempts than those that are fatal.

Substance use disorders occur when regular use of alcohol and/or drugs impacts daily functioning, including health problems, disability, and inability to meet main responsibilities at home, work, or school. Drug poisoning deaths are a preventable public health problem; they are the leading cause of injury death in Utah, outpacing deaths due to firearms, falls, and motor vehicle crashes. Every month, 53 Utah adults die as a result of a drug poisoning, 84.3% of which are accidental or of undetermined intent, and of these, 75.6% involve opioids. Utah is particularly affected by prescription opioids, which are responsible for half of the accidental and undetermined drug poisoning deaths in the state.
Poor mental wellbeing is highly prevalent in the communities Intermountain and its hospitals serves. The prevalence of frequent mental distress is steadily increasing in the communities Intermountain serves and nationally.

Minority populations tend to experience higher rates of frequent mental distress.

Females and adults younger than 65 are more likely to experience depression.
Males, however, are more likely than females to die by suicide. While rates of suicide deaths are highest among men between the ages of 35-64, suicide continues to be the leading cause of death for Utahns ages 10 to 24.

Youth feelings of sad or hopeless, seriously considering suicide, and/or making a suicide attempt are highly prevalent in Intermountain service areas. Minority youth tend to experience higher rates of these experiences compared to their white, non-Hispanic peers.

<table>
<thead>
<tr>
<th></th>
<th>White/Non-Hispanic</th>
<th>Hispanic</th>
<th>Non-White/Non-Hispanic</th>
<th>All youth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Felt Sad or Hopeless</td>
<td>27.9%</td>
<td>36.9%</td>
<td>31.1%</td>
<td>29.5%</td>
</tr>
<tr>
<td>Seriously Considered Attempting Suicide</td>
<td>17.5%</td>
<td>22.7%</td>
<td>22.0%</td>
<td>18.7%</td>
</tr>
<tr>
<td>Attempted Suicide</td>
<td>6.8%</td>
<td>13.5%</td>
<td>14.6%</td>
<td>8.5%</td>
</tr>
</tbody>
</table>

While Intermountain service areas are seeing some improvement in preventing drug poisoning deaths, it remains a leading cause of death. Males and older adults are more likely to die as a result of drug poisoning.

Mental well-being was the number one priority identified by every hospital community. Results from the prioritization exercise, which included specific hospital community representatives, showed mental health was the number one priority recommended (83% ranked it top three). Suicide (44% ranked it top three) and Prescription Opioid Misuse (22% ranked it top three) were also highly recommended.
Prevent Avoidable Disease & Injury

Why we are focusing on prediabetes, high blood pressure, immunizations and unintentional injury deaths as health priorities

Diabetes is a disease that can have devastating consequences. It is a leading cause of non-traumatic lower-extremity amputation, renal failure, heart disease and blindness among adults younger than 75. This disease also has an enormous economic burden. Currently, about 80 million Americans aged 20 and older have pre-diabetes, a condition that puts them at high risk for developing diabetes. For many individuals, taking small steps, such as losing 5-7 percent of their weight or increasing physical activity, can help them delay or prevent developing diabetes. Without making lifestyle changes, approximately half of individuals diagnosed with prediabetes progress to diabetes within ten years.

High blood pressure (hypertension) is an important risk factor for heart disease and stroke, both of which continue to be a leading cause of death. In most cases, it can be effectively managed with medication and lifestyle changes (such as diet, exercise, and abstaining from tobacco use). Treatment works best when high blood pressure is identified early. Because high blood pressure does not produce symptoms, regular screening is recommended.

Immunizations are one of the most cost-effective health prevention measures. Development of vaccinations has been cited by the U.S. Public Health Service as one of the Ten Great Public Health Achievements in the 20th Century. Vaccines play an essential role in reducing and eliminating disease. Utah continues to have one of the lowest rates of these childhood immunizations and HPV immunization, which is administered to adolescents, in the nation.

In both Utah and Idaho, unintentional injuries are a leading cause of death and disability. In Utah, unintentional injuries, accounting for 1,238 deaths and 9,715 hospitalizations each year, with thousands of other less severe injuries being treated. The top five leading causes of unintentional injury deaths for all ages in Utah and Idaho were poisoning, motor vehicle traffic crashes, falls, and suffocation, and drowning (with falls being the leading cause of injury deaths for Utahns individuals 65 and older).

Avoidable diseases and injury are highly prevalent

Prediabetes also affects different populations at a higher rate. For example, in the Intermountain service area, individuals with less than a high school degree are more likely to have prediabetes.

Minority populations in the Intermountain service area experience higher rates of high blood pressure (also known as hypertension).
Intermountain service areas continue to have some of the lowest rates of childhood and adolescent immunizations in the nation.

<table>
<thead>
<tr>
<th>Childhood Immunizations</th>
<th>Utah</th>
<th>Idaho</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>67.9% (rank 40)</td>
<td>69.2% (rank 36)</td>
<td>70.4%</td>
</tr>
<tr>
<td>HPV – females</td>
<td>42.1% (rank 47)</td>
<td>52.1% (rank 28)</td>
<td>53.1%</td>
</tr>
<tr>
<td>HPV – males</td>
<td>32.9% (rank 44)</td>
<td>36.5% (rank 39)</td>
<td>44.3%</td>
</tr>
</tbody>
</table>

For the past decade, unintentional injuries and suicides have been the leading causes of child injury deaths in Utah and Idaho. While the rate of unintentional injury deaths has decreased, there is still work to be done to prevent these avoidable deaths and injury in the Intermountain service areas.

The leading causes of unintentional injury deaths for children 1-19 in the Intermountain service area are:

<table>
<thead>
<tr>
<th>Rank</th>
<th>Cause of Death</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Motor vehicle crash</td>
<td>113</td>
</tr>
<tr>
<td>2</td>
<td>Drowning/submersion</td>
<td>24</td>
</tr>
<tr>
<td>3</td>
<td>Poisoning</td>
<td>21</td>
</tr>
</tbody>
</table>

Avoidable diseases and injury were critical priorities identified by many hospital communities. Results from the prioritization exercise with leaders also showed chronic conditions related to obesity, specifically high blood pressure and prediabetes, as health needs. When selected, many leaders recommended obesity over all other health issues; however, only a total of 50% selected obesity as a top three health issue, so it was not prioritized as highly as mental well-being. The two health issues are highly related, and many strategies will work to address both. Immunizations were ranked in the top three by 20%. Prevention of unintentional injury deaths was not a health issue originally included in the CHNA prioritization process. However, as Intermountain Healthcare completes a reorganization of their Children’s Health service lane, the Executive Leadership Team recognized an opportunity to align with and expand previous community health efforts that were previously only offered through Primary Children’s Hospital.

Air Quality

Why We Are Focusing on Air Quality

Air pollution refers to any biological, physical, or chemical particle that is introduced to otherwise clean air. Pollutants come from many human activities (factories, transportation) and environmental sources (volcanoes, windblown dust). Air quality measures the amount of pollution in the air. Particulate Matter 2.5 (PM2.5) is a measure of air quality. PM2.5 can get deep inside the lungs and cause a variety of symptoms, such as painful breathing, chest tightness, headache, and coughing. PM2.5 can exacerbate respiratory infections, trigger asthma attacks and symptoms, and cause temporary reductions in lung capacity. Additionally, PM2.5 prevents physical exercise, which is essential to maintaining good physical and mental health and preventing chronic conditions.

Air Quality in much of Utah is poor

Air Quality was identified by key stakeholders as a key barrier to achieving success in the other prioritized health needs

Results from the prioritization exercise with leaders had air quality ranked in the top three recommendations by 4% of leaders. Intermountain’s Executive Leadership Team recognized the relationship between mental well-being and chronic conditions related to obesity, and wanted to respond to the community input that air quality is a critical barrier to preventing and managing these health issues. As Intermountain strives to increase their sustainability efforts and as the largest employer in the state of Utah, there is also interest in becoming an example of how large organizations can contribute positively to environmental health issues in the communities it serves.
McKay-Dee Hospital

Located in the urban community of Ogden, in northern Utah, McKay-Dee Hospital has 312 staffed beds and offers a full spectrum of inpatient and outpatient medical services. In 2019, they participated in a community health needs assessment to understand how to help people live the healthiest lives possible. This hospital participated in a collaborative, system approach to identify health indicators, gather community input, and determine the significant health needs to address over the next few years. McKay-Dee Hospital identified the significant health needs as:

- Improve Mental Well-Being, Prevent Avoidable Disease & Injury, and Improve Air Quality

McKay-Dee Hospital, which is part of Intermountain Healthcare, joined 27 other agencies from Utah to co-chair a statewide collaboration that guides and implements the CHNA process with public health, behavioral health, and other not-for-profit organizations. The collaboration has improved access to data, reduced duplication of efforts, and increased ability to align strategies in addressing complex health issues. McKay-Dee Hospital defined its community using zip codes that align with local public health efforts from the Utah Department of Health Small areas.

What we heard from the community

McKay-Dee Hospital co-hosted a community input meeting with the Utah Department of Health and its local public health department. This meeting included representatives from: food pantries, health advocate groups, healthcare providers (including FHQCs), human service agencies, law enforcement, local business, local government, low-income, uninsured, underserved populations, behavioral health service providers and local mental health authorities, minority organizations, safety net clinics, school districts/higher academic institutions, state and local health departments. Highlights from this community input meeting include:

- Poor nutritional education and lack of access to affordable, healthy foods are a critical factor for chronic diseases associated with unhealthy weight and behaviors.
- Mental health is a huge unmet need in the community.
- Substance misuse is related to unmet mental health needs.
- Housing is increasingly unaffordable.
- Long term poverty impacts mental and physical health.
- High rates of adolescent pregnancy and sexually transmitted infections.

What we know about the health needs

Below are health indicators that present the most opportunity to improve health in this community:

<table>
<thead>
<tr>
<th>Health Indicator</th>
<th>Weber-Morgan</th>
<th>State of Utah</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequent mental distress</td>
<td>20.6%</td>
<td>17.5%</td>
</tr>
<tr>
<td>Depression</td>
<td>23.2%</td>
<td>21.6%</td>
</tr>
<tr>
<td>Suicide death rate</td>
<td>28.6 per 100,000</td>
<td>22.0 per 100,000</td>
</tr>
<tr>
<td>Drug poisoning death rate</td>
<td>27.2 per 100,000</td>
<td>22.4 per 100,000</td>
</tr>
<tr>
<td>Childhood immunizations</td>
<td>NA</td>
<td>67.9%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>8.0%</td>
<td>7.7%</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>29.5%</td>
<td>25.7%</td>
</tr>
<tr>
<td>Unhealthy air days (as measured by AQI)</td>
<td>23</td>
<td>174</td>
</tr>
</tbody>
</table>

Why are these health issues important?

- According to the Centers for Disease Control and Prevention (CDC), chronic conditions related to obesity, such as diabetes and poor cardiovascular health, continue to be the leading cause of death and disability in the United States. The community this hospital serves is no exception.
- Mental health disorders are medical conditions that disrupt a person's thinking, feeling, mood, ability to relate to others and daily functioning. Just like chronic diseases, mental health disorders are treatable, however, many cases often go unrecognized and untreated. There is a strong relationship between chronic disease, depression, and other mental health concerns.
- Suicide is the sixth leading cause of death in Utah.
- Drug poisoning deaths are a preventable public health problem; they are the leading cause of injury death in Utah, outpacing deaths due to firearms, falls, and motor vehicle crashes.
- Immunizations are one of the most cost-effective, safe, and effective health prevention measures and play an essential role in reducing and eliminating disease.
- Unintentional injuries and suicides have been the leading causes of child injury deaths in Utah.
- Air quality measures the amount of pollution in the air. Poor air quality is associated with several adverse health outcomes, including reproductive health issues, poor birth outcomes, and an increase risk of heart attacks, strokes, and high blood pressure.

How are we going to address these health needs?

Based on the results of the CHNA, Intermountain Healthcare engaged representatives of state and local health departments and multiple community partners to identify potential implementation plans. Partners who participated in the previous community input meeting were invited again to discuss strategies, in addition to representatives from community libraries and case managers. These planning efforts were used to develop a three-year plan outlining health improvement strategies for McKay-Dee Hospital to address the significant health needs using evidence-based programs.

McKay-Dee Hospital's implementation plan leverages system and local resources to create partnerships that will improve health outcomes, with a particular focus on low-income, underserved, and uninsured populations. The implementation plan, which is reported in a separate document, includes a description of the resources Intermountain has committed to the strategies and how such resources will be augmented by collaborative partnerships in each hospital community. Outcome measures will be tracked and reported annually through the evaluation process.

For more information about Intermountain Healthcare’s community health efforts, contact: Mikelle Moore, Chief Community Health Officer and Senior Vice President, mikelle.moore@imail.org Stephanie Croasdel Stokes, Consultant, Strategic Research, stephanie.stokes@imail.org
A comprehensive approach was used to identify the community health improvement strategies to address the significant health priorities from this community health needs assessment. Using Intermountain’s Operating Model (a fully integrated framework to drive a culture of Continuous Improvement, that aligns leaders and caregivers in achieving the goals of the organization) internal operational and clinical leadership councils, workgroups and committees along with input from external advisory panels formed through community input meetings—all experts in clinical care, public health, and human services and leaders in their local communities—guided the implementation planning process to create community health improvement strategies for the Intermountain and each hospital’s service area.

Community partners were identified and invited to participate in individual hospital input and planning meetings. Meetings were convened to present Intermountain’s 2020-2022 health priorities and aims to gather strategies and input on how to best address individual priorities in each community we serve.

Intermountain worked with both internal and community partners to create a comprehensive inventory of existing local programs and interventions to address the identified health priorities, focusing on those evidence-based best practices with application to community health improvement initiatives. The community health implementation planning team scored and vetted both internal and external proposed strategies and conducted a thorough literature review on evidenced-based programs that addressed the health priorities and demonstrated health improvement.

Identified strategies for each of the CHNA identified health priorities (Aims) and their drivers are detailed in the graphics below:

- **Aim:** Improve Mental Well-being
  - **Drivers:**
    - Reduce mental health hospital stays for high-risk patients
    - Increase community participation in mental health programs

- **Aim:** Increase Access to Primary Care
  - **Drivers:**
    - Increase number of primary care providers
    - Improve access to care through telemedicine

- **Aim:** Increase Access to Substance Abuse Services
  - **Drivers:**
    - Increase availability of detox and treatment services
    - Enhance collaboration between substance abuse services and mental health services

- **Aim:** Increase Access to Mental Health Services
  - **Drivers:**
    - Increase number of mental health providers
    - Enhance integration of mental health services into primary care}

Identified strategies for each of the CHNA identified health priorities (Aims) and their drivers are detailed in the graphics below:

- **Aim:** Improve Avoidable Disease & Injury
  - **Drivers:**
    - Increase community awareness of avoidable diseases
    - Increase access to education and prevention programs

- **Aim:** Increase Access to Healthy Food
  - **Drivers:**
    - Increase availability of healthy food options
    - Enhance community engagement in healthy food initiatives

- **Aim:** Increase Access to Physical Activity
  - **Drivers:**
    - Increase availability of physical activity programs
    - Enhance community participation in physical activity challenges

- **Aim:** Increase Access to Social Services
  - **Drivers:**
    - Increase availability of social services
    - Enhance community engagement in social services programs
Impact Evaluation of Previous Implementation Strategy

2018 Community Benefit Implementation Plan Impact Summary

Identified Need
Prevent prediabetes, high blood pressure, depression, prescription opioid misuse. Suicide was added as a significant health need in between the 2016 and 2019 CHNAs.

Intervention and Results

1. Prevention of chronic disease (including prediabetes and high blood pressure)
Prediabetes: Strategies focused on identifying people with prediabetes to prevent the development of type 2 diabetes, which is the leading cause of non-traumatic lower-extremity amputation, renal failure, blindness among adults younger than 75, and one of the leading causes of heart disease. If left untreated, prediabetes progresses to type 2 diabetes. Community Health focused efforts on providing screening, brief intervention and referral to treatment for those identified at risk.

High blood pressure: Strategies focused on identifying people at risk for high blood pressure which increases risk of heart disease and stroke (among the highest causes of mortality in the United States, and due to its asymptomatic nature, it is often undiagnosed until further complications arise). Community Health focused efforts on providing screening, brief intervention and referral to treatment for those identified at risk.

Impact from this strategy:
• Established a Diabetes Operations Council to align diabetes prevention efforts across the system
• Screened over 13,000 high-risk community members
• 98% screened reside in areas of the highest need as per local area deprivation indexes
• 1 in 3 were found to be at-risk for prediabetes and referred to appropriate community-based resources
• Over 1 in 10 were found to be at-risk for high blood pressure and referred to appropriate community-based resources
• Of those that participate in Diabetes Prevention Programs, the majority lost 5% or more of their body weight
• Over 90% of those at high-risk are contacted and referred to a preventive program (CDSMP, CPSMP, Better Choices Better Health, Prediabetes 101, NDPP)
• Provided over 60 CDSMP classes with over 500 participants

2. Prevention of depression
Depression adversely affects mental health through changes in how an person thinks, feels, and behaves. It is the most common of mental disorders in adults. Approximately 18 percent of adults in the U.S. are affected by depression; Utah is slightly higher with more than 20 percent. Depression is also more common in people with other health conditions, such as diabetes and heart disease, and can worsen outcomes in people with those conditions as well as contribute to a poorer overall quality of life. Community Health focused efforts on providing screening, brief intervention and referral to treatment for those identified at risk.

Impact from this strategy:
• Screened over 13,000 high-risk community members
• More than 1 in 10 were found to be at-risk for depression and referred to appropriate community-based resources
• Expanded community-based Behavioral Health Networks to 15 organizations with over 30,000 visits provided

3. Prevention of prescription opioid misuse
Prescription opioid abuse is a concern across the U.S., with Utah especially at risk with the death rate exceeding the national rate. In Utah, there were more deaths from unintended prescription opioid overdose (an average of 24 annually) than from firearms, falls, or motor vehicle crashes.

Impact from this strategy:
• Developed and led the Opioid Community Collaborative
• Supported the Use-Only-as-Directed campaign
• Reduced prescribed opioids by 5.4 million tablets prescribed for acute conditions
• Supported a drop box program for disposal of community medications, which saw the disposal of over 29,000 pounds of medication
• Over 65,000 Naloxone Kits distributed through Intermountain’s partnership with Utah Naloxone with 3,343 reversals reported

Due to rising concern in each of Intermountain’s hospital communities, suicide prevention was added in 2018 as a health priority. It’s one-year impact is as follows:

4. Prevention of death by suicide
Suicide was the leading cause of death for Utahns ages 10 to 17 and ages 18 to 24. It was the second leading cause of death for ages 25 to 44 and the fourth-leading cause of death for ages 45-64. Overall, suicide is the eighth-leading cause of death for Utahns (age-adjusted rate).

Impact from this strategy:
• Promotion of safe firearm storage through a $2 million, three-year media and education risk reduction campaign
• Over 1,000 Utah professionals were trained in Counseling on Access to Lethal Means (CALM)
• Over 10,000 caregivers and 12,000 community members have completed at least one Intermountain supported training this year to enhance their confidence and competence in supporting others and themselves at times of mental and emotional distress
• Over 7,000 gunlocks were distributed in the community

Area Deprivation Index
Intermountain Healthcare is committed to serving the most vulnerable communities and populations. Income, education, and other economic and social risk factors affect individual health and well-being. In the 2016 CHNA, Intermountain used the Area Deprivation Index to understand these social determinants of health in the context of geography and continues to use this metric to understand effect of the planned interventions. The Area Deprivation Index (ADI) is a validated, community socio-economic composite measure developed specifically for Utah by Intermountain. The ADI measures the distribution of socio-economic disadvantage within a community at the U.S. Census block group level. Higher socio-economic deprivation levels in communities (noted in orange and red on the map below) are often associated with poorer health and health delivery outcomes. While the ADI does not provide information on specific health needs in a community, it does provide context and information about segments of communities in which greater health disparities may be expected and where implementation strategies could be targeted.
Elements included in the Area Deprivation Index:
- Median family income (dollars)
- Income disparity
- Percent of families below poverty level
- Percent of population below 150 percent poverty threshold
- Percent of single parent households with dependents under age 18
- Percent of households without a motor vehicle
- Percent of households without a telephone
- Percent of housing units without complete plumbing
- Percent occupied housing units
- Percent of households with less than one person per room
- Median monthly mortgage (dollars)
- Median gross rent (dollars)
- Median home value (dollars)
- Percent of employed persons over age 16 with a white collar occupation
- Percent of unemployed civilian labor force over age 16
- Percent of population over age 25 with less than nine years of education
- Percent of population over age 25 with at least a high school education

Intermountain is committed to providing quality care regardless of a patient’s ability to pay and outreach to vulnerable communities. Many of the strategies just described were located in communities that experience more health disparities. In an effort to continue to use the ADI to guide strategy, Intermountain monitored the ADI of health screening event participants. As illustrated in the chart below, health screening event participants were often more “deprived”, as defined by the ADI, than most Intermountain patients.
Conclusion

Intermountain Healthcare is grateful for the support of community members and agencies for their participation in the process of understanding local community health needs and developing strategies to improve health. Intermountain Healthcare will conduct its next CHNA in 2022 and looks forward to continuing collaborations to improve the health of our community.

The Intermountain Healthcare CHNA was completed by Intermountain Community Health and Strategic Research Departments with expert guidance from the Utah CHNA Collaboration.

Send written comments on this Community Health Needs Assessment to: 2016chnacommments@imail.org

Acknowledgement

This assessment would not be possible without the Utah Department of Health Office of Public Health Assessment. Their talented team of data specialists helped Intermountain identify reliable public health measures that best illustrate the health of a community. Their dedication to the quality of the data and its dissemination helped make this assessment a true community collaboration. Contributors from the Utah Department of Public Health Assessment included Anna Dillingham, Navina Forsythe, Lynne Macleod, Kim Neerings, and Tong Zheng. Intermountain is also grateful for Navina Forsythe’s continued leadership of the Utah CHNA Collaboration, which is co-chairs with Stephanie Stokes.

For more information about the CHNA contact

Mikelle Moore, Chief Community Health Officer and Senior Vice President, mikelle.moore@imail.org
Mikelle Moore, Chief Community Health Officer and Senior Vice President, mikelle.moore@imail.org

Appendix A

<table>
<thead>
<tr>
<th>Health Indicator</th>
<th>Utah Value</th>
<th>National Rank</th>
<th>Idaho Value</th>
<th>National Rank</th>
<th>United States Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Deaths (deaths per 100,000 population)</td>
<td>22.9</td>
<td>40</td>
<td>14.2</td>
<td>16</td>
<td>16.9</td>
</tr>
<tr>
<td>Excessive Drinking (Percentage of adults)</td>
<td>12.20</td>
<td>1</td>
<td>16.60</td>
<td>10</td>
<td>19.00%</td>
</tr>
<tr>
<td>High School Graduation (Percentage of students)</td>
<td>85.20</td>
<td>27</td>
<td>79.70</td>
<td>40</td>
<td>84.10%</td>
</tr>
<tr>
<td>Obesity (Percentage of adults)</td>
<td>25.20</td>
<td>4</td>
<td>29.30</td>
<td>19</td>
<td>31.30%</td>
</tr>
<tr>
<td>Physical Inactivity (Percentage of adults)</td>
<td>21.10</td>
<td>5</td>
<td>24.20</td>
<td>13</td>
<td>25.60%</td>
</tr>
<tr>
<td>Smoking (Percentage of adults)</td>
<td>8.90%</td>
<td>1</td>
<td>14.30</td>
<td>10</td>
<td>17.10%</td>
</tr>
<tr>
<td>Air Pollution (Micrograms of fine particles per cubic meter)</td>
<td>8.3</td>
<td>36</td>
<td>6.7</td>
<td>10</td>
<td>8.4</td>
</tr>
<tr>
<td>Children in Poverty (Percentage of children ages 0-17)</td>
<td>10.70%</td>
<td>2</td>
<td>15.30%</td>
<td>22</td>
<td>18.40%</td>
</tr>
<tr>
<td>Chlamydia (Cases per 100,000 population)</td>
<td>315.7</td>
<td>5</td>
<td>356.3</td>
<td>7</td>
<td>497.3</td>
</tr>
<tr>
<td>Pertussis (Cases per 100,000 population)</td>
<td>8.7</td>
<td>42</td>
<td>4.9</td>
<td>29</td>
<td>5.6</td>
</tr>
<tr>
<td>Salmonella (Cases per 100,000 population)</td>
<td>10.9</td>
<td>6</td>
<td>10.9</td>
<td>6</td>
<td>16.7</td>
</tr>
<tr>
<td>Occupational Fatalities (deaths per 100,000 population)</td>
<td>4.3</td>
<td>17</td>
<td>4.8</td>
<td>28</td>
<td>4.4</td>
</tr>
</tbody>
</table>

NA = Data not publicly reported or unavailable due to small sample size in the community.

The table below shows the definition of each hospital community by zip code and the Utah Department of Health Small Areas. Each Small Area includes medically underserved, low-income, and minority populations. The Utah Department of Health created Small Areas in order to facilitate reporting data at the community level. Small Areas are determined based on specific criteria, including population size, political boundaries of cities and towns, and economic similarity, and were reviewed and approved by public health experts. These zip codes and associated Small Areas were used to assemble available data for health indicators.

<table>
<thead>
<tr>
<th>Intermountain Hospital</th>
<th>Assigned Zip Code</th>
<th>CITY</th>
<th>COUNTY</th>
<th>STATE</th>
<th>Small Area Name</th>
<th>Local Health District</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alta View</td>
<td>84020</td>
<td>Draper</td>
<td>Salt Lake</td>
<td>UT</td>
<td>Draper</td>
<td>Salt Lake</td>
</tr>
<tr>
<td>Alta View</td>
<td>84070</td>
<td>Sandy</td>
<td>Salt Lake</td>
<td>UT</td>
<td>Sandy (West)</td>
<td>Salt Lake</td>
</tr>
<tr>
<td>Alta View</td>
<td>84052</td>
<td>Sandy</td>
<td>Salt Lake</td>
<td>UT</td>
<td>Sandy (Northeast)</td>
<td>Salt Lake</td>
</tr>
<tr>
<td>Alta View</td>
<td>84094</td>
<td>Sandy</td>
<td>Salt Lake</td>
<td>UT</td>
<td>Sandy (Center) V2</td>
<td>Salt Lake</td>
</tr>
<tr>
<td>American Fork</td>
<td>84009</td>
<td>Utah</td>
<td>Utah</td>
<td>UT</td>
<td>American Fork</td>
<td>Utah</td>
</tr>
<tr>
<td>American Fork</td>
<td>84004</td>
<td>Alpine</td>
<td>Utah</td>
<td>UT</td>
<td>Alpine</td>
<td>Utah</td>
</tr>
<tr>
<td>American Fork</td>
<td>84005</td>
<td>Eagle Mountain</td>
<td>Utah</td>
<td>UT</td>
<td>Eagle Mountain/Cedar Valley</td>
<td>Utah</td>
</tr>
<tr>
<td>American Fork</td>
<td>84042</td>
<td>Lindon</td>
<td>Utah</td>
<td>UT</td>
<td>Pleasant Grove/Lindon</td>
<td>Utah</td>
</tr>
<tr>
<td>American Fork</td>
<td>84043</td>
<td>Lehi</td>
<td>Utah</td>
<td>UT</td>
<td>Lehi</td>
<td>Utah</td>
</tr>
<tr>
<td>American Fork</td>
<td>84045</td>
<td>Saratoga Springs</td>
<td>Utah</td>
<td>UT</td>
<td>Saratoga Springs</td>
<td>Utah</td>
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<tr>
<td>American Fork</td>
<td>84062</td>
<td>Pleasant Grove</td>
<td>Utah</td>
<td>UT</td>
<td>Pleasant Grove/Lindon</td>
<td>Utah</td>
</tr>
<tr>
<td>Bear River Valley</td>
<td>84301</td>
<td>Bear River City</td>
<td>Box Elder</td>
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Appendix B

The table below shows the definition of each hospital community by zip code and the Utah Department of Health Small Areas. Each Small Area includes medically underserved, low-income, and minority populations. The Utah Department of Health created Small Areas in order to facilitate reporting data at the community level. Small Areas are determined based on specific criteria, including population size, political boundaries of cities and towns, and economic similarity, and were reviewed and approved by public health experts. These zip codes and associated Small Areas were used to assemble available data for health indicators.
The table below lists the health indicators reviewed for the 2019 CHNA:

<table>
<thead>
<tr>
<th>Health Indicator</th>
<th>Sevier Valley</th>
<th>Idaho County</th>
<th>Utah County</th>
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<tr>
<td>Births to Women under 18</td>
<td>83311 Albion</td>
<td>83318 Burley</td>
<td>83336 Heyburn</td>
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<tr>
<td>Births from Unintended Pregnancy</td>
<td>83334 Minidoka</td>
<td>83343 Mirida</td>
<td>83347 Paul</td>
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<td>Binge Drinking</td>
<td>83312 Almo</td>
<td>83323 Delco</td>
<td>83342 Malta</td>
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<td>Drinking among pregnant women</td>
<td>83346 Oakley</td>
<td>83350 Rupert</td>
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**APPENDIX C**

The table below lists the health indicators reviewed for the 2019 CHNA:

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<tr>
<th>Indicator</th>
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<td>83336 Heyburn</td>
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<td>Breastfeeding</td>
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<td>83343 Mirida</td>
<td>83347 Paul</td>
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<tr>
<td>Burn (minor)</td>
<td>83312 Almo</td>
<td>83323 Delco</td>
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<td>Campylobacter</td>
<td>83346 Oakley</td>
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<td>Childhood vaccination</td>
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<td>Chlamydia</td>
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<td>Coronary Heart Disease</td>
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*The Cassia Regional Hospital defined its community using zip codes that align with local public health efforts and County Health Rankings & Roadmaps. The hospital community includes medically underserved, low-income, and minority populations. These zip codes were used to assemble available data for health indicators.*

**List Intermountain Healthcare Hospitals w/ link to CHNA and Implementation Plans**

**Alta View Hospital in Sandy, Utah**

**American Fork Hospital in American Fork, Utah**
https://intermountainhealthcare.org/location/american-fork-hospital/hospital-information/american-fork-hospital-chna/

**Bear River Valley Hospital in Tremonton, Utah**

**Cassia Regional Hospital in Burley, Idaho**

**Cedar City Hospital in Cedar City, Utah**

**Delta Community Hospital in Delta, Utah**

**Dixie Regional Medical Center in St. George, Utah**

**Fillmore Community Hospital in Fillmore, Utah**

**Garfield Memorial Hospital in Panguitch, Utah**
Heber Valley Hospital in Heber City, Utah

Intermountain Medical Center in Salt Lake City, Utah

Layton Hospital in Layton, Utah
https://intermountainhealthcare.org/location/layton-hospital/hospital-information/layton-hospital-chna/

LDS Hospital in Salt Lake City, Utah

Logan Regional Hospital in Logan, Utah

McKay-Dee Hospital in Ogden, Utah

Orem Community Hospital in Orem, Utah

Park City Hospital in Park City, Utah

Primary Children’s Hospital in Salt Lake City, Utah

Riverton Hospital in Riverton, Utah

Sanpete Valley Hospital in Mount Pleasant, Utah

Sevier Valley Hospital in Richfield, Utah

TOSH-The Orthopedic Specialty Hospital in Murray, Utah

Utah Valley Hospital in Provo, Utah