

# Fillmore Community Hospital

## Community Health Improvement Strategy 2023



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## OUR MISSION

Helping people live the healthiest lives possible®

## OUR VISION

Be a model health system by providing extraordinary care and superior service at an affordable cost.

## FUNDAMENTALS OF EXTRAORDINARY CARE

**Safety:** Patients and caregivers experience Zero Harm.

**Quality:** Always deliver evidence-based care that meets each individual's healthcare goals and leads to top performance nationally.

**Experience:** Patients and customers have an Intermountain experience that leads to lasting loyalty.

**Equity:** Eliminate disparities and create opportunities for caregivers, patients, members, and communities to thrive.

**Access:** All customers receive the care and information where, when, and how they want it, with seamless coordination across the system.

**Stewardship:** Be an indispensable community partner, achieving the healthiest communities with the lowest cost per person in the nation. Be recognized globally as a financially sound, forever organization.

**Engaged Caregivers:** Caregivers have an unparalleled work experience that supports them in delivering the fundamentals of extraordinary care.



## OUR VALUES

Integrity | Trust | Equity | Excellence | Accountability | Mutual Respect



## Executive Summary

Intermountain Healthcare (Intermountain) is a Utah-based, nonprofit integrated health system of 33 hospitals (includes a "virtual" hospital), a Medical Group with more than 3,800 physicians and advanced practice clinicians at 385 clinics, a health plans division called SelectHealth, and other health services. Intermountain is widely recognized as a leader in clinical quality improvement and value-based care. Health needs across the lifespan are included in this report. The health needs of children and adolescents are highlighted in the Intermountain Primary Children's Hospital community health needs assessment (CHNA) report and summary. Primary Children's Hospital 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. On April 1, 2022, SCL Health and Intermountain merged into one organization, expanding our reach to communities in six states. This CHNA and corresponding implementation strategy are focused in the geographic areas of Utah and Cassia, Idaho (see map in Appendix A).

Our Intermountain mission, helping people live the healthiest lives possible®, is best realized with a comprehensive understanding of the communities it serves. Therefore, since 2009, Intermountain has engaged in a process for each of its hospitals and other communities served through clinics to identify local area health needs through a community health needs assessments. This local, community approach enhances the understanding of what annually reviewed national benchmarking metrics reveal about community health. This community intelligence comprises of:

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

As a result of this extensive needs assessment and prioritization process, described in the associated CHNA reports for Utah and Cassia, Idaho, Intermountain hospitals and communities in this geographic area identified the significant health priorities as:

### **Improve Mental Well-Being, Improve Chronic & Avoidable Health Outcomes, and Address & Invest in Social Determinants of Health**



**Improve  
Mental Well-Being**



**Improve Chronic and  
Avoidable Health  
Outcomes**



**Address and Invest in  
Social Determinants  
of Health**

The 2022 CHNA report informs Intermountain leadership, public health partners, and community stakeholders of the significant health needs in our communities. This intelligence allows hospitals and their local partners to develop strategies that leverage Intermountain and community resources to address those needs throughout the Intermountain system.

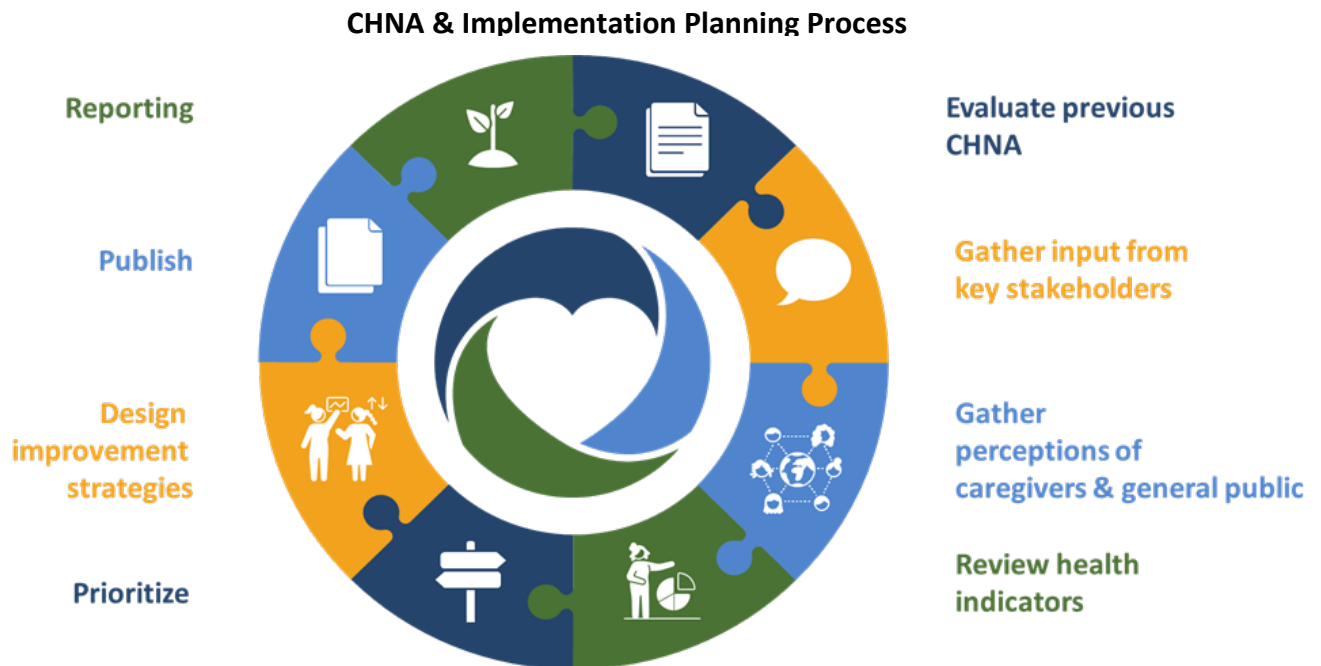
The Patient Protection and Affordable Care Act (ACA) requires each nonprofit hospital to conduct a CHNA every three years and to develop an implementation strategy to address, measure, and report the impact of significant health priorities. This report fulfills a vital component of that requirement by documenting the collection of reliable information through a community health needs assessment that allows the organization to develop meaningful implementation strategies. These priorities have been reviewed and approved by the IHC Health Services Board of Trustees, who has final responsibility for Intermountain's actions and is thus the authorized body for each of its hospitals.

Results of the CHNA and prioritization process were used to develop a three-year implementation strategy for each hospital, in Utah and Cassia Idaho, to address the prioritized health needs. Using community input, we identified evidence-based programs to benefit our communities by leveraging Intermountain's resources as an integrated healthcare system with those of community partners.

Each hospital's strategies leverage system and local resources to create local community partnerships to improve health for low-income, medically underserved, underrepresented, and uninsured communities. The implementation strategy includes a description of the resources Intermountain has committed to the initiatives and how these resources will be augmented through collaboration with community stakeholders in each hospital community. Outcome measures will be tracked and reported annually through the evaluation process.

## Implementation Strategy Planning

A comprehensive approach was used to identify the community health improvement strategies to address the identified health priorities of 1) improve mental wellbeing, 2) improve chronic and avoidable health outcomes and 3) address and invest in social determinants of health in each hospital's implementation strategy in Utah and Cassia, Idaho. (Refer to the full Community Health Needs Assessment for more information on the process used to identify the priorities).



Internal operational and clinical leadership councils, workgroups and committees, along with input from external advisory panels, guided the implementation strategy process to create implementation strategies for each hospital's service area in Utah and Cassia, Idaho.

Community partners were identified and invited to participate in individual hospital input and strategic planning meetings. These meetings were co-hosted with local and state public health partners and held in the same session as the community input meetings described previously.

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 strategy team assessed

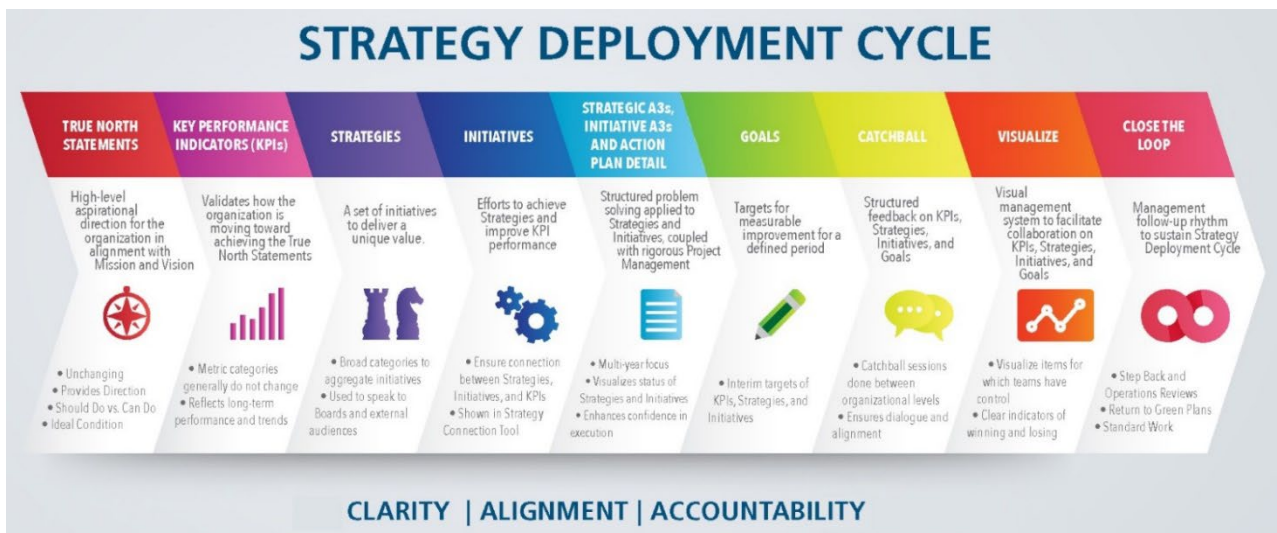


both internal and external proposed strategies and conducted literature reviews on evidenced-based programs that addressed the health priorities and demonstrated health improvement.

Community partners involved in this process include:

- Association for Utah Community Health (Utah’s Primary Care Association)
- Comagine Health
- Community-based mental health providers
- Community libraries
- Federally Qualified Health Centers (FQHCs) in Utah and Southeast Idaho
- Idaho Department of Health and Welfare
- Idaho South Central Public Health District V
- Local colleges and universities
- Local Mental Health and Local Substance Abuse Authorities
- Local law enforcement
- Local non-profit organizations
- Safety-net clinics
- School districts
- Senior centers
- Utah Department of Health & Human Services
- Utah Local Health Departments
- Utah Division of Substance Use and Mental Health
- Utah Substance Use Advisory Council

Internally, stakeholders in Utah and Cassia, Idaho included clinical programs, medical group providers and clinics, specialty and hospital-based care, operational and support services. Community Health analyzed, synthesized, vetted and scored all proposed strategies and initiatives from all internal and external sources. Leaders across the enterprise had the opportunity to review and provide feedback for the community health implementation strategy.



## The Intermountain Operating Model

The Community Health Implementation Strategy is strongly supported by the Intermountain Operating Model (IOM). The model is a daily management system that helps to create clarity, alignment, and accountability across the organization. It provides a framework to help us manage our work, make improvements, sustain the gains, and to deploy best practices across the system. The IOM creates a culture of continuous improvement at all tiers in the organization. Through the IOM, specifically our strategy deployment cycle (see below), the CHNA strategies and initiatives were discussed, and strategy developed across departments, clinical programs and services to align community health priorities to system-wide efforts.



## Establishing Criteria for Community Health Improvement Strategies

Intermountain presented the CHNA results to local stakeholders, many of whom were later identified as collaborative partners in each hospital community and worked with them to create a comprehensive inventory of existing local programs and interventions to address the identified health priorities through community input meetings. In addition, Intermountain's community health implementation strategy team conducted an inventory of all Intermountain and SelectHealth's (Intermountain's affiliated and integrated health plan) programs and initiatives to identify those evidence-based best practices with application to community health improvement initiatives.

Community participants included:

- Association for Utah Community Health (Utah's Primary Care Association)
- Comagine Health
- Community-based mental health providers
- Community libraries
- Federally Qualified Health Centers (FQHCs) in Utah and Southeast Idaho
- Idaho Department of Health and Welfare
- Idaho South Central Public Health District V



- Local colleges and universities
- Local Mental Health and Local Substance Abuse Authorities
- Local law enforcement
- Local non-profit organizations
- Resource and case management programs for uninsured, low-income residents
- Safety net clinics
- School districts
- Senior centers
- Utah Department of Health
- Utah Local Health Departments
- Utah Division of Substance Abuse and Mental Health
- Utah Substance Abuse Advisory Council

### Selection of Community Health Strategies

The inventory of evidence-based interventions was scored by the Intermountain community health implementation strategy team according to the following dimensions:

- Ability to implement and maintain fidelity to achieve anticipated outcomes
- Cost – total expense of the intervention (education materials, instructor, screening supplies, promotional materials, evaluation and data management)
- Effectiveness – measure of improved health as a result of intervention
- Evidence based either through peer review, published researched, or validated outcomes
- Existing or potential to create community collaboration
- Health improvement – measure of change in a person’s health status and how it can be maintained over a period
- Potential to influence public policy to improve health
- Reach – measure of people in the target population participating in intervention
- Sustainability – measure of how the intervention can be sustained over a period

The highest scoring intervention strategies were selected for implementation to address the health priorities; all hospitals will address the three priorities over the next three years through local application of strategies.

Intermountain created logic models to illustrate what we plan to do, why we do it, what we hope to achieve, and how we will measure success. The logic model below summarizes the CHNA and Implementation strategy



**Access, Equity and Value Framework**

Implementation strategies were created with a strong focus on access, equity, and value. These three areas are themes throughout every plan and ensure we reduce disparities in outcomes, improve level of access to services and programs, and value to community.

**Intermountain Identified Community Health Needs (Priorities)**

Intermountain has chosen to organize the health needs into three main priorities. Intermountain has established a community health improvement plan to address the health priorities of improving mental well-being, improving chronic and avoidable health outcomes and addressing and investing in social determinants of health.

Our upstream approach will allow Community Health to leverage resources throughout the organization and affect change across all identified priorities. Strategies will move across the lifespan and will be implemented in alignment with the system priorities in order to be consistently aligned in addressing these priorities for all our caregivers, patients, and community members – especially those who are medically underserved or underrepresented. Strategies are summarized below with the detailed framework in the individual hospital community health improvement plans (Appendix B).

## Improve Mental Well-being

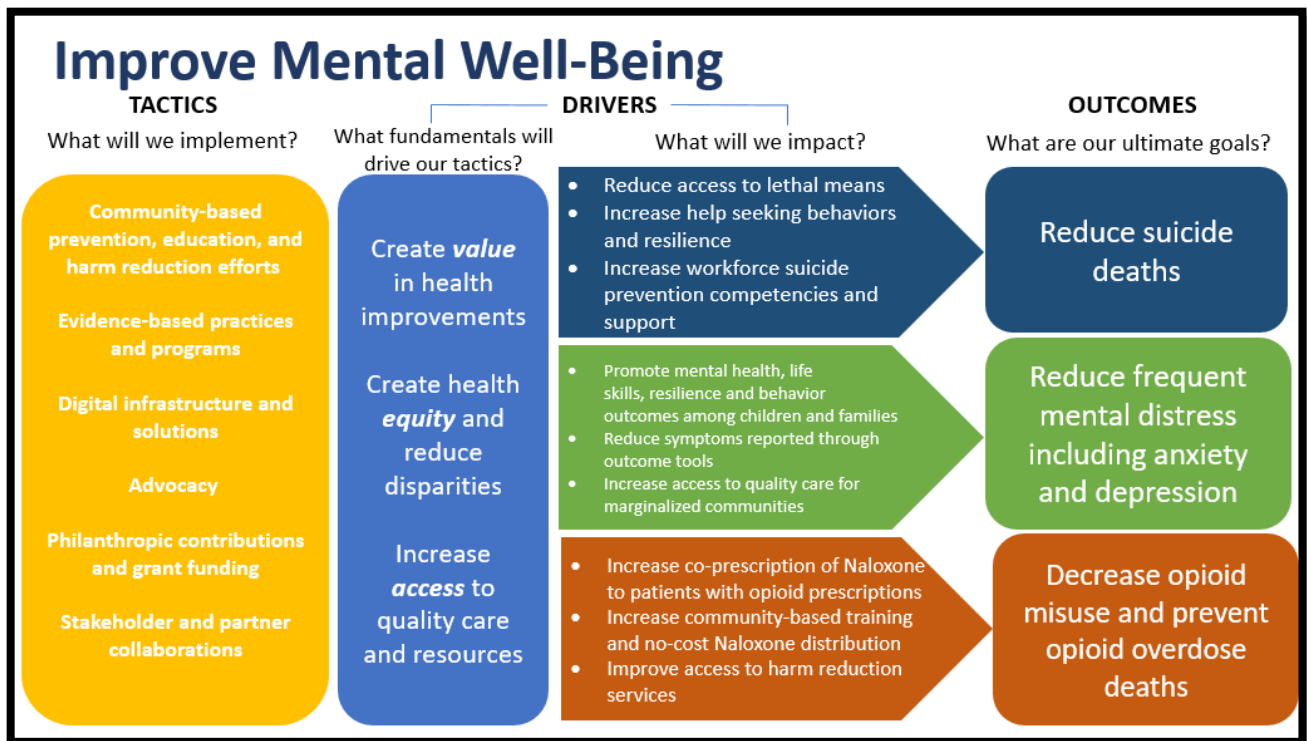
### **Why are we focusing on mental well-being as a health priority?**

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 is influenced by numerous factors, including biological and genetic vulnerabilities, acute or chronic physical health conditions, and environmental conditions and stresses. Of all mental health conditions, 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 39% percent of adolescents in Utah reporting feeling sad or hopeless.<sup>11</sup>

Utah and Idaho have some of the highest suicide rates in the country. Overall, suicide is in the top ten leading causes of death in Utah. 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 fifth-leading cause of death for ages 45-64. In Idaho, suicide is the 2nd leading cause of death for Idahoans ages 10-44 and fourth-leading cause of death for ages 45-54.

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 and 22 Idaho adults die because of drug poisonings; of these, approximately three-quarters involve opioids. Utah and Idaho are particularly affected by prescription opioids, which are responsible for about half of the accidental and undetermined drug poisoning deaths in both states.



## Improve Mental Well-being Priority Areas

### Reduce suicide deaths

- 1. Improve suicide focused care by supporting the implementation and expansion of the Zero Suicide framework**—The Zero Suicide Framework is a Transformational Framework for Health and Behavioral Health Care Systems. The foundational belief is that suicide deaths for individuals in care are preventable. The model operationalizes the core components necessary for health care systems to transform suicide care into seven elements: Lead, Train, Identify, Engage, Treat, Transition, Improve.
- 2. Expand community-based suicide prevention strategies including:**
  - Reduce access to lethal means through supporting policy changes, safety and prevention education, distribution of lock devices such as cable gun locks.
  - Clinical and community suicide prevention and resiliency trainings following evidence based or proven effective curricula such as Question Persuade Refer (QPR), Counseling on Access to Lethal Means (CALM), Creating Safety, Youth Mental Health First Aid (YMHFA) and more.

- Support improved coordination between community crisis resources to enhance the support callers receive.

### **Reduce frequent mental distress including anxiety and depression**

3. **Deploy upstream mental well-being resources and digital tools** - Provide the *Talk to Tweens* program and materials to schools, districts and community partners. Provide training including Counseling on Access to Lethal Means (CALM), Question, Persuade, Refer (QPR) and others. Enable the community to access digital tools such as myStrength and Connect Care. Provision of prevention and Early Intervention Training for all or identified community members at risk reduces mental distress and improves access to effective, evidence-based strategies to reduce risk and increase protective factors for individuals and families.
4. **Improve access to behavioral healthcare through the Behavioral Health Network (BHN) and refine current data collection practices to better measure and report on impact and reach** - The BHN provides free or reduced cost behavioral health treatment access to Individuals and families without insurance or who are underinsured and at or below 400% of the federal poverty limit, who otherwise wouldn't be able to access treatment. Enhanced data collection and analysis will allow for strengthened outcome measurement.
5. **Improve caregiver mental well-being** - Expand self-care, help-seeking, peer support and QPR training for Intermountain Caregivers; develop and implement a comprehensive caregiver suicide prevention and postvention plan. Collaborate with internal and external partners to create self-care, peer support, and help seeking health system messaging campaign that can be shared with and used by other health systems.

### **Decrease opioid misuse**

6. **Expand opioid harm reduction strategies including:**
  - Increase opioid antagonist (naloxone) education and availability through a collaboration with Utah Naloxone, whose mission is to increase naloxone accessibility in Utah.
  - Provide community-based education and distribution of naloxone through the Intermountain opioid education speakers bureau.
  - Support the harm reduction strategies of the Utah Syringe Exchange Program in partnership with Utah Naloxone and the Utah Department of Health and Human Services.
7. **Intermountain Opioid Stewardship:**

- Partner with the Behavioral Health Clinical Program on buprenorphine induction expansion within Emergency Department settings that include warm hand-offs to community treatment partners to continue the patients opioid use disorder treatment.
- Partner with the Intermountain Health Emergency Services Clinical Program as they work to meet the Utah Department of Health / Comagine Health *Levels of Care for Treating Overdose and Opioid Use Disorder in Utah Emergency Departments and Hospitals*. This includes, but is not limited to:
  - Universal substance use disorder screening for all Emergency Department patients
  - Education to all patients prescribed opioids on safe use, storage and disposal
  - Dispense naloxone for patients who are at risk utilizing a clear protocol
  - Offer Peer Support Services in the ED as available
  - Provide active referral to appropriate community partners, such as treatment, peer support, etc.
  - Provide active referral to syringe exchange program as appropriate and available
  - Develop and implement policies and procedures for buprenorphine initiation
- Monitor opioid prescribing by Intermountain providers to ensure continued decreases in quantities prescribed.
- Monitor high dose opioid prescribing to ensure the overall percent of high dose prescribing stays below threshold. Measured in Morphine Milligram Equivalent (MME)  $\geq 90$  MME.
- Monitor the percentage of opioid prescriptions that co-prescribe naloxone to ensure the percentage continues to increase.

## Improve Chronic and Avoidable Health Outcomes

### **Why are we focusing on prediabetes, high blood pressure, immunizations, vaping, and unintentional injury 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.<sup>12</sup> For many individuals, taking small steps, such as losing five to seven percent of their weight or increasing physical activity, can help them delay or prevent the development of diabetes. Without making lifestyle changes, approximately half of individuals diagnosed with prediabetes progress to diabetes within ten years.

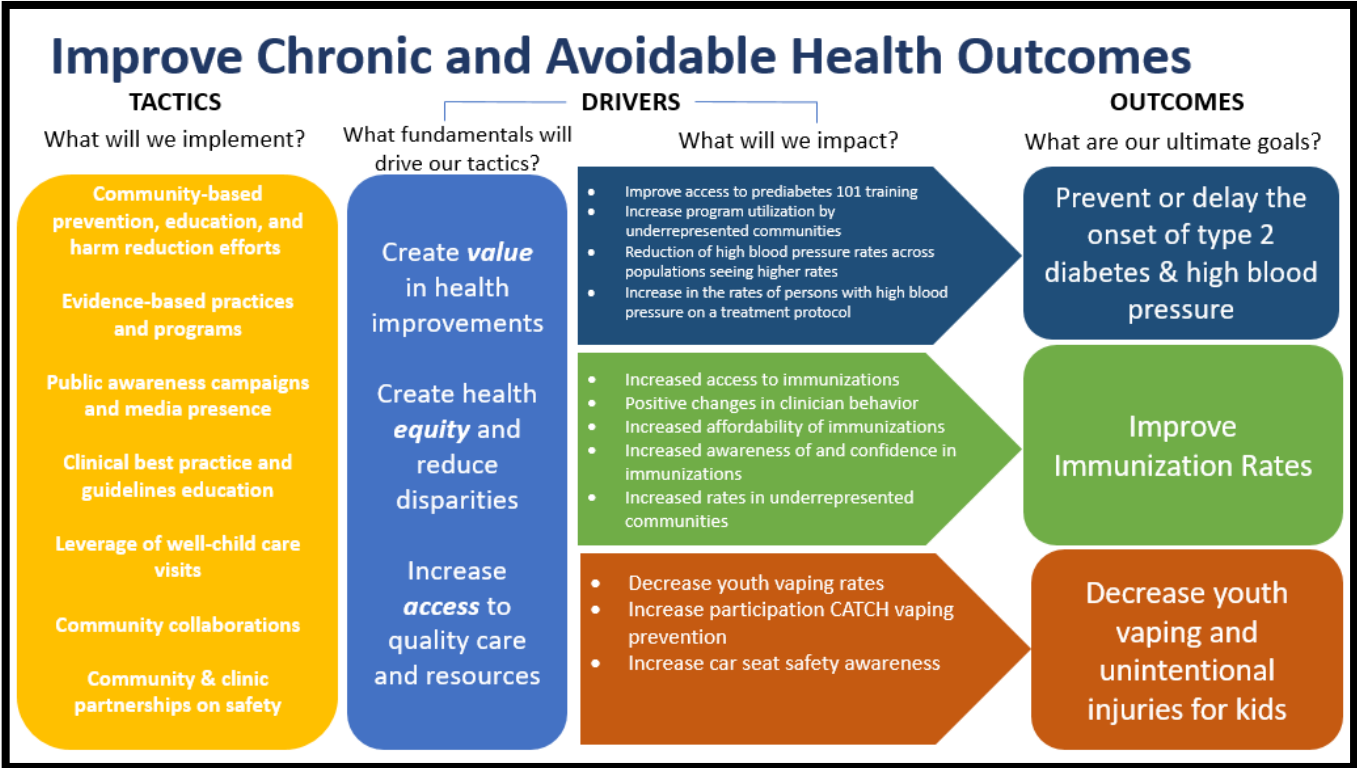
High blood pressure (hypertension) is an important risk factor for heart disease and stroke, both of which continue to be a leading cause of death. In most cases, it can be effectively managed with medication and lifestyle changes (such as diet, exercise, and abstaining from tobacco use). Treatment works best when high blood pressure is identified early. Because high blood pressure does not produce symptoms, regular screening is recommended. Recently revised guidelines lowered the cutoff for what counts as high blood pressure, which means that even more people may unknowingly have it. In 2016-2017, the total direct cost of high blood pressure was \$52.4 billion. By 2035, it is projected that the total direct costs of high blood pressure could reach \$220.9 billion.<sup>12</sup>

Immunizations are one of the most cost-effective health prevention measures. The development of vaccinations has been cited by the U.S. Public Health Service as one of the Ten Great Public Health Achievements of the 20th Century. Vaccines play an essential role in reducing and eliminating the 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. Flu immunization continues to be of the highest importance, particularly in the presence of potential co-infection with COVID-19. We continue to support community partners, state and local health departments, and other private entities through a Intermountain led immunizations collaborative with the purpose to share data and resources to increase statewide vaccinations. Flu vaccination has been made available to uninsured adults for free, and the administration fee for children in the VFC program was eliminated to decrease barriers to receiving the vaccine.

Electronic cigarettes or vape products are battery-powered devices that turn liquids into aerosol. They are marketed under a variety of different names but are mostly referred to as electronic cigarettes, e-cigarettes, vape products, mods, or tanks. They may also be known as JUUL, Vuse, Suorin, MarkTen, and Blu. The liquids frequently contain nicotine and flavors. Since 2011, Utah has seen a sharp increase in vape product experimentation and use among youth and young adults. Given the uncertain public health impact of vaping and the potential for increasing nicotine addiction among young people, monitoring the use of vape products and enforcing and strengthening policies that regulate youth access are emerging public health priorities.

In both Utah and Idaho, unintentional injuries in children is a leading cause of death and life-long disability. In Utah, unintentional injuries account 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, suffocation, and drowning (with falls being the leading cause of injury deaths for Utahns individuals 65 and older).



**Improve Chronic and Avoidable Health Outcomes Priority Areas**

**Prevent high blood pressure and Diabetes**

1. **Increase screening for diabetes and high blood pressure** - Intermountain collaborates with nonprofit organizations and Local Health Departments to provide prediabetes screenings using the CDC prediabetes risk test and identify those at risk for type 2 diabetes. Those identified as high risk receive preventive intervention through educational materials and coordination of health resources
2. Increase chronic disease self-management program utilization through collaboration with state and county health departments, and community organizations focused on underrepresented community members. Intermountain participates in the Utah Live Well Coalition aimed at fostering partnerships and

supporting organizations providing self-management programs. We provide mentorship for newly implementing organizations and marketing support for classes being offered as well as connections and resources across the system.

3. Improve access to primary care treatment for chronic diseases
4. Deploy Community Health Workers (CHWs)

### **Increase immunizations**

5. Improve flu and HPV immunization rates through collaborative work with local and state government entities, community partners and private businesses. Intermountain maintains and supports an immunization community collaborative with the aim to implement best practices for the administration of vaccines and reduce vaccine preventable diseases and their consequences in the community. For this reason, we support the creation and distribution of marketing materials, develop education and distribute information, share data and quality metrics across organizations, and provide connection and resources across our geographic areas to increase equitable immunizations efforts as needed.

### **Decrease unintentional injuries for kids**

6. Hold on to Dear Life is the system Injury Prevention program for children. It includes nine safety areas including car seats, heat stroke prevention, backover prevention, helmets, ATV, window, water, pedestrian safety and emotional wellbeing. By partnering with hospitals, clinics, and other organizations around the region, we provide education and safety gear to prevent avoidable injuries.

### **Decrease youth vaping**

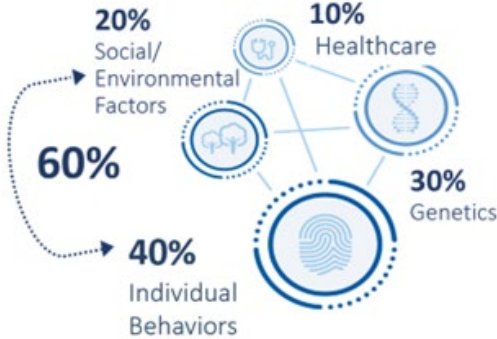
7. Vaping among youth in Utah has increased dramatically over the past decade. We are bringing an evidence-based vaping prevention program to the state, funding training for school districts and health departments employees and offering technical support for implementation. We are also active participants on a tobacco-free coalition that is working on vaping prevention. We are supporting messaging campaigns to education the public and providers about vaping and how to talk address the topic with youth.

## **Address & Invest in Social Determinants of Health**

### **Why We Are Focusing on the Social Determinants of Health**

Addressing social determinants of health is important for improving health and reducing health disparities. Though healthcare is essential to health, it is less of a determinant or driver than other factors. Research shows that health outcomes are driven by an array of factors, including underlying genetics, health behaviors, social and environmental factors.

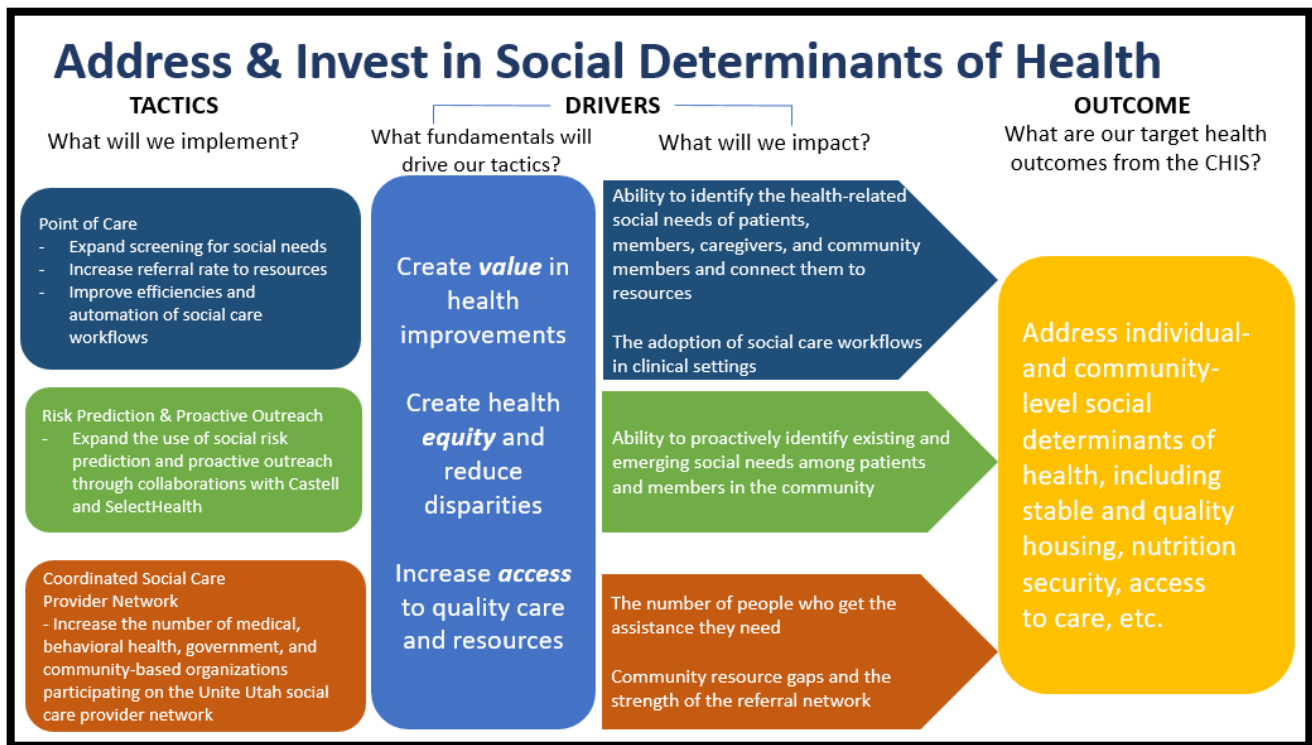
Numerous research studies consistently show that health behaviors, such as exercise, diet, and smoking, and social and economic factors are the primary drivers of health outcomes. Addressing social determinants of health is not only important for improving overall health, but also for reducing health disparities that are often rooted in social and economic disadvantages.



Analysis of public health data by demographic characteristics is essential to the reduction and elimination of health disparities. The Minority Health and Health Disparities Research and Education Act of 2000 describes health disparities as differences in "the overall rate of disease incidence, prevalence, morbidity, mortality, or survival rates in the population as compared to the health status of the general population."<sup>15</sup> The definition can be applied to any demographic group, not just racial/ethnic minorities. Analysis by demographic characteristics also shows at what age certain diseases and conditions typically appear.

Health equity is the principle of pursuing the highest possible standard of health for all while focusing on those with the greatest obstacles. Social determinants have a large impact on disparities and health equity. In order to improve health outcomes for those with disparities, social determinants often need to be targeted for intervention and prevention efforts.

At Intermountain, we see ourselves as an anchor institution in the communities we serve. This work serves as a backbone for our strategy and initiatives in Social Determinants of Health. The Health Anchor Network defines an anchor mission approach as “a commitment to intentionally apply an institution’s long-term, place-based economic power and human capital in partnership with the community to mutually benefit the long-term well-being of both.” Under this framework, we developed strategies to link our assets to support health and well-being and equitably address health disparities. Many of these activities inform and affect our daily business practices to further improve community health.



## Address & Invest in Social Determinants of Health Priority Areas

**Improve high school graduation rates, stable and quality housing, air and water quality, nutrition security, and equitable hiring and sourcing practices.**

1. **Expand identification of social needs through screening and analytics** - Intermountain primary care clinics and emergency departments, and community partners, such as Federally Qualified Health Centers and Local Mental Health Authorities, work together to identify patients with social needs and connect them to community and government resources. We are expanding the use of digital platform to manage social care referrals and community health workers to provide additional assistance to those at higher risk.
2. **Implement social care assistance fund** - this initiative intends to create a funding mechanism with an accompanying clinical workflow that allow caregivers and community partners (e.g., Federally Qualified Health Centers), to address urgent patient needs that cannot immediately be met through community resources. These short-term needs would then, if needed, allow time to connect patients to longer term community-based solutions

(e.g., housing assistance, utility assistance, etc.). Closing this gap has the potential to prevent adverse outcomes for patients (e.g., admission, ER visit, decline in health, etc.).

- a. **Increase healthcare coverage and access** - with an emphasis on collaboration with other health systems, insurers, and community-based organizations, we focus on partnership, procedure and policy that expands healthcare coverage to improve access to care. Internal to Intermountain Health, we are piloting an effort of enrollment in pediatric ambulatory care settings as an extension of our existing enrollment process in acute care settings
- b. **Improve nutrition security** – caregivers,, patients, SelectHealth members, and community are the key focus areas for nutrition security work. Patient screening and resource referral are currently underway. The process of selecting a vendor to pilot a nutrition security-based intervention is in progress. Community based efforts will be supported through funding and close collaboration with community-based organization and state and local health departments
- c. **Invest in affordable housing** – Intermountain Health’s place-based investing strategy seeks to address the social determinants of health by investing in local projects and organizations that support upstream drivers of health outcomes. The three current areas of focus include affordable housing, financial inclusion, and employment. These investments are made with local entities in our service areas to ensure that our efforts are aligned with the objectives of the community and to leverage local relationships and existing trust. Over the next four years, \$30 million will be invested in the communities we serve, supporting thousands of units of affordable housing and financial wellness for hundreds of households.
- d. **Improve educational outcomes** – the Intermountain Community Care Foundation has established a grant fund specifically to support evidence-based practices and programs to encourage education innovation in Utah. We are also seeking community-based collaboratives to build community capacity, improved digital infrastructure and solutions including school telehealth, and establishing hiring pathways for the Healthcare Career Academy.
- e. **Deploy local, equitable and diverse sourcing and hiring to create well-being** – Through our Anchor initiative, we have setup relationships with community partners to hire individuals who face barriers to employment and create sustainable pathways for underrepresented individuals to find training and job opportunities within our system. To increase diverse and local sourcing partners, we have increased the diversity within our suppliers through training and equitable access to our supply chain.



- f. **Improve sustainability and environmental health conditions** – We have broadened our focus on sustainability to reduce our carbon footprint and water utilization while continuing our efforts on efficient energy use, waste reduction and clean air, as well as reduction in use of chemicals and gases of concern for the environment. These programs will be supported through funding and collaborating with local programs and through internal system initiatives.

### **Decrease Trauma**

3. **Expand and improve Intimate Partner Violence (IPV) screening in clinics** - Between 2021 and 2022, Intermountain Health made significant progress in training on and screening for domestic violence in the clinical setting. The United States Preventive Services Task Force (USPSTF) recommends that clinicians screen for intimate partner violence (IPV) in women of reproductive age and provide or refer women with positive screening results to ongoing support services. Our community health and clinical teams have trained 15 clinics and their associated providers to screen for IPV. There is an actionable strategy for expanding and improving upon this training in a minimum of three additional clinics.
4. **Create and disseminate sexual assault (SA) response education for providers** - Collaboration between Intermountain Health providers, community organizations, domestic violence service providers, and Sexual Assault Nurse Examiners (SANE) nurses is crucial for caring for patients who have experienced sexual assault. This network of partnerships ensures the patient is well-informed and placed at the center of their care plan. There is a continued commitment to maintain up-to-date response protocols and address the unique needs of the survivors cared for at Intermountain Health locations.

## **Monitoring and Evaluation**

Intermountain Health will monitor and evaluate the goals and strategies in the Implementation Strategy to track progress and report anticipated impacts. A practical and ongoing monitoring process will allow course correction if the implementation is not achieving the intended outcomes. Evaluation aims will focus on the impact of the strategies and determine whether they are achieving the desired improvements within equity, value, and access. Community Health is ultimately responsible for implementing this plan and has in place an evaluator role to support reporting a balanced set of measures and follow a logical step-by-step evaluation process. Monitoring and evaluating the initiatives includes: defining the data source and points for process and impact measures, data collection methods and analysis, reporting results, and evaluation review.

The monitoring process will be tailored to each strategy and will include the collection and documentation of data to track the performance of activities presented in Appendix B. This work

is strongly influenced by the Intermountain Operating Model referenced above. This model is a fully integrated framework that aims to drive a culture of Continuous Improvement to maximize benefit for all members of the communities we serve. It provides a complete management system to align leaders, caregivers and community in achieving common goals. To determine baseline measures of performance indicators, we used data collected from the previous implementation strategy metrics and indicators wherever possible. The Community Health team will monitor performance measures monthly to ensure progress is being made in each area.

Evaluation methods will build upon monitoring efforts to measure short- and long-term impact on health outcomes, equity, value, and access. A step-by-step evaluation plan will outline process and outcome-based metrics, in alignment with each strategy's logic model. This structure of evaluation methodology and logic models allows adherence to standards and demonstration of credible outcomes.

Learnings will be used to inform ongoing practices as well as future recommendations. Goal progress and impact will be reported annually for each hospital and the Intermountain system. Results and lessons learned will be shared with stakeholders in all hospitals and their communities and will inform future Community Health Needs Assessment and Implementation Strategy cycles.

## **Intermountain Allocated Resources**

Intermountain has committed significant resources to address the health priorities for each hospital community. Budget for the community health improvement initiatives includes:

- Designing and implementing public awareness messaging campaigns
- Developing Continuing Medical Education (CME) courses and materials
- Providing staff for community-based program implementation
- Providing scholarships for priority related education to community providers and partners
- Purchasing materials and supplies to support implementation strategies (e.g. naloxone kits, gunlocks)
- Strategic cash and in-kind contributions to community nonprofit agencies to support efforts to address health priorities
- Measurement and evaluation of each initiative by existing staff and/or outsourced experts

Intermountain is committed to addressing these key priorities throughout its system for the benefit of all (caregivers, patients, and community members). The community health initiatives described are in alignment with evidence-based care process models developed by clinical programs and services. Community Health and Intermountain's clinical and operational teams will work together to ensure these community health strategies improve the health of the communities we serve.

## **Approval**

The Affordable Care Act (ACA) requires the CHNA and Implementation strategies 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”.<sup>1</sup>

IHC Health Services, Inc. is governed by a Board of Trustees. The Board of Trustees oversees Intermountain’s mission in the communities it serves, its hospital operations, and its local community boards. While the Board of Trustees has delegated to these local community boards the oversight of patient safety, quality, and experience at their respective facilities as a local governing body, the Board of Trustees is the authorized body that has approved and adopted the CHNA and Implementation Strategies in accordance with the Affordable Care Act.

## **Conclusion**

Intermountain’s implementation strategies were developed following the Intermountain Operating Model and were reviewed by geographic leadership and approved by the IHC Health Services Board of Trustees as required by the Affordable Care Act (ACA). Intermountain will conduct its next CHNA in 2025 and will develop health improvement strategies to address the identified health priorities from that assessment.

## **Acknowledgement**

This implementation strategy is the result of collaboration and support of state and Local Health Departments, state and Local Mental Health and Substance Abuse Authorities, school districts, universities, safety net providers, local not-for-profit human service agencies, laws enforcement, community members and other experts. We recognize the invaluable contribution and support from Intermountain’s clinical experts, programs and services. Many additional collaborators will be important to the successful implementation of the community health improvement plan strategies. Intermountain staff is grateful for the support of community members and agencies for their participation in developing the community health strategies throughout our service area in Utah and Southeast Idaho. We look forward to working together to improve community health.

## **For more information about the implementation strategy:**

Lisa Nichols, Associate Vice President, Intermountain Healthcare,

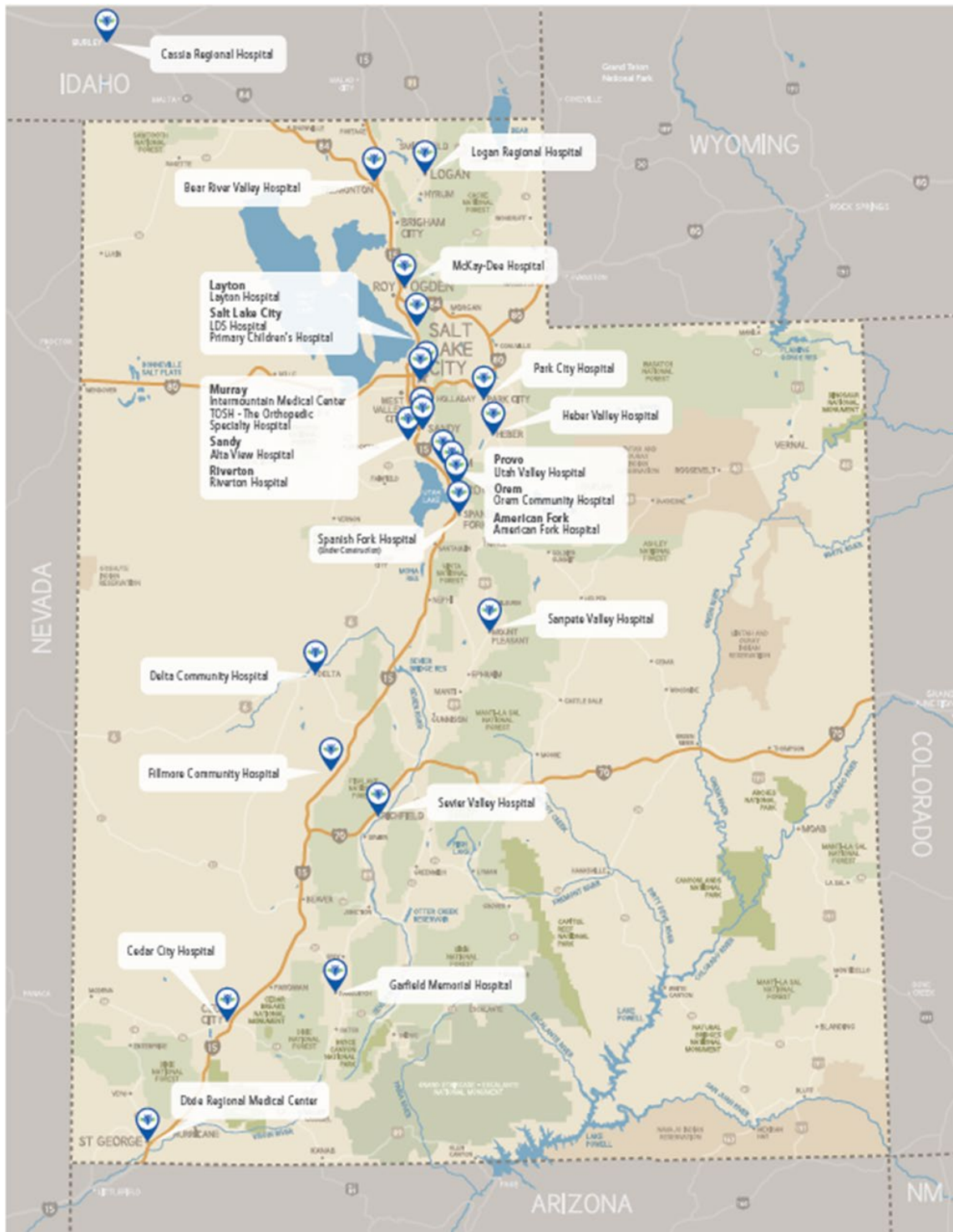
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<sup>1</sup> 501(r) Federal Register Vol 79, No 250, Department of Treasury

## Appendix A Map Intermountain Hospitals in Utah and Cassia, Idaho



## Appendix B Fillmore Community Hospital Implementation Strategies

Located in the rural community of Fillmore, Utah, the hospital has 19 licensed beds and is one of two hospitals in Millard County. This Critical Access Hospital offers a broad spectrum of inpatient and outpatient medical services. In 2022, they participated in a community health needs assessment to understand how to help people live the healthiest lives possible. The hospital collaborated with key partners, including public health experts, to identify health indicators, gather community input, and determine the significant health needs to address over the next three years.

| Priority: Improve Mental Well-Being   |   |   |
|---|---|---|
| Activities  | Community Partners  | Enterprise/Hospital Resources   |
| <b>Target Outcome: Reduce the rate of deaths by suicide</b>   |   |   |
| <ul style="list-style-type: none"> <li>Expand training to community and focused strategies for caregivers</li> <li>Reduce the risk of access to lethal means</li> <li>Behavioral Health crisis support coordination (Behavioral Health Navigation line, ARCS line, SUD Assessment and Referral Line) with community (211) and crisis resources (988)</li> </ul> | <ul style="list-style-type: none"> <li>Utah Department of Health &amp; Human Services and Public Safety:               <ul style="list-style-type: none"> <li>Violence and Injury Prevention Program</li> <li>Office of Substance Use and Mental Health</li> <li>Office of the Medical Examiner</li> </ul> </li> <li>Utah Suicide Prevention Executive Committee</li> <li>Central Utah Health Department</li> <li>Central Utah Counseling Center</li> <li>State and local suicide prevention coalitions</li> <li>Crisis Intervention Teams- Utah</li> </ul> | <ul style="list-style-type: none"> <li>Community Health Improvement (CHI) budget for training</li> <li>Lethal means restriction: gun locks/trigger locks/gun safes</li> <li>Behavioral Health Clinical Program Navigation Team</li> <li>Caregiver Mental Well-Being team</li> <li>Community Health Program Manager local geography support for trainings and lethal means implementations</li> <li>Intermountain Community Care Foundation (ICCF) Child &amp; Family Mental Well-Being (C&amp;FMWB) funds to support activities with community partners</li> <li>Support the implementation and expansion of Caregiver mental well-being efforts</li> </ul> |
| <b>Target Outcome: Reduce the rate of deaths by opioid overdose</b>   |   |   |

|  |   |  |
|--|---|--|
| <ul style="list-style-type: none"> <li>• Reduce overdose harm</li> <li>• Opioid Community Collaborative implementation</li> <li>• Community naloxone distribution</li> </ul> | <ul style="list-style-type: none"> <li>• Utah Department of Health &amp; Human Services and Public Safety: <ul style="list-style-type: none"> <li>○ Violence and Injury Prevention</li> <li>○ Syringe Exchange Program</li> <li>○ Office of Substance Use and Mental Health</li> <li>○ Office of the Medical Examiner</li> </ul> </li> <li>• Utah Attorney General Opioid Task Force</li> <li>• Central Utah Health Department and Substance Abuse Authorities, Prevention/Communities That Care coalitions</li> <li>• Opioid Community Collaborative</li> <li>• Utah Naloxone</li> </ul> | <ul style="list-style-type: none"> <li>• Community Health Improvement (CHI) budget for charitable contributions to UDOH. Utah Naloxone and other partners as identified</li> <li>• Hospital/care site installation of Know Your Script messaging</li> <li>• Intermountain Health Pharmacy Service Line</li> <li>• Community Health, Pain Services, Emergency Medicine and other service lines support for internal opioid stewardship initiatives</li> <li>• Community Partners for Opioid Overdose Awareness and Naloxone Training</li> </ul> |
|--|---|--|

**Target Outcome: Reduce frequent mental distress in adults and youth**

|   |  |   |
|---|--|---|
| <ul style="list-style-type: none"> <li>• Increase Utilization of Digital tools</li> <li>• Mental Health Institute Center of Excellence</li> <li>• Primary Children’s Hospital Talk to Tweens Expansion</li> <li>• Behavioral Health Network implementation/expansion</li> </ul> | <ul style="list-style-type: none"> <li>• Utah Department of Health</li> <li>• Central Utah Health Department</li> <li>• Central Utah Counseling Center</li> <li>• Local suicide and substance use prevention coalitions/Communities That Care coalitions</li> <li>• State Board of Education</li> <li>• Millard School District</li> <li>• Behavioral Health Network Partner organizations</li> <li>• PTA</li> </ul> | <ul style="list-style-type: none"> <li>• Behavioral Health Clinical Programs partnership on digital tools / budget</li> <li>• Intermountain Community Care Foundation (ICCF) funding for Behavioral Health Network (BHN) BHN implementation for uninsured/underinsured</li> <li>• Local hospital Behavioral Health Patient Navigators for BHN</li> <li>• Partnership with Weber Human Services</li> <li>• Community Health Implementation (CHI) funding or ICCF funding to support local coalitions/schools/district</li> </ul> |
|---|--|---|



|  |  |   |
|--|--|---|
|  | <ul style="list-style-type: none"> <li>• Utah Collaborative for School Mental Health</li> <li>• Utah Prevention Network</li> </ul> | <p>implementation of proven effective strategies</p> <ul style="list-style-type: none"> <li>• Staffing and funding to support the implementation of Caregiver Well-Being initiatives</li> <li>• Funding to support Primary Children’s Health Talk to Tweens curriculum</li> </ul> |
|--|--|---|

| <b>Priority: Improve Chronic &amp; Avoidable Health Outcomes</b>   |  |  |
|--|--|--|
| <b>Activities</b>  | <b>Community Partners</b>  | <b>Enterprise/Hospital Resources</b>   |
| <b>Target Outcome: Prevent high blood pressure and diabetes</b>  |  |  |
| <ul style="list-style-type: none"> <li>• Build and deploy a comprehensive and sustainable prediabetes program</li> <li>• Create linguistically appropriate &amp; culturally relevant programs</li> <li>• Leverage collaborations with community organizations</li> <li>• Utilize a targeted marketing &amp; public awareness strategy</li> <li>• Increase high blood pressure awareness and access to resources for targeted populations</li> <li>• Understand race, ethnicity and preferred language barriers to diagnosing and managing high blood pressure</li> </ul> | <ul style="list-style-type: none"> <li>• Omada</li> <li>• Aligned non-profit organizations <ul style="list-style-type: none"> <li>○ Youth Futures</li> <li>○ Holy Cross Ministries</li> <li>○ Community Health Connect</li> <li>○ Comunidades Unidas</li> </ul> </li> <li>• Local clinics</li> <li>• Central Utah Health Department</li> <li>• Utah Department of Health and Human Services</li> <li>• Association for Utah Community Health</li> <li>• Utah State University Extension</li> <li>• American Heart Association Go Red for Women</li> <li>• Utah Million Hearts Coalition</li> </ul> | <ul style="list-style-type: none"> <li>• Office of Health promotion Wellness (OHPW) provides prediabetes 101 content for classes in the community and Coordinate Omada with Castell Health</li> <li>• SelectHealth</li> <li>• Acute Care</li> <li>• Ambulatory Care</li> </ul> |
| <b>Target Outcome: Increase Immunization Rates, decrease youth vaping, decrease unintentional injury for kids</b>  |  |  |

|  |   |   |
|--|---|---|
| <ul style="list-style-type: none"> <li>• Immunization at well-child checks</li> <li>• Community &amp; clinic partnerships on kids safety</li> <li>• Car seat safety</li> <li>• Youth vaping prevention program</li> <li>• Community pediatric nutrition classes</li> </ul> | <ul style="list-style-type: none"> <li>• Immunizations Community Collaborative</li> <li>• Safe Kids</li> <li>• See Through the Vape</li> <li>• PTA</li> <li>• State and Local HDs</li> <li>• Millard School District</li> <li>• FQHCs</li> <li>• Community Coalitions</li> <li>• East Millard Prevention Coalition</li> </ul> | <ul style="list-style-type: none"> <li>• Immunizations Operations Committee</li> <li>• Castell</li> <li>• Pediatric Medical Group</li> <li>• Trauma Services</li> <li>• Nutrition Services</li> <li>• SelectHealth</li> </ul> |
|--|---|---|

| Priority: Address & Invest in Social Determinants of Health   |   |   |
|---|---|---|
| Activities  | Community Partners  | Enterprise/Hospital Resources   |
| <b>Target Outcome: Increase social determinants of health screening and referrals and improve nutrition security</b>  |   |   |
| <ul style="list-style-type: none"> <li>• Increase Social Determinants of Health (SDOH) screening and referral rates care clinics in Utah and Idaho</li> <li>• Expand the use of social risk prediction and proactive outreach</li> <li>• Increase the number of food assistance programs receiving referrals</li> </ul> | <ul style="list-style-type: none"> <li>• County WIC/SNAP offices</li> <li>• Community-based food assistance organizations</li> <li>• Utahns Against Hunger</li> <li>• Unite Us</li> <li>• Utah Food Bank</li> </ul>   | <ul style="list-style-type: none"> <li>• Medical Group</li> <li>• Castell</li> <li>• DTS</li> <li>• Acute Care Management</li> <li>• R1</li> <li>• Phreesia</li> <li>• Develop/collaborate with partners on programs to increase SNAP and WIC enrollment</li> <li>• Provide reliable food pantry for Children’s Health community</li> </ul> |
| <b>Target Outcome: Decrease trauma</b>  |   |   |
| <ul style="list-style-type: none"> <li>• Expand and improve intimate partner violence screening in Clinics</li> <li>• Disseminate and standardize provider education on sexual assault response protocols</li> </ul>  | <ul style="list-style-type: none"> <li>• Utah Domestic Violence Coalition</li> <li>• Utah Coalition Against Sexual Assault</li> <li>• Peace House</li> <li>• Wasatch Forensic Nurses</li> <li>• The DOVE Center</li> <li>• Canyon Creek Services</li> </ul> | <ul style="list-style-type: none"> <li>• Medical Group</li> <li>• Behavioral Health Clinical Programs</li> </ul>  |
| <b>Target Outcome: Deploy sourcing and hiring to create well-being, improve educational outcomes</b>  |   |   |

|   |   |  |
|---|---|--|
| <ul style="list-style-type: none"> <li>• Expand hiring pathways and connect new community partners</li> <li>• Pathways for hiring including the Healthcare Career Academy</li> <li>• Career development planning</li> <li>• Mentoring and peer support</li> </ul>   | <ul style="list-style-type: none"> <li>• Health Anchor Network National Collaboration</li> <li>• U of U Pediatrics</li> <li>• Millard School District</li> <li>• University of Utah</li> <li>• Weber State University</li> <li>• Latinos In Action</li> <li>• Department of Workforce Services</li> <li>• Youth Works, Youth Futures, One Refugee</li> </ul>  | <ul style="list-style-type: none"> <li>• Phlebotomy</li> <li>• Supply Chain</li> <li>• Environmental Services</li> <li>• Human Resources</li> <li>• Children’s Health</li> <li>• Food Services</li> <li>• Human Resources</li> <li>• Pharmacy Services</li> </ul>                        |
| <b>Target Outcome: Invest in affordable housing</b>   |   |  |
| <ul style="list-style-type: none"> <li>• Invest in quality affordable housing in all our regions through new construction or preservation</li> <li>• Provide access to affordable and scarce financial resources</li> <li>• Improved access to credit and promote financial stability</li> <li>• Reduced utility bills or other expenses</li> </ul> | <ul style="list-style-type: none"> <li>• Health Anchor Network</li> <li>• Utah Housing Coalition</li> <li>• Local Housing Coalitions</li> <li>• Switchpoint- Studio 6</li> <li>• Utah Housing Preservation Fund</li> <li>• New West Community Capital</li> <li>• Community Investment Management</li> <li>• Triple Bottom Line Fund</li> <li>• Rocky Mountain Homes Fund</li> <li>• Catalyst</li> <li>• Utah Valley Family Support Center</li> <li>• First Step House</li> <li>• The Road Home</li> </ul> | <ul style="list-style-type: none"> <li>• Homecare</li> <li>• SelectHealth</li> <li>• Hospital administration</li> <li>• Behavioral Health</li> <li>• Integrated Management</li> <li>• Human Resources</li> </ul>   |
| <b>Target Outcome: Improve environmental health conditions</b>  |   |  |
| <ul style="list-style-type: none"> <li>• Increase expense with diverse and local suppliers</li> <li>• Increase local purchasing trainings targeting local and diverse vendors</li> <li>• Remove concern chemicals from sourced products</li> </ul>  | <ul style="list-style-type: none"> <li>• Utah Black Chamber</li> <li>• Wasatch Resource Recovery</li> <li>• Local Health Departments</li> <li>• University of Utah</li> <li>• Utah Clean Air</li> <li>• Health Anchor Network</li> </ul>  | <ul style="list-style-type: none"> <li>• Supply Chain</li> <li>• Office of Sustainability</li> <li>• Legal and Compliance</li> <li>• Hospital administrators</li> <li>• Environmental Services</li> <li>• Fleet management</li> <li>• Medical Group</li> <li>• Data analytics</li> </ul> |

|   |   |   |
|---|---|---|
| <ul style="list-style-type: none"> <li>• Eliminate PVC and DEHP from medical product categories</li> <li>• Increase solar use</li> <li>• Increase alternate fuel vehicle use</li> <li>• Increase renewable energy use</li> <li>• Community electronics and battery recycling</li> <li>• Decrease desflurane use</li> <li>• Replace single-use, disposable products from medical products</li> </ul> | <ul style="list-style-type: none"> <li>• Clean Air Task Force</li> <li>• Elizabeth’s Catering</li> <li>• Schmidt’s Pastry Cottage</li> <li>• Julie Ann Caramels</li> <li>• Kumbayah Kitchen</li> </ul>  | <ul style="list-style-type: none"> <li>• Waste Management</li> <li>• Facilities management</li> </ul>   |
| <b>Target Outcome: Increase healthcare coverage and access</b>  |   |   |
| <ul style="list-style-type: none"> <li>• Support community-based efforts to increase enrollment in health care coverage</li> <li>• Support Telehealth expansion in schools and community-based organizations</li> <li>• Partner to reduce Medicaid churn</li> </ul>   | <ul style="list-style-type: none"> <li>• Association for Utah Community Health (AUCH)</li> <li>• Equitable Health Insurance Committee (AUCH)</li> <li>• Take Care Utah</li> <li>• Voices for Children</li> <li>• Utah Department of Health</li> <li>• University of Utah</li> </ul> | <ul style="list-style-type: none"> <li>• Grant funding to FQHCs and school-based clinics</li> <li>• SelectHealth</li> <li>• Data analytics</li> </ul> |



  
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