



UNIVERSITY OF UTAH
HEALTH CARE

Community Health Needs Assessment Implementation Plan 2014-2017



BACKGROUND

University of Utah Health Care is the Intermountain West's only academic health care system, combining excellence in patient care, the latest in medical research, and teaching to provide leading-edge medicine in a caring and personal setting. The system provides care for Utahns and residents of five surrounding states in a referral area encompassing more than 10 percent of the continental United States.

Whether it's for routine care or highly specialized treatment in orthopedics, stroke, ophthalmology, cancer, radiology, fertility, cardiology, genetic-related diseases, organ transplant, or many other areas of medicine, University of Utah Health Care offers the latest technology and advancements, including some services available nowhere else in the region.

As part of that system, University Hospitals & Clinics relies on more than 1,100 board-certified physicians who staff four university hospitals (University Hospital, Huntsman Cancer Hospital, University Orthopaedic Center, and the University Neuropsychiatric Institute); 10 community clinics; and several specialty centers including the John A. Moran Eye Center, the Cardiovascular Center, the Clinical Neurosciences Center, and the Utah Diabetes Center.

University of Utah Health Care is consistently ranked among US News & World Report's Best Hospitals, and its academic partners at the University of Utah School of Medicine and Colleges of Nursing, Pharmacy, and Health are internationally regarded research and teaching institutions.

COMMUNITY NEED AND COMMUNITY BENEFIT

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

- UUHC supports patients in need through the direct provision of charity care, as well as write-offs of debt for those unable to complete payment due to hardship. In the most recent fiscal year, UUHC provided over \$78.3 million in charity care and an additional \$58.5 million in bad debt write-offs.
- UUHC provides direct service to residents with special health-related needs and those living in under-served communities through outreach and education efforts, telemedicine and outreach clinics, free screenings, and direct patient care through partnerships with multiple community agencies.

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 needs. This report documents the process through which UUHC 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 NEEDS ASSESSMENT PROCESS

The focus of the CHNA was on Salt Lake County; however, some of the implications and strategies address a broader region, including rural areas beyond Salt Lake County.

The CHNA process was led by UUHC leadership and staff, and supported by a consulting team with public health and health policy expertise from Stamats Healthcare Marketing.

The multi-faceted CHNA process, conducted from March-August 2014, encompassed:

1. Epidemiological and socio-demographic analysis. This intensive data analysis drew on multiple national, state, and county public data sources. Health risks, behaviors, and access to health care services for Salt Lake County (SLC) residents were compared with those of Utah, the US, and Health People 2020 goals. Relative risk and relative rate calculations helped identify the greatest gaps for the SLC population.
2. Qualitative interviews. Consultants conducted interviews with ten community business and government agency leaders, as well as UUHC Board members. These interviews provided perspectives on current and emerging health issues, as well as emerging community and environmental situations that may affect health and quality of life.
3. Focus groups. All segments of the community were represented through a series of six focus groups, including four groups with the leadership of community agencies that work directly with under-served populations, and two groups with UUHC clinical and non-clinical staff who serve the community, manage outreach programs, and interact daily with community members. The community agency focus groups represented (1) agencies serving specific ethnic and cultural segments, (2) agencies that provide health services to the individuals and communities in need, (3) agencies that provide support counseling for a wide range of health-related needs (including behavioral health, rape recovery, addiction recovery, and others), (4) education, youth services, and wellness agencies. A total of 57 individuals participated in the six focus groups.

4. Priority setting. Potential priority health risks and gaps in access to care were identified from the summary of the three stages of research (identified above). These lists were narrowed down and the final priorities selected in two meetings with the UUHC CHNA team, conducted in May and July, 2014. Criteria for priority-setting included:
 - Severity of the issue, as represented by some or all of the following: highly acute, affects a large number of people, has significant economic and/or opportunity cost, growing or worsening over time
 - Availability of known, feasible interventions, with measurable impact, that are likely to achieve results and improve community's quality of life and health in a reasonable time frame
 - Unaddressed or under-addressed issue: no/few organizations or (insufficient) resources focusing on it effectively at present
 - UUHC synergies: special expertise, strategic priority, and/or programs in place to serve as building blocks
5. Development of implementation strategies. Implementation strategies were outlined during a session conducted with a wide range of UUHC clinical and administrative leadership, including those involved in direct community outreach. Each implementation team will include representatives of relevant community agencies, as well as UUHC clinicians and staff.

KEY FINDINGS OF THE ASSESSMENT

The areas with the highest relative risks in comparison with the state of Utah, the US as a whole, and/or Healthy People 2020 goals included:

- Environmental factors: Air quality, crime rate
- Health indicators: Suicide, poisonings
- Maternity: Infant mortality, low birth weight
- Disability: age 18-64
- Infectious conditions, including STDs
- Asthma, other respiratory conditions
- Various cancers: incidence, mortality
- Diabetes: incidence, mortality
- Senior frailty: falls, Parkinson's
- Binge drinking
- Low rate of childhood immunizations
- Low use of preventive dental care

In addition, the assessment identified population dynamics and access issues that may affect health status and wellbeing, such as:

- High rate of youth and young adult population growth
- Rapidly growing ethnic and cultural diversity, including growth of the immigrant and refugee populations – affecting English language proficiency as well as cultural literacy and ability to navigate the health system
- High percentage of adults ages 18-64 who are disabled
- STD and infectious disease rates
- Lower-than-average percentage of mothers who received first trimester prenatal care
- Lower rates of health care coverage and higher rates reporting cost as a barrier to obtaining health care, vs. reference populations
- Limited access to behavioral health services – particularly ongoing care, appropriate placement, and medication access for those with chronic or long-term conditions – among individuals facing financial, access, and other barriers to care

The qualitative research identified ways in which these health risks and access barriers affect specific population segments. In addition, the qualitative research delineated culture- and community-specific barriers to health maintenance, access to and use of health care services, and effective communication with health care providers.

PRIORITY SELECTION

Priorities for community health enhancement were determined after weighing the severity of each area of heightened relative risk, the availability of known and effective interventions, determination that the area was un-addressed or under-addressed by existing resources, and synergies with other UUHC and UNI initiatives. Three-year implementation plans have been outlined and implementation teams identified for each of the priorities.

1. Diabetes: early identification and effective risk reduction for populations with potential for the development of this condition
2. First trimester prenatal care: ensuring consistent early access to prenatal care to reduce risks for at-risk women and their babies
3. Behavioral health services: addressing the behavioral health needs of patients where they present within the UUHC system, minimizing long-term individual, family, social and UUHC costs associated with untreated or late-treated mental health issues in the UUHC patient population

IMPLEMENTATION STRATEGIES

Priority #1: Diabetes

Goal

- Early identification and effective risk reduction for populations with potential for the development of this condition

Performance Measures

- HEDIS metrics (A1C, eye exam, etc.) and compliance, tracked through UUHC systems

Strategies/Tactics

- Partner with appropriate community agencies to prioritize needs by geography and target audiences
- Develop culturally sensitive education and intervention programs that encompass family involvement and provide resources to help manage diabetes risk; partner with agencies to implement
- Conduct screenings to facilitate early identification of potential diabetes, focusing on selected at-risk populations and geographies
- Implement an evolving range of tactics to sustain impact of program over time

Priority #2: First Trimester Prenatal Care

Goal

- Ensure consistent early access to prenatal care to reduce risks for at-risk women

Performance Measures

- Process measures, such as number of educational sessions conducted in the community
- Outcomes measures, such as reduction in percentage of first-time mothers delivering at UUHC with no first trimester care

Strategies/Tactics

- Address lack of financial coverage for prenatal care for undocumented (note, development of low cost, sliding scale clinics is underway; potential to expand awareness and use at South Main Clinic)
- Offer free pregnancy testing; develop plan to facilitate access to care before promoting this
- Tele-health for low risk prenatal care; conducting a pilot; potential to expand
- Expand use of group prenatal care visits

Priority #3: Behavioral/Mental Health

Goals

- Address behavioral health needs of patients where they present within the UUHC system
- Minimize long-term individual, family, social, and UUHC costs associated with untreated or late-treated mental health issues in the UUHC patient population

Performance Measures

- Reduction in behavioral health ED visits by UUHC patients recently seen for other conditions
- Fewer and shorter duration of ED observation cases awaiting placement in behavioral health unit or community agencies
- Expanded access to behavioral health services

Strategies/Tactics

- Integration of mental health via care plan for appropriate patients prior to leaving primary care clinics
- Expanded access to services with mix of mental health provider types
- Development of tele-health for consults throughout state
- Placement of child and adult psych residents with area community clinics