UNIVERSITY NEUROPSYCHIATRIC INSTITUTE

Community Health Needs Assessment
Implementation Plan
2018–2020

HEALTH
UNIVERSITY OF UTAH

BACKGROUND

University of Utah Neuropsychiatric Institute (UNI) is dedicated to the de-stigmatization of mental illness through excellence and compassionate clinical care, collaborative research, community outreach and education related to behavioral and mental health. UNI is committed to patient-centered care and an approach that addresses all aspects of the individual—biological, psychological, social and spiritual—essential to achieving balance in mental health. UNI treats patients of all ages and stages of life, providing child, adolescent, adult and geriatric psychiatric care and substance abuse treatments. UNI is part of the University of Utah Healthcare and the University of Utah Hospitals & Clinics (UUHC).

University of Utah Neuropsychiatric Institute provides care in a 170-bed inpatient facility that is designed to offer a safe and healing environment where personal insight and recovery begins. The University of Utah School of Medicine's Department of Psychiatry is located on-site and provides patients with expertise and advanced care not available elsewhere in the Intermountain West. In addition to an inpatient unit, UNI operates a significant outpatient practice. UNI physicians are actively engaged in teaching and research, activities that enhance their ability to provide the latest advances in psychiatry.

COMMUNITY NEED AND COMMUNITY BENEFIT

University of Utah Health strives to identify and address the health and wellbeing-related needs of our immediate and regional communities through multiple approaches.

- UNI holds to the strong belief that essential mental health care services should be accessible to all residents of the community it serves, without regard to race, religion, gender, national origin, physical or mental disability, veteran status or ability to pay. UNI has established a financial assistance policy to ensure this takes place for those insured and underinsured and uninsured alike. Discounts of up to 100% of charges are offered on a sliding scale. This is based on income as a percentage of the Federal Poverty Level guidelines, available liquid assets, and charges for services rendered. The charges associated with patients who meet UNI's guidelines to qualify as charity care are not pursued. The total of this charity care is approximately $7.7 million annually. Additionally, UNI writes off approximately $6.7 million in bad debt.
- Although UNI incurs shortfalls between its established charges for services and amounts paid by several state and federal programs, these shortfalls are not included as charity care. Additionally, UNI provides a number of services that are not self-supporting for which collections are less than the costs required to provide the services. These negative margin services greatly benefit uninsured and low-income patients as well as the broader community and are provided as a part of the UNI mission.
- UNI maintains a self-pay discount program in which self-pay patients automatically receive a discount on total charges. This program reduces uninsured patients' liabilities to a level more equivalent to insured patients. The self-pay discounts are approximately $1.3 million annually.
- UNI provides direct service to residents with special health-related needs and those living in under-served communities. Details of these programs are discussed later in this report.

The Patient Protection and Affordable Care Act (ACA), signed into law in March 2010, requires each nonprofit hospital to conduct a Community Health Needs Assessment (CHNA) every three years. After identifying and prioritizing unmet needs, each hospital is required to develop a three-year implementation strategy to address one or more identified community health need. This report documents the process through which UNI conducted the CHNA, the key findings, the identified priorities, and the implementation strategies, and fulfills the requirement to make results of the CHNA available to the public.

COMMUNITY HEALTH NEEEDS ASSESSMENT PROCESS

The focus of the Community Health Needs Assessment (CHNA) was primarily on Salt Lake County (SLCo); however, some of the implications and strategies address a broader region, including the many rural areas in Utah beyond SLCo.

The CHNA process was led by UNI leadership and staff, and was done in conjunction with Utah Public Health Partners (UHIP). UHIP created the Utah Statewide Health Improvement Plan (SHIP) and works collaboratively with numerous health care providers and all 13 local area Health Departments to produce the Statewide Health Assessment 2016 (SWA). Several employees of the University of Utah served on the Utah Health Improvement Plan Coalition that produced the SHIP and the SWA, including Dr. Ana Maria Lopez and Steve Eliason. The mission of the UHIP is "To unite the Utah Public Health System and improve the health of the people of Utah. The SHIP is to promote collaboration and coordination among Utah's public health system partners to improve the health of all who live and work in Utah. The SHIP is a road map to guide collective efforts focused on key priorities and outcomes that, when achieved, will result in a healthier Utah for all. It should promote alignment of individual agency and partner strategic plans and initiatives toward common goals for the health of the people of Utah."

The following groups helped participate in the process of creating the SHIP:

- Community Advisory Panel
- Students/Interns
- State Health Assessment Workgroup
- Utah Health Improvement Plan Operational Committee
- Utah Health Improvement Plan Coalition

Local health districts in Utah that also participated include the following:

- Bear River (Box Elder, Cache, Rich counties)
- Central Utah (Juab, Millard, Piute, Sevier, Wayne, Sanpete counties)
- Davis County
- Salt Lake County
- San Juan
- Southeast Utah (Carbon, Emery, Grand counties)
- Southwest Utah (Garfield, Iron, Kane, Washington, Beaver counties)

- Summit County
- Tooele County
- TriCounty (Daggett, Duchesne, Uintah counties)
- Utah County
- Wasatch County
- Weber-Morgan

The Utah State Health Assessment, conducted by UHIP, is a comprehensive evaluation of population health and the collaborative public health system needs and strengths. The following information discusses the process that was used to gather feedback from community members, evaluate data on health issues, review other reports, and prioritize concerns. The results of the process are also presented.

A statewide needs assessment is conducted on a regular basis to inform the public health system, and healthcare providers, what health issues need resources and collaborative intervention or prevention efforts. The Association of State and Territorial Health Officials State Health Assessment Guidance and Resources was utilized as the model for the process. Several collaborative groups were utilized or newly formed to facilitate these efforts. Data on more than 100 health indicators, broken out, where possible, by geography, age, sex, race, ethnicity, income, and education as well as trends over time were reviewed. Twenty-seven community input meetings were held around the state to gather views on the health issues of greatest need and disparity for a particular area. Other needs assessments conducted by community or health agencies were reviewed. A prioritization methodology was decided upon and applied to the data and information gathered. The top 30 priorities were then taken to a broader Utah Health Improvement Plan Coalition that consists of state and local health agencies, Tribes, partner agencies, and health systems, including UUHC, for further review and prioritization. The Coalition also assisted in the public health system strengths, weaknesses, opportunities, and threats analysis.

Member of the Community Advisory Panel (CAP), which included the Utah Department of Health and the 13 local health departments, worked together to host 27 focus group meetings around the state to gather feedback regarding the health needs and disparities of each community. People from the community were invited to attend. The following groups were invited to be represented:

- State, local, tribal, or regional public health department
- Healthcare advocates
- Nonprofit and community-based organizations
- Academic experts
- Local government officials
- Local school districts
- Healthcare providers
- Community health centers and other safety net clinics

- Private businesses and workforce representatives
- Representatives of medically underserved, low-income, and minority populations
- Members of the public

Attendees were asked what the greatest needs and disparities in their community were regarding:

- Weight and unhealthy behaviors
- Access to healthcare
- Behavioral health access
- Children's health
- Environment

As a result of this process CAP derived a list of seven primary health issues and three health system issues to consider for action as part of the Utah State Health Improvement Plan. Healthcare access was a main area of concern in both the health issues prioritization and the strengths, weaknesses, opportunities, and threats discussion.

The health issues prioritized for consideration for the UHIP include:

- Diabetes/pre-diabetes
- Obesity/physical activity
- Mental health/suicide
- Prescription drug misuse/overdose deaths
- Healthcare access
- Air quality
- Immunizations

The results of the strengths, weaknesses, opportunities, and threats discussion suggest the following areas of the health system may need attention:

- Funding
- Mental/physical health integration
- Improved access to care in rural areas

Data Indicators

More than 100 data indicators were initially chosen by the Community Advisory Panel to review. The State Health Assessment Workgroup later added some measures for the Utah State Health Assessment. The health data was provided, where possible, by trend over time, gender, race, ethnicity, education, income, and local health district.

Review of Other Health Assessments

Needs assessments completed in the past five years were gathered and reviewed so that the committees could benefit from analysis that had already been conducted. Sixteen needs assessments from state health programs, LHDs, health systems, and community agencies were collected, reviewed, and priority areas identified and entered into a matrix. A list of the health assessments reviewed can be found in the Other Data Utilized section of this report.

Prioritization

The State Health Assessment Workgroup did the first round of prioritization. The following criteria were decided on when assessing health indicators:

- Root cause—upstream of health indicators
- Feasibility to change
- Size—how many people it affects
- Seriousness
- Disparities
- Community input
- Return on investment—health & financial

The data for these health indicators were reviewed online by the State Health Assessment Workgroup and the above criteria rated.

The top 30 scoring indicators then were mapped against:

- The Utah Department of Health Strategic Plan: Healthiest People goals
- The CDC 6|18 initiative
- Needs assessments from last five years
- Utah State Innovation Model project priorities
- Community input
- Current State Health Improvement Plan goals
- America's Health Rankings areas of concern

The Utah Health Improvement Plan Coalition then took the reduced list of indicators and discussed and voted on priorities to recommend to the Utah Health Improvement Plan Executive Committee. They were instructed that the purposes of the State Health Assessment and the Utah Health Improvement Plan were to identify statewide health improvement priorities that a) are important to the community and b) will benefit from a collaborative process to share and focus limited resources to improve the health of all Utahans. The Coalition was broken into groups to discuss the priority list for the State Health Assessment and the Utah Health Improvement Plan.

They were asked to consider the following things:

- Size—What issues affect the most individuals?
- Disparities—Are there disparities in the issue that need to be remedied?
- Root cause—Does the issue lead to other health problems (upstream)?
- Seriousness—What is the seriousness of the health issue? (mortality, morbidity)
- Community readiness—What issues have high community interest or demand?
- Feasibility—What issues are we able to impact by working collaboratively?
- Return on investment—Which issues, if improved, would lead to the greatest health and/or financial return on investment?
- Evidence-based practices—Which issues have proven strategies?
- Should specific issues/measures be targeted or should the priorities be more general?

And answer the following questions:

- Which issues cannot be ignored or do you feel are the most urgent, and why?
- Which health issues would benefit from a collaborative approach, and why?
- Which issues are we ready to tackle (considering cultural, political, resources, capacity, community readiness) and why?

HISTORICAL DATA REGARDING MENTAL HEALTH & SUICIDE RATES

The data on the following pages is taken from the SHIP and helped inform UNI's leadership team on the goal of Improving Mental Health and Reducing Suicide:

- The suicide rate is the number of resident deaths resulting from the intentional use of force against oneself per 100,000 population.
- The 2014 Utah age-adjusted suicide rate was 20.5 per 100,000 population. From 2012 to 2014, the Utah age-adjusted suicide rate was 20.8 per 100,000 persons. This is an average of 557 suicides per year.
- In 2014, suicide was the leading cause of death for Utahans aged 10–17 and 18–24. It is the second leading cause of death for those aged 25–44 and the fourth-leading cause of death for Utahans aged 45–64. Overall, suicide is the eighth-leading cause of death for Utahans aged 10+.
- The overall suicide rate in 2015 was 24.5 per 100,000 population, which equated to 609 fatalities. The preliminary numbers for 2016 of 638 fatalities appears to be the highest year on record.
- The suicide rate in Utah has been consistently higher than the national rate.
- In Utah from 2012 to 2014, males had significantly higher suicide rates than females in every age group. Males (31.2 per 100,000 population) had a significantly higher age-adjusted suicide rate compared to females (10.1 per 100,000 population).
- Males aged 75 and older, followed closely by males aged 45–54 and 55–64, had the highest suicide rates among other male age groups. Females 45–54 years of age, followed closely by females aged 35–44 and 18–19, had the highest suicide rates among other female age groups.
- The proportion of adults who reported ever being told they had a depressive disorder varies by a number of population characteristics including age, sex, race, income, and education.
- Adults aged 50–64 had significantly higher rates of depression than other age groups. Conversely, Utahans aged 65 and older had significantly lower rates of depression.
- In Utah during 2014, adult women (26.9%) had significantly higher rates of doctor-diagnosed depression than men (14.8%).
- Hispanic (18.4%), Asian (7.1%), and Hawaiian/Pacific Islander (12.2%) adults reported lower lifetime depression than the state rate during 2012–2014.
- Adults with a household income less than $25,000 (31.6%) and those with a household income $25,000–$49,999 (22.7%) had significantly higher rates of lifetime doctor-diagnosed depression, while adults with household incomes $50,000–$74,999 (18.9%) and those with an income greater than $75,000 (15.7%) had lower rates of lifetime depression during 2012–2014.
- Depression also varied by education during 2012–2014. Utah adults aged 25 and older with a college education (17.4%) had a lower rate of doctor-diagnosed depression than adults with less than a high school education (23.6%), those with a high school or GED (22.0%), and those with some college (23.3%).
- Adults in Salt Lake County (22.4%) local health district (LHD) reported higher rates of doctor-diagnosed depression than the state rate, while adults in Summit County (17.4%), Utah County (19.6%) and Wasatch County (17.0%) LHDs reported lower rates of doctor-diagnosed depression during 2012–2014.

Risk Factors

The 2013 Prevention Needs Assessment showed that students who had been bullied both at school and electronically were at especially high risk, being 5.8 times more likely to have considered suicide.

A lower risk of suicide ideation was found among students who regularly attended religious services or activities and regularly ate a meal with their family. Even among those who had experienced an episode of depressive symptoms in the previous year, students reporting religious involvement and family mealtimes were still less likely to have considered suicide in the past year.

Many conditions and stressors may be related to suicide including:

- Previous suicide attempt(s).
- History of depression or other mental illness.
- Alcohol or drug abuse.
- Family history of suicide or violence.
- Physical illness.
- Local epidemics of suicide.

Utah adults who reported chronic illnesses and/or poor health status in general, were also more likely to have reported having ever been told they had a depressive disorder. It is known that behavioral health problems often co-occur with chronic diseases and may exacerbate poor health outcomes.

Risk factors may include, but are not limited to, genetic or biological factors, stressful situations or major life events, drug use, certain personality traits, lack of social support/ social isolation, and trauma.

The following infographics from the SWA shows data relating to:

- Mental Health Status
- Depression
- Suicide

Mental Health Status

Figure: Percentage of Utahns Aged 18+ With Poor Mental Health by Year, 2009–2014

Trend graph depicts age-adjusted rates.

Map: Adult (18+) Mental Health Status by Local Health District, Utah, 2014

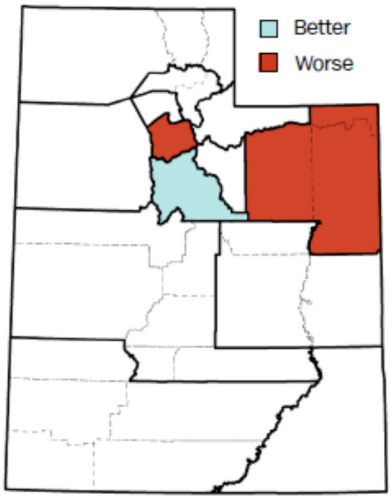
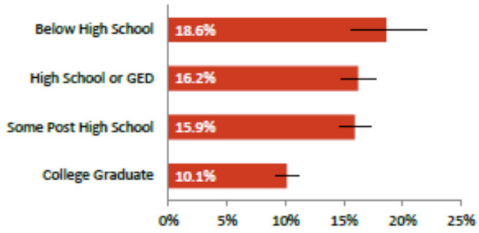


Figure: Mental Health Status by Education, Utah Adults 25+, 2014

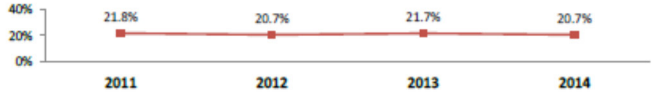


	Crude (burden)		Age-adjusted (comparison)		
STATE COMPARISON (2014)^	**Rate**	**95% CIs**	**Rate**	**95% CIs**	
U.S.	16.3%	16.0% - 16.5%	16.5%	16.2% - 16.7%	
South Dakota (best)	11.7%	10.4% - 13.2%	12.1%	10.7% - 13.7%	
UTAH (19th of 51)	15.9%	15.2% - 16.7%	15.5%	14.8% - 16.2%	
Tennessee (worst)	20.3%	18.6% - 22.1%	20.7%	18.9% - 22.7%	
AGE IN YEARS (2014)					
18–34	20.3%	18.8% - 21.8%	-	-	!
35–49	15.4%	14.0% - 16.8%	-	-	
50–64	13.7%	12.4% - 15.0%	-	-	✓
65+	9.2%	8.1% - 10.4%	-	-	✓
GENDER (2014)					
Male	12.1%	11.1% - 13.0%	11.6%	10.8% - 12.6%	✓
Female	19.8%	18.6% - 20.9%	19.4%	18.3% - 20.5%	!
RACE (2012–2014)					
American Indian/AK Native	21.3%	16.9% - 26.4%	21.1%	16.9% - 26.0%	!
Asian	15.6%	11.9% - 20.2%	12.5%	9.5% - 16.2%	
Black	15.1%	10.9% - 20.6%	16.5%	11.9% - 22.4%	
Pacific Islander	17.3%	11.9% - 24.7%	15.0%	9.4% - 23.0%	
White	16.0%	15.5% - 16.5%	15.7%	15.3% - 16.2%	
ETHNICITY (2014)					
Hispanic	14.6%	12.4% - 17.0%	15.2%	12.8% - 18.0%	
Non-Hispanic	16.1%	15.3% - 16.9%	15.7%	15.0% - 16.5%	
INCOME (2014)					
0–$24,999	26.1%	24.0% - 28.2%	26.0%	24.0% - 28.2%	!
$25,000–$49,999	16.3%	14.8% - 18.0%	16.3%	14.7% - 17.9%	
$50,000–$74,999	13.4%	11.8% - 15.1%	13.4%	11.7% - 15.2%	✓
$75,000 or more	10.3%	9.2% - 11.5%	10.9%	9.6% - 12.4%	✓
EDUCATION—Adults 25+ (2014)					
Below High School	19.1%	16.0% - 22.7%	18.6%	15.6% - 22.0%	!
High School or GED	16.5%	15.0% - 18.1%	16.2%	14.8% - 17.7%	!
Some Post High School	16.1%	14.9% - 17.5%	15.9%	14.7% - 17.3%	!
College Graduate	10.3%	9.4% - 11.3%	10.1%	9.2% - 11.1%	✓
LOCAL HEALTH DISTRICT (2014)					
Bear River	15.3%	12.4% - 18.8%	14.6%	11.9% - 17.8%	
Central Utah	15.4%	11.8% - 20.0%	15.1%	11.6% - 19.5%	
Davis County	15.4%	13.2% - 17.8%	15.0%	13.0% - 17.4%	
Salt Lake County	17.1%	15.9% - 18.5%	16.8%	15.6% - 18.2%	!
San Juan*	12.4%	4.8% - 28.5%	10.5%	4.4% - 23.2%	
Southeast Utah†	17.1%	12.7% - 22.8%	16.6%	12.1% - 22.3%	
Southwest Utah	14.4%	11.8% - 17.5%	14.7%	12.0% - 17.8%	
Summit County	11.8%	8.6% - 16.1%	13.2%	9.4% - 18.3%	
Tooele County	17.7%	13.3% - 23.2%	17.2%	13.0% - 22.5%	
TriCounty	20.1%	15.8% - 25.4%	20.1%	15.8% - 25.2%	!
Utah County	14.6%	12.7% - 16.6%	13.4%	11.7% - 15.1%	✓
Wasatch County	13.3%	10.2% - 17.2%	12.5%	9.5% - 16.3%	
Weber-Morgan	16.4%	14.1% - 19.0%	16.3%	14.0% - 18.9%	

† Includes Carbon, Emery, and Grand counties
^ U.S. data were age-adjusted using slightly different age categories, accounting for the difference in Utah's age-adjusted rate.

Depression

Figure: Percentage of Utahns Aged 18+ With Depression by Year, 2011–2014



Trend graph depicts age-adjusted rates.

Map: Adult Depression by Local Health District, 2012–2014

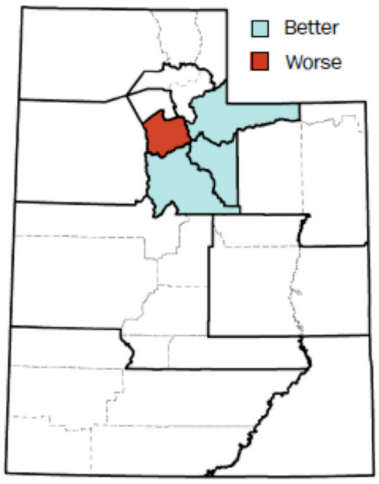


Figure: Adult Depression by Race, Utah, 2012–2014

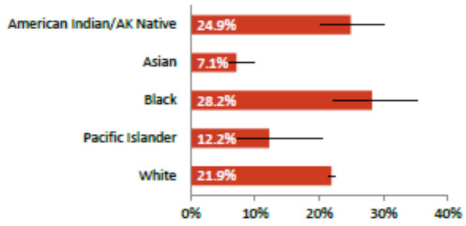
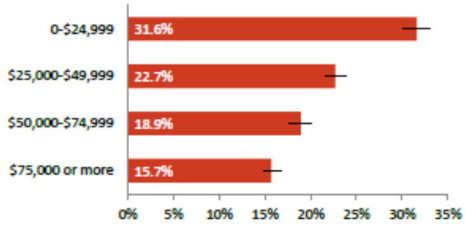


Figure: Adult Depression by Income, Utah, 2012–2014

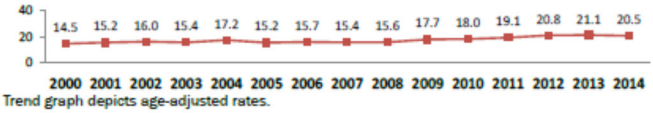


	Crude (burden)		Age-adjusted (comparison)		
STATE COMPARISON (2014)	**Rate**	**95% CIs**	**Rate**	**95% CIs**	
U.S.	17.8%	17.5%-18.0%	17.7%	17.5%-17.9%	
Hawaii (best)	10.7%	9.8%-11.7%	10.9%	9.9%-12.0%	
UTAH (34th of 51)	20.7%	20.0%-21.5%	20.8%	20.0%-21.6%	
Maine (worst)	23.7%	22.5%-24.9%	24.3%	22.9%-25.8%	
AGE IN YEARS (2014)					
18–34	20.8%	19.4%-22.3%	–	–	–
35–49	21.6%	20.1%-23.2%	–	–	–
50–64	22.9%	21.4%-24.5%	–	–	– !
65+	16.5%	15.0%-18.0%	–	–	– ✓
GENDER (2014)					
Male	14.8%	13.8%-15.8%	14.8%	13.8%-15.8%	✓
Female	26.6%	25.5%-27.9%	26.9%	25.7%-28.1%	!
RACE (2012–2014)					
American Indian/AK Native	24.1%	19.6%-29.3%	24.9%	20.2%-30.1%	
Asian	7.8%	5.4%-11.2%	7.1%	5.0%-10.0%	✓
Black	25.1%	19.4%-31.9%	28.2%	22.1%-35.3%	!
Pacific Islander	13.6%	8.4%-21.4%	12.2%	7.0%-20.4%	✓
White	21.9%	21.3%-22.4%	21.9%	21.4%-22.5%	!
ETHNICITY (2012–2014)					
Hispanic	17.8%	16.1%-19.6%	18.4%	16.6%-20.3%	✓
Non-Hispanic	21.7%	21.1%-22.2%	21.7%	21.2%-22.3%	
INCOME (2012–2014)					
0–$24,999	29.8%	28.4%-31.2%	31.6%	30.1%-33.0%	!
$25,000–$49,999	22.2%	21.1%-23.3%	22.7%	21.6%-23.9%	!
$50,000–$74,999	19.5%	18.3%-20.7%	18.9%	17.7%-20.1%	✓
$75,000 or more	16.0%	15.2%-16.9%	15.7%	14.8%-16.7%	✓
EDUCATION—Adults 25+ (2012–2014)					
Below High School	23.9%	21.6%-26.5%	23.6%	21.3%-26.0%	
High School or GED	22.3%	21.2%-23.4%	22.0%	20.9%-23.1%	
Some Post High School	23.7%	22.7%-24.6%	23.3%	22.4%-24.2%	!
College Graduate	17.8%	17.0%-18.5%	17.4%	16.7%-18.2%	✓
LOCAL HEALTH DISTRICT (2012–2014)					
Bear River	19.7%	17.8%-21.8%	20.1%	18.2%-22.1%	
Central Utah	20.9%	18.4%-23.6%	21.4%	18.8%-24.1%	
Davis County	21.5%	20.0%-23.1%	21.2%	19.7%-22.8%	
Salt Lake County	22.8%	21.9%-23.7%	22.4%	21.5%-23.3%	!
San Juan	19.1%	12.9%-27.4%	18.2%	12.4%-25.9%	
Southeast Utah†	21.2%	18.1%-24.7%	21.9%	18.5%-25.9%	
Southwest Utah	20.5%	18.4%-22.6%	21.2%	19.0%-23.5%	
Summit County	17.7%	14.8%-21.1%	17.4%	14.5%-20.8%	✓
Tooele County	22.5%	19.6%-25.8%	21.9%	19.1%-25.0%	
TriCounty	19.4%	16.8%-22.3%	19.5%	17.0%-22.3%	
Utah County	19.8%	18.5%-21.1%	19.6%	18.4%-20.9%	✓
Wasatch County	17.6%	14.4%-21.3%	17.0%	13.8%-20.8%	✓
Weber-Morgan	22.6%	20.9%-24.5%	22.6%	20.9%-24.4%	

† Includes Carbon, Emery, and Grand counties

Suicide

Figure: Suicides per 100,000 Population in Utah by Year, 2000–2014



Trend graph depicts age-adjusted rates.

	Crude (burden)		Age-adjusted (comparison)		
STATE COMPARISON (2014)^	**Rate**	**95% CIs**	**Rate**	**95% CIs**	
U.S.	13.4	13.3-13.5	13.0	12.8-13.1	
District of Columbia (best)	7.9	5.9-10.3	7.8	5.8-10.3	
UTAH (47th of 51)	19.0	17.3-20.5	20.5	18.8-22.3	
Montana (worst)	24.5	21.5-27.6	23.9	20.8-27.0	
AGE IN YEARS (2014)					
10–14	2.4	0.9-5.2	-	-	✓
15–17	19.2	12.7-27.9	-	-	
18–19	31.5	20.7-45.8	-	-	!
20–24	19.0	14.0-25.2	-	-	
25–34	21.6	17.4-26.4	-	-	
35–44	28.0	22.9-33.8	-	-	!
45–54	30.3	24.5-37.2	-	-	!
55–64	26.8	21.0-33.6	-	-	!
65–74	20.3	14.1-28.2	-	-	
75+	35.0	25.3-47.1	-	-	!
GENDER (2014)					
Male	28.2	25.5-31.0	31.2	28.2-34.4	!
Female	9.4	7.9-11.1	10.1	8.5-12.0	✓
RACE (2012–2014)					
American Indian/AK Native	23.7	16.1-33.7	22.9	15.2-33.1	
Asian	10.4	6.5-15.9	11.0	6.7-17.0	✓
Black	10.5	5.4-18.3	11.3	4.9-22.1	
Pacific Islander*	8.3	3.3-17.0	7.5	2.9-15.7	✓
White	19.8	18.8-20.8	20.3	19.3-21.4	
ETHNICITY (2012–2014)					
Hispanic	8.9	7.3-10.8	10.2	8.0-13.0	✓
Non-Hispanic	20.7	19.7-21.8	21.1	20.1-22.2	!
LOCAL HEALTH DISTRICT (2012–2014)					
Bear River	14.9	11.7-18.6	16.4	12.8-20.7	✓
Central Utah	30.6	23.9-38.7	33.6	26.0-42.7	!
Davis County	15.4	13.0-18.1	17.0	14.3-20.0	✓
Salt Lake County	20.1	18.6-21.8	21.3	19.6-23.0	
San Juan*	22.2	10.6-40.7	25.4	12.1-47.1	
Southeast Utah†	42.2	31.5-55.3	43.7	32.3-57.8	!
Southwest Utah	22.0	18.5-25.9	23.5	19.7-27.9	
Summit County	15.6	9.2-24.6	16.8	9.6-27.3	
Tooele County	23.1	16.6-31.2	25.7	18.4-35.0	
TriCounty	29.4	21.8-38.8	32.6	24.1-43.2	!
Utah County	14.4	12.6-16.4	16.2	14.1-18.6	✓
Wasatch County	15.1	7.8-26.3	15.9	8.2-27.8	
Weber-Morgan	21.5	18.3-25.0	22.1	18.8-25.9	

† Includes Carbon, Emery, and Grand counties
^ National data from CDC WONDER.

* Use caution in interpreting, the estimate has a relative standard error greater than 30% and does not meet UDOH standards for reliability.

Map: Suicide by Local Health District, Utah, 2012–2014

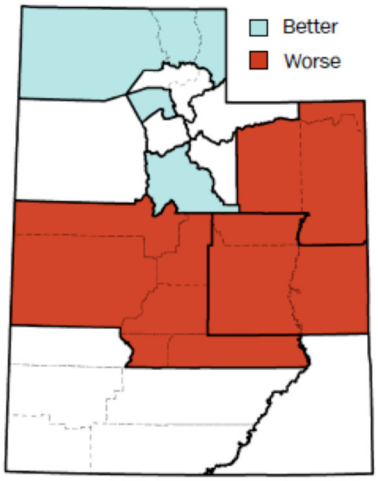
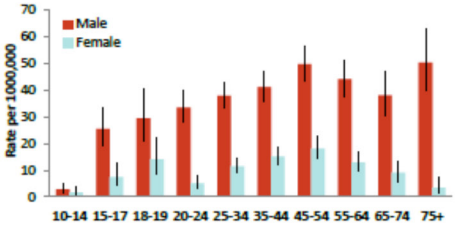


Figure: Suicide by Age and Gender, Utah, 2012–2014



PRIORITY SELECTION

Priorities for UNI's community health needs assessment were determined after analyzing that data in the SWA and reviewing the availability of known and effective interventions, determination that the area was un-addressed or under-addressed by existing resources, and synergies with other UNI initiatives. Three-year implementation plans have been outlined and implementation teams identified for each of the priorities.

One of the overall goals for our behavioral health services includes addressing the behavioral health needs of patients, and others, where they present within the UNI system, minimizing long-term individual, family and social costs associated with untreated or late-treated mental health issues in the UNI patient population, and suicide prevention within the broader non-patient population. Based on the prioritization of the health issues as prioritized by UHIP in the SWA and SHIP we plan to focus on the objective of "Improving Mental Health and Reducing Suicide". We plan to address this objective through the following goals, performance measures and strategies/tactics.

IMPLEMENTATION STRATEGIES

Improving Mental Health & Reducing Suicide

Goals

- Better address the behavioral health needs, and access, for patients and the community at large to help improve mental health and minimize the rate of suicide in the State of Utah
- Increase access to psychiatric care and behavioral health care within the Emergency Department (ED) and our network of Community Clinics

Performance Measures

- Expanded access to outpatient behavioral health services, in addition to increasing access to primary care patients
- Increased ED diversion strategy encounters
- Reduce the duration for ED psychiatric cases awaiting placement in our inpatient behavioral health unit

Strategies/Tactics

- Better integration of mental health services within our Community Clinics to provide appropriate patient care prior to leaving our primary care clinics
- Increase the number of crisis intervention and hospital diversion encounters through the use of our crisis hotline, warmline, SAFE UT App, Mobile Crisis Outreach Teams, Wellness Recovery Center and Receiving Center
- Increase the availability of psychiatric services embedded with the main Emergency Department
- Promote mental health awareness through community outreach efforts