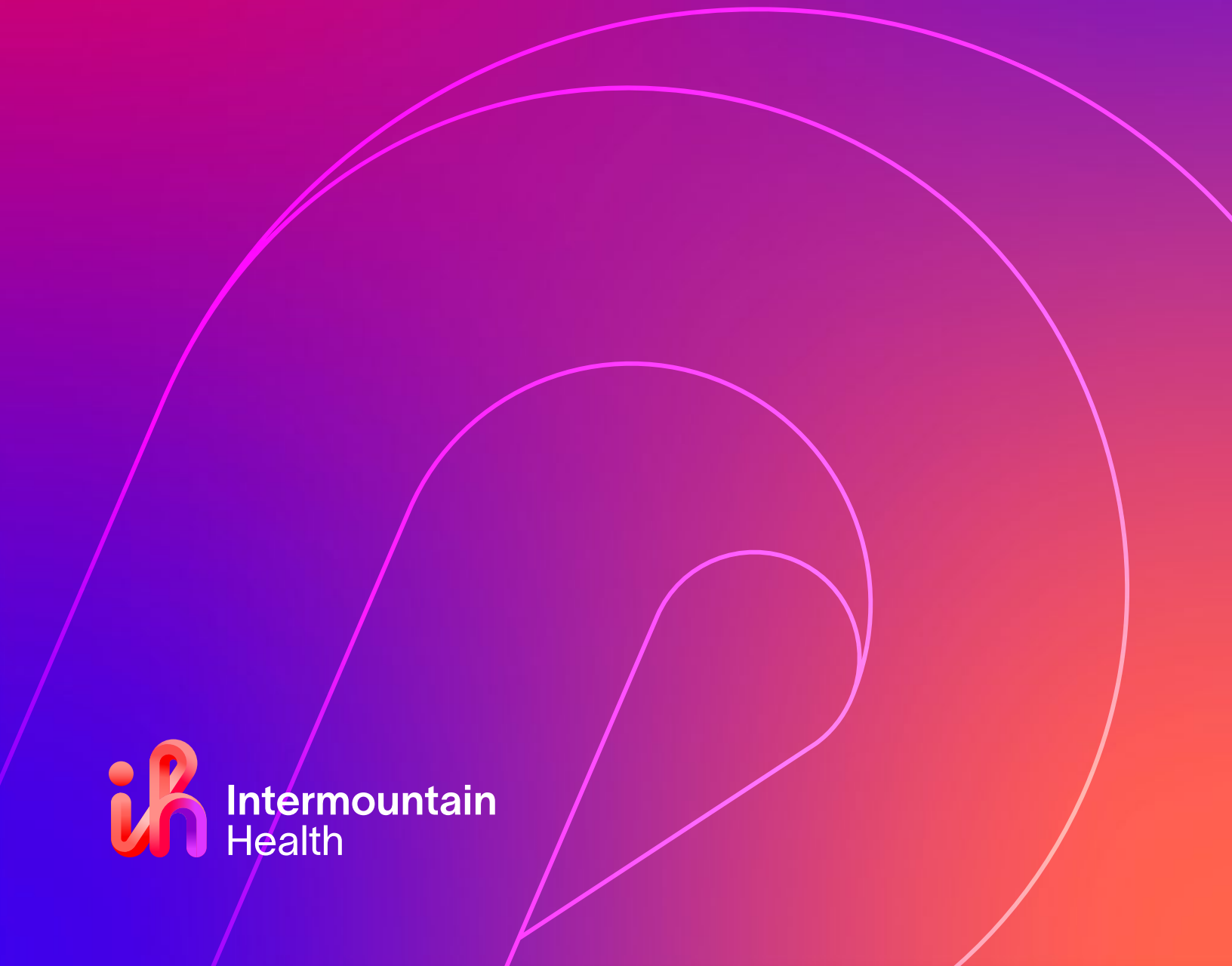
Intermountain Health | Bear River Valley Hospital

2025 Community Health Needs Assessment



Intermountain Health

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Executive Summary

The Power of We

Dear neighbors,

For more than a year, our Intermountain Health Community Health team worked to understand the unmet health needs of the service area through our Community Health Needs Assessment process. This report shares those findings, which are the backbone of our mission of helping people live the healthiest lives possible.

A wealth of quantitative and qualitative health data informed this assessment, including public health indicators, stakeholder and resident surveys, public meeting discussions, and interviews with subject matter experts. To the individuals and organizations who worked with us to understand the community's significant health needs: thank you. We are grateful for your collaboration.

This report outlines our process and the key lessons we have learned. It also serves to highlight our community's significant health needs, which will be prioritized for investment over the next three years. Specifically, we aim to improve behavioral health, invest in social drivers of health, increase access to care, and prevent childhood injury and illness.

Our efforts now shift from assessing needs to developing an Implementation Strategy to meet those needs. We know that having an impact means working together - the Power of We. As we consider how Intermountain's resources can be allocated in the service area, we want to collaborate with community-based organizations, local government agencies, and area leaders to improve community health.

Sincerely,

Sue Robel,
Canyons Region President

Lisa Nichols,
Vice President of Community Health

2025 CHNA Significant Health Needs

Intermountain Health

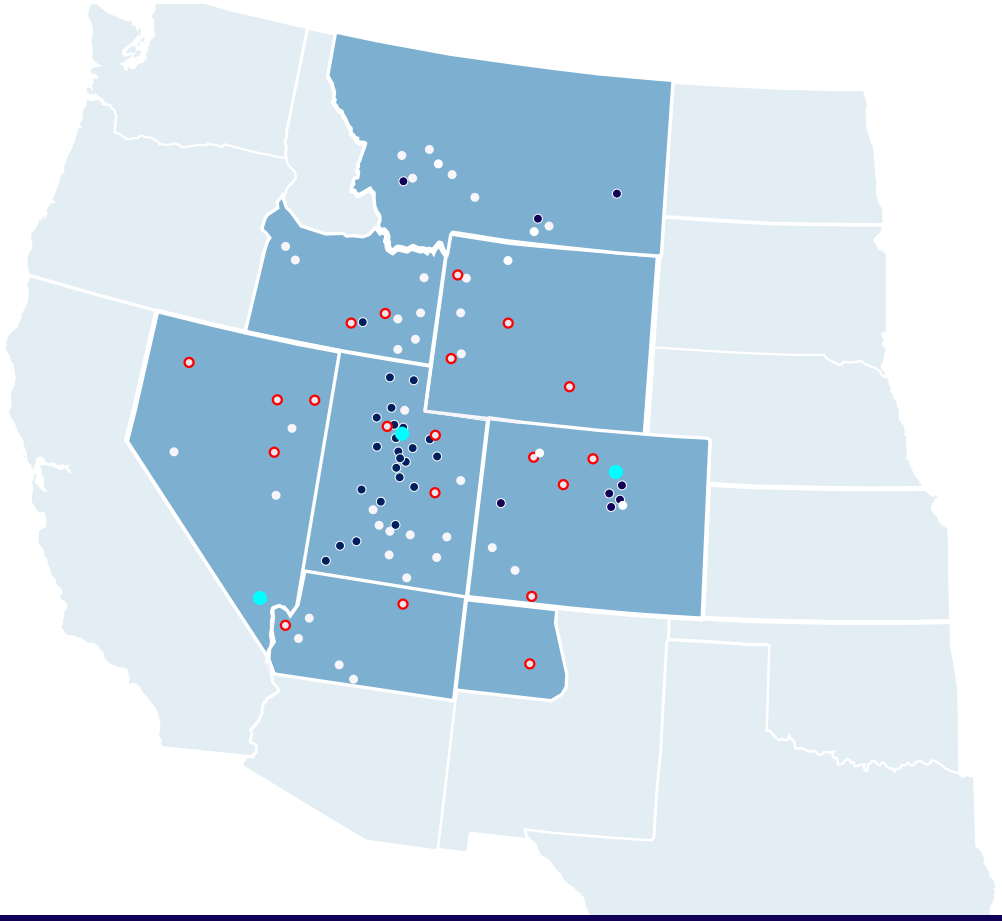
Headquartered in Utah with locations in six primary states and additional operations across the western U.S., Intermountain Health is a nonprofit system of 33 hospitals, 409 clinics, a medical group of nearly 5,000 employed physicians and advanced care providers, a health plan division called Select Health with more than one million members, and other health services.

With more than 68,000 caregivers on a mission to help people live the healthiest lives possible, Intermountain is committed to improving community health and is widely recognized as a leader in transforming healthcare. We strive to be the model health system by taking full clinical and financial accountability for the health of more people, partnering to proactively keep people well, and coordinating and providing the best possible care.

Our Mission

Helping People Live the Healthiest Lives Possible®

Our Values



Intermountain is headquartered in Salt Lake City, Utah, with regional offices in Broomfield, Colorado, and Las Vegas, Nevada.

- Hospitals
- Region Headquarter
- Affiliate/Outreach Partnerships
- Classic Air Medical Bases

Intermountain Health's 400+ clinics are not highlighted on the map

Intermountain Health by the Numbers

6 Primary States
(UT, NV, ID, CO, MT, WY)

33 Hospitals
Including One Virtual Hospital

4,700+
Licensed Beds

1.1 Million
Select Health Members

409
Clinics

68,000+
Caregivers

$17.15 Billion[1]
Total Revenue

4,800+
Employed Physicians & APPs

[1] Revenue for the year ended December 31, 2024

Bear River Valley Hospital

Bear River Valley Hospital in Tremonton, Utah, opened its doors in 2009. It offers a wide range of wellness, diagnostic, and treatment services, including a Level IV Trauma Center, surgical services, heart and vascular services, women's health, orthopedics, physical therapy and rehabilitation, wound care, and sleep services. The hospital is also integrated with Intermountain's virtual hospital and air medical transport services.

To submit comments on the 2025 CHNA Report or to request a paper copy, please email IH_CommunityHealth@imail. org.

Acknowledgments

The Patient Protection and Affordable Care Act (ACA) requires each nonprofit hospital to conduct a Community Health Needs Assessment (CHNA) every three years to identify significant health needs and develop an Implementation Strategy in response. Intermountain Health adheres to all applicable laws and continuously reviews regulatory requirements to ensure compliance. Accordingly, we may adjust our CHNA processes and Implementation Strategy as regulations change.

The Intermountain Health CHNA process examines unmet health needs and health disparities in geographical areas by analyzing primary and secondary data. Intermountain determines significant health needs through an objective, evidence-based prioritization process with final approval by Regional Boards.

The identified needs guide efforts to align strategies and leverage resources with other public health and community organizations. By regularly assessing and prioritizing community health needs, the hospital can work collaboratively to improve overall health.

Both the CHNA and Implementation Strategy, which is developed and adopted to address health needs, are publicly available on Intermountain's website.

The Value of the Collaborative

Intermountain Health joined the Utah Community Health Needs Assessment Collaborative for our 2025 CHNA. It resulted in collaborative opportunities to improve the quality of health data, reduce duplication, and align on health needs.

The collaborative adopted an evidence-based process that streamlined data collection and prioritization. It also improved the mechanisms for gathering community input by collectively designing surveys, presenting at input meetings, and engaging public and local stakeholders through distinctive community connections. Both the quantitative and qualitative data were made available to participating organizations for use in their own needs assessments.

A full list of organizations participating in the collaborative, including health districts, healthcare providers, and other stakeholders, is available in the appendix.

What Is Health Equity at Intermountain Health?

Intermountain Health's mission – helping people live the healthiest lives possible – includes everyone and requires valuing, understanding, and including the backgrounds and experiences of people in the communities we serve. Health equity is the principle of pursuing the highest possible standard of health with a focus on improving the well-being of our most vulnerable communities.

Our Community Health Needs Assessment process is driven by data. We look carefully at public health data to understand the prevalence of health issues in our communities and where those issues create the greatest disparities or differences in healthy outcomes.

We talk with residents, community-based organizations, and local leaders to understand how health disparities connect and how they affect individuals and families across the lifespan. With an understanding of the needs our communities face, we develop a Community Health Implementation Strategy that directs our resources to remove barriers and invest resources where they will have the greatest impact. Using data and community input to identify the greatest needs and targeting our approach to meeting those needs is health equity in action.

As a healthcare system, employer, and community leader, Intermountain is committed to improving health equity in the communities we serve.

APPENDIX: INTERMOUNTAIN HEALTH CHNA GLOSSARY

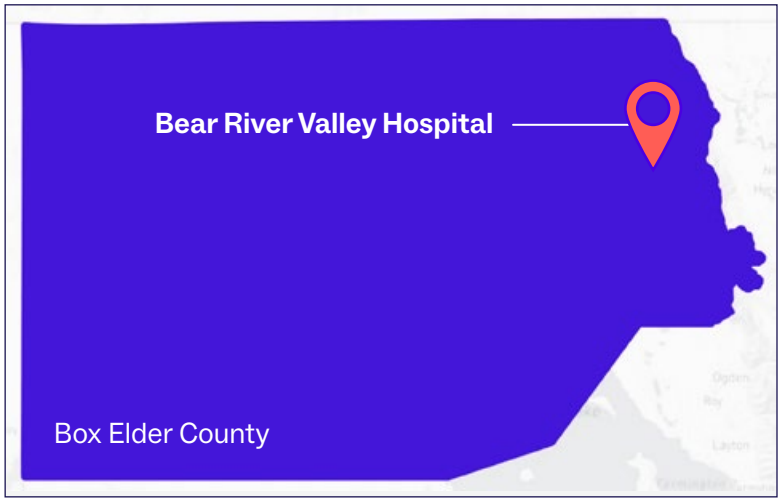
APPENDIX: UTAH COMMUNITY HEALTH NEEDS ASSESSMENT COLLABORATIVE

Community Profile

Service Area

The primary service area is determined geographically by the ZIP codes where most patient admissions originate. It is also defined by the populations served at the hospital including underrepresented, underserved, low-income, and minority community members.

County	Zip Code	
Box Elder	84301	84316
	84302	84324
	84306	84329
	84307	84330
	84309	84331
	84311	84334
	84312	84336
	84313	84337
	84314	84340



Community Demographics

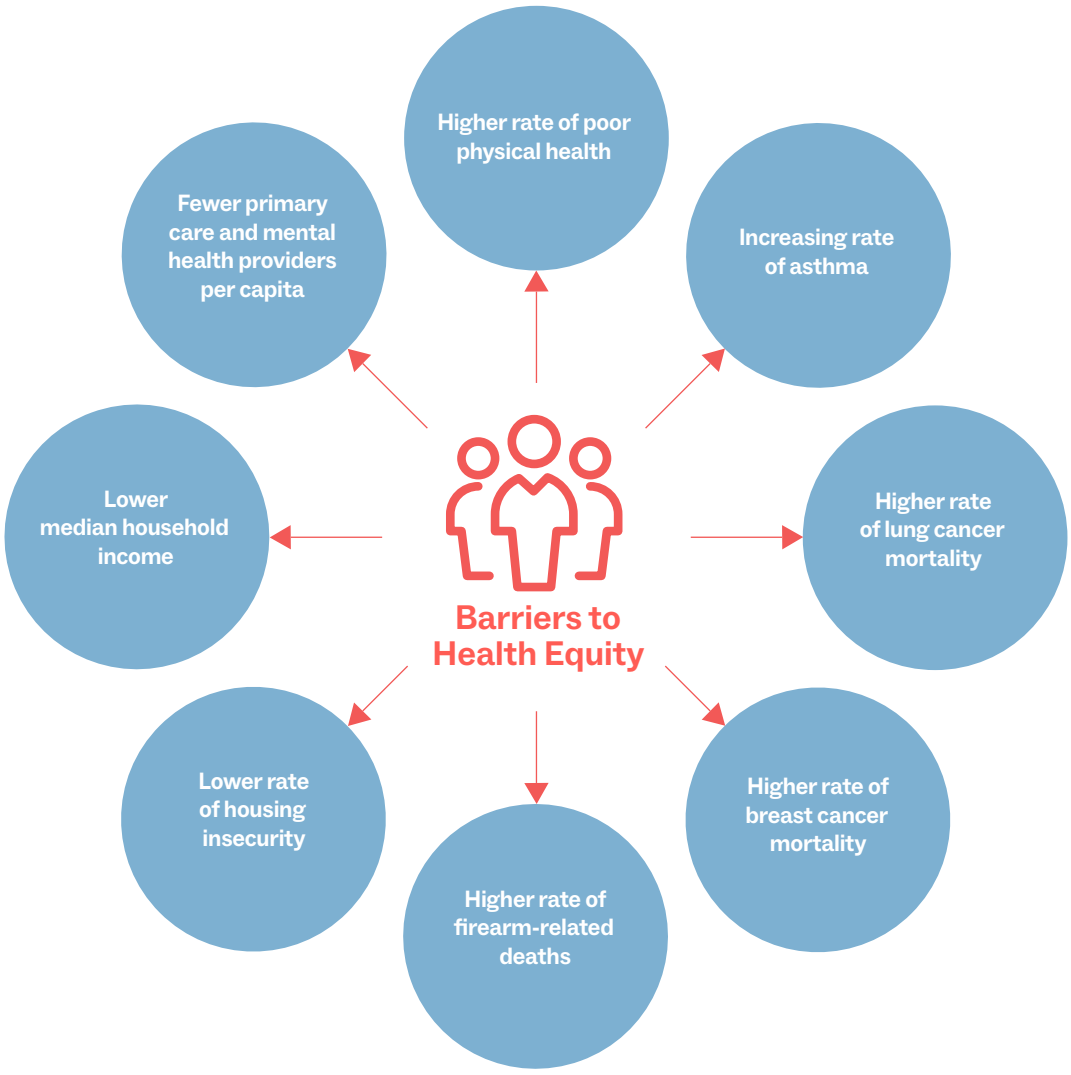
Demographic Factors	Hospital Service Area	Utah	United States
Population	59,725	3,331,187	332,387,540
Persons Under 18 Years	30.9%	28.3%	22.2%
Persons 65 Years and Over	12.8%	11.6%	16.8%
Female Persons	48.8%	49.4%	50.5%
High School Graduate or Higher (age 25 years+)	92.6%	93.3%	89.4%
Persons in Poverty (100% Federal Poverty Level)	8.6%	8.6%	12.4%
Median Household Income (2023 dollars)	$77,865	$91,750	$78,538
Persons without Health Insurance (under age 65)	8.0%	8.7%	8.6%
White, not Hispanic or Latino	86.3%	75.7%	58.2%
Hispanic or Latino	9.9%	15.4%	19.0%
Black or African American	0.4%	1.0%	12.0%
Asian	0.7%	2.3%	5.8%
American Indian and Alaska Native	0.4%	0.7%	0.5%
Native Hawaiian and Other Pacific Islander	0.2%	0.9%	0.2%
Two or More Races	2.1%	3.6%	3.9%
Households Where Spanish is Primary Language	7.9%	12.1%	13.0%

A demographic snapshot of the service area compared to Utah and the United States (Source: U.S. Census Bureau: American Community Survey, 2019-2023)

Data-Driven Needs

The CHNA process involves a data-driven comprehensive analysis of the unique health needs of the communities served. By identifying county level health disparities through primary and secondary data, Intermountain can better understand how they affect our communities and direct our resources to remove barriers and invest resources where they will have the greatest impact. The following barriers to health were identified in the CHNA secondary data.

Service Area Compared to Utah



APPENDIX: SECONDARY DATA SOURCES

Collaborating with Our Communities

Focus on Collaboration

Intermountain Health takes a collaborative approach with our community to improve health and address health equity through the CHNA. This approach incorporates evaluation of Intermountain's previous CHNA process and impact of Implementation Strategies. It also relies on working closely with local leaders and residents to understand unique health needs in each community. Intermountain and its collaborators invited a broad range of community members with diverse backgrounds, voices, and experiences to participate and offer input in the 2025 CHNA.

Participants

Intermountain collaboratively solicited participation from a variety of individuals and organizations representing local public health departments and the medically underserved, low-income, and minority residents. There was a public request for written comments concerning the most recently conducted CHNA and Implementation Strategy, and no responses were received. The 2025 CHNA had intentional participation from these sectors:

- Healthcare consumers and consumer advocates
- Not-for-profit and community-based organizations
- Academic experts
- Local government officials
- Local school districts
- Healthcare providers and community health centers
- Public health professionals
- Health insurance and managed care organizations
- Private businesses
- Labor and workforce representatives
- Residents of the community

CHNA Timeline

The governance and decision-making process for the 2025 CHNA is data-driven and community-centric, following a cycle of data collection, analysis, and community feedback before final approval by the Intermountain Health Regional Board.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Secondary Data Analysis	●	●	●	●								
Stakeholder & Public Surveys	●	●										
Community Input Meetings				●	●	●	●					
Analysis & Prioritization of Health Heeds						●						
Stakeholder Interviews								●	●	●		
Board Approval of CHNA Report											●	
CHNA Report Publication												●

APPENDIX: COMMUNITY INPUT PARTICIPANTS

CHNA Data Methodology and Prioritization

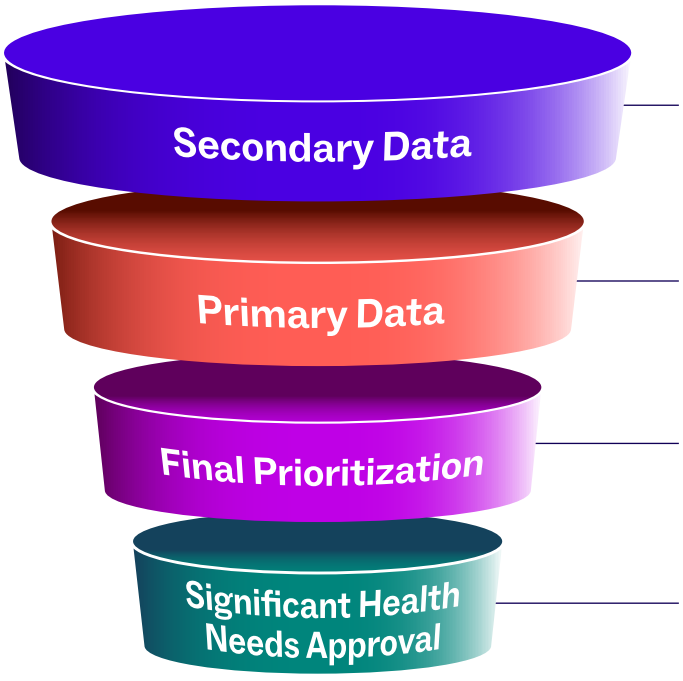
The CHNA prioritization methodology began with analyzing secondary data while concurrently gathering primary data through public and stakeholder surveys. This preliminary analysis took into consideration identifying the community's health needs for children and across the lifespan.

These findings were presented at community input meetings to inform the prioritization process. This valuable local involvement provided in-depth and diverse insight on the backgrounds and experiences of people in the communities we serve.

The CHNA concluded with the application of validated analysis and scoring models that produced the final significant health needs. The findings were presented to the governing board for approval.

Additional stakeholder interviews followed prioritization to provide insights into current resources and community capacity to address significant health needs. This input informs the development of an Implementation Strategy.

Data Methodology & Prioritization Process



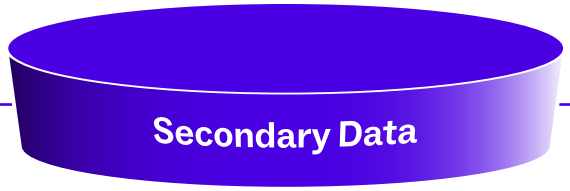
Gather and analyze population-level health data from national and state sources.

Collect primary data input from the public and stakeholders to refine and inform identified health needs.

Analyze all data using a validated prioritization process to determine significant health needs.

Present significant health needs to governing board for approval.

APPENDIX: PERSONS INVOLVED IN DATA COLLECTION AND ANALYSIS

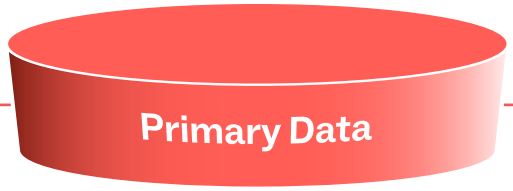


Intermountain Health generated secondary data from the data platform, Metopio™, to access data sources, including the American Community Survey, Behavioral Health Risk Factor Surveillance System, Centers for Medicare and Medicaid, and others inventoried in the appendix. Local health departments provided supplementary data insights during community input meetings.

Where localized data were available, the analysis identified notable changes in health indicators over time and differences between select demographic, minority, and medically underserved groups.

Intermountain used the following criteria to analyze the larger body of health indicators and identify a narrower field for community input discussions and prioritization:

- Review leading causes of death by age group, with additional focus on leading injury-related deaths.
- Assess data relevant to the significant health needs identified in the hospital's previous CHNA to determine impact and inclusion in the current cycle.
- Identify emerging trends and patterns not included in criteria above regarding health outcomes, healthcare access, health behaviors, and social needs.



Intermountain used primary data to harness the community's voice and included a broad representation of perspectives and experiences. As part of the Utah CHNA Collaborative, there was close collaboration with local health departments to engage local residents and stakeholders, which fostered a shared understanding of health needs and commitment to improving the communities we serve.

The tools and methods used to collect and analyze primary data were designed to engage populations across the lifespan and also understand the pediatric needs in all communities. Overall, the process was sequenced to identify, understand, refine, and prioritize the community's health needs.

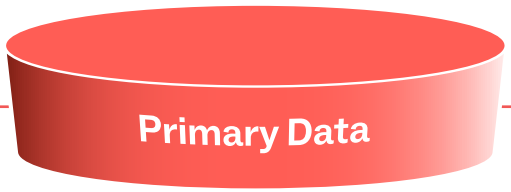
Public Survey

Intermountain Health administered the CHNA Public Survey via email using the Qualtrics® platform between January 6 and February 3, 2025. The technology allowed for panel management that produced responses from a representative and diverse sample of community members from the service area. The survey provided the public with an opportunity to voice their experiences regarding health needs, barriers to equal health opportunities, emerging needs not identified in secondary data, and community strengths.

Community Stakeholder Survey

The CHNA Community Stakeholder Survey was sent via email in English and Spanish between January 21 and February 14, 2025, to stakeholders representing community organizations, healthcare, public health, education, and local government. The stakeholders were selected based on an exhaustive statewide review to ensure a diverse mix of representation.

The results expanded input gathered during the public survey and provided additional feedback and insight on health needs, including existing efforts and capacity to address needs.



Community Input Meetings

The community input meetings were held in Spring and Summer 2025. They were co-facilitated by Intermountain Health and local health departments, which provided insights on current and emerging health needs. Invited stakeholders included representatives from medically underserved, low-income, and minority populations.

The attendees discussed the preliminary health needs identified through primary data surveys and secondary health data. The meetings were designed to understand local impact of these health needs and to gain awareness of others not included in the preliminary analysis.

Community Stakeholder Interviews

Intermountain conducted Community Stakeholder Interviews via phone following prioritization of significant health needs. These in-depth phone interviews capitalized on the engagement of stakeholders during the CHNA process and informed the development of Implementation Strategies. Interviewees were selected based on their expertise and community involvement and their input allowed Intermountain to identify potential community collaborators, existing efforts, and resources.

Following community input meetings, participants were surveyed to help identify the top ten health needs across the state. These are the preliminary health needs that were scored during the prioritization process.

Chronic diseases	Community safety	Financial security	Food security
Healthcare access	**Preliminary Health Needs**		Health insurance costs
Housing stability	Mental health	Substance use and addiction	Suicide

APPENDIX: SECONDARY DATA SOURCES

APPENDIX: COMMUNITY INPUT INVENTORY

APPENDIX: SUMMARY OF PRIMARY DATA FINDINGS

Final Prioritization

Intermountain Health began the final prioritization of the preliminary health needs by applying the Hanlon Method for Prioritizing Problems.

The Hanlon Method is a nationally-recognized technique used in public health needs assessments and recommended by the National Association of County and City Health Officials. Its scoring process reliably develops objective, data-driven priorities regarding the size and seriousness of the issue, and potential effectiveness of the intervention.

Intermountain Health leadership, hospital presidents, internal subject matter experts, and Community Health leaders scored the preliminary health needs, which were used to calculate the final Hanlon Method scores.

Following the scoring process, the team applied the PEARL test to screen out health needs based on feasibility to impact through community health improvement efforts. The PEARL test used these criteria:

- **P** **Propriety:** Is a hospital-led or -supported activity for the health need suitable?
- **E** **Economics:** Does it make economic sense for the hospital to address the need? Are there economic consequences if a need is not addressed by the hospital?
- **A** **Acceptability:** Will the community accept the hospital's intervention? Is the intervention wanted?
- **R** **Resources:** Is funding available or potentially available for the intervention?
- **L** **Legality:** Do current laws allow the intervention to be implemented?

This analysis determined the significant health needs that would be the focus of the Implementation Strategy for the upcoming three-year cycle. Through this process there were instances where additional health needs were identified, unified under one heading, or prioritized.

Significant Health Needs Approval

With comprehensive data analysis, gathering of public and stakeholder input, and determination of the significant health needs, the Intermountain Health Regional Board approved the CHNA process, findings, and report as presented on November 13, 2025. It was published to the Intermountain Health website before December 31, 2025.

CHNA Significant Needs

PRELIMINARY HEALTH NEEDS

Childhood injury

Injuries are the leading cause of death and disability in children (ages 0 to 18 years).

Chronic diseases

Heart disease, cancer, stroke, and respiratory disease are leading causes of death in the service area.

Financial security

The median household income is $14,000 less than the statewide median.

17% of residents have incomes below 150% of the poverty level, compared to 15% in all of Utah.

Food security

Food insecurity is increasing in the service area and is higher among children than adults.

Healthcare access

The uninsured rate among Hispanic/Latino residents is three times higher than the rate for the service area.

Housing stability

Nearly one in four households are spending 30% or more of their income on housing.

Mental health

Adults reporting poor mental health increased from 12% in 2017 to 17% in 2022.

Substance use and addiction

Deaths by drug overdose occur more frequently in the service area than deaths by motor vehicle crashes.

SIGNIFICANT HEALTH NEEDS

IMPLEMENTATION STRATEGY

Identify hospital and community resources to address significant health needs

Develop strategies to address significant health needs with an emphasis on health equity and anticipated impact

Collaborate with other community organizations to have the greatest possible impact on data-identified needs

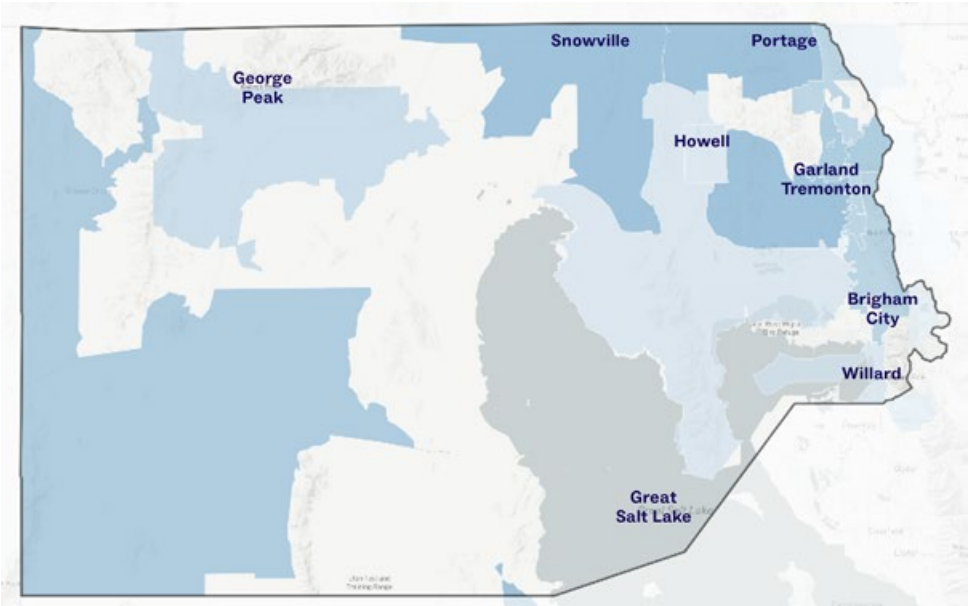
Improve Behavioral Health

The 2025 CHNA prioritizes improving behavioral health as a significant health need through addressing mental health, suicide, and substance use and addiction. This unifies the preliminary health needs identified during data collection and prioritization under Behavioral Health.

"We all agree that mental health is important but translating that awareness into action remains a major challenge. It highlights deeper issues: stigma, time constraints, lack of perceived urgency preventing many from engaging until a crisis occurs." *— Community Stakeholder*

Mental Health

Self-Reported Poor Mental Health | 2022
Box Elder County: **17.4%**
±1.5% of adults



Metopio | Ties © Mapbox, Data source: Centers for Disease Control and Prevention (CDC) PLACES, BRFSS

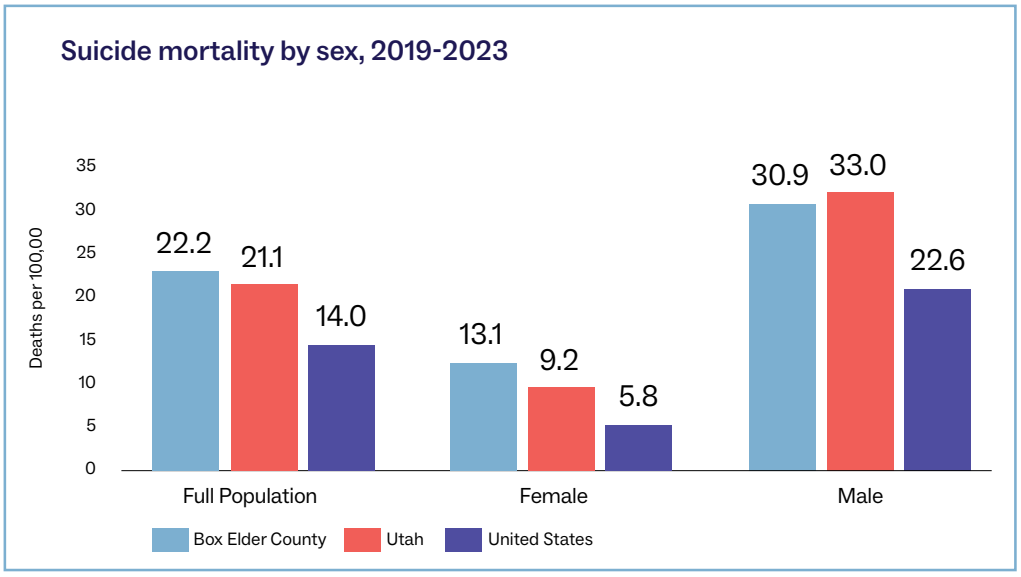
About 17% of adult residents in Box Elder County reported poor mental health, ranging from 15% to 18% across the communities. There is little variation across the county, however Snowville, Portage, and Tremonton experience the highest rates at almost 18%.

DISPARITIES, HEALTH EQUITY & BEHAVIORAL HEALTH

Mental Health	Suicide	Substance Use and Addiction
95% of stakeholders surveyed felt mental health should be prioritized over the next three years, and it was ranked as their highest community concern.	Suicide rates are 60% higher in the service area than in the nation.	The rate of overdose deaths among women is much lower than men in Utah, but rates among men and women in the service area are the same.

Improve Behavioral Health

Suicide



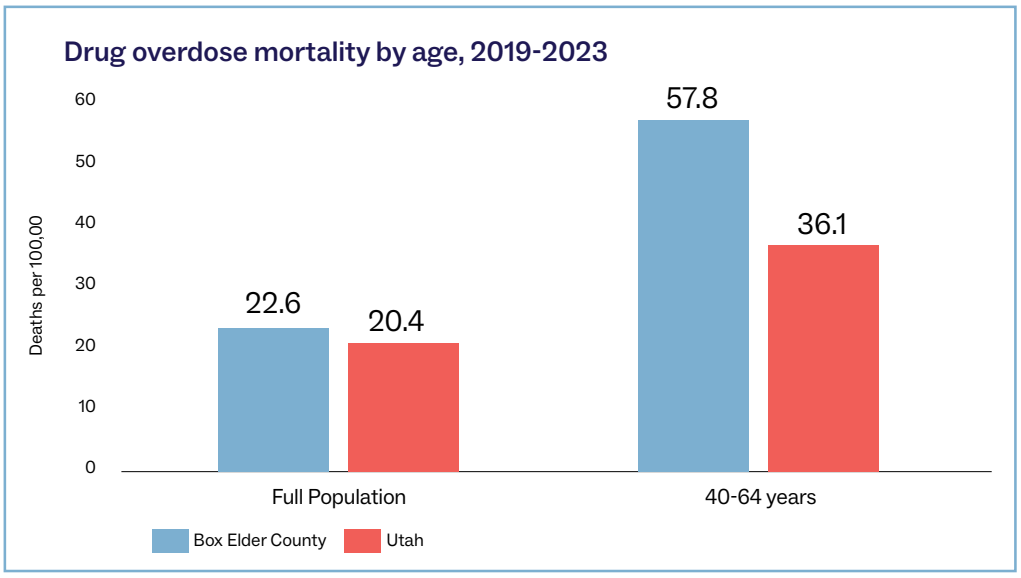
Created on Metopio. Data source: CDC National Vital Statistics System

Suicide is the ninth leading cause of death in the service area. The rate of suicide among men in the service area is more than double the rate in women.

54% of deaths by suicide in Utah are due to firearms.

Note: National data source used binary data about sex (male/female)

Substance Use and Addiction



Created on Metopio. Data source: CDC National Vital Statistics System

Residents ages 40 to 64 years have the highest rate of drug overdose mortality at 58 deaths per 100,000, compared to 23 in the full population.

About 74% of overdose deaths in Utah involve more than one substance and 48% of all deaths by overdose involve fentanyl.

COMMUNITY STRENGTHS

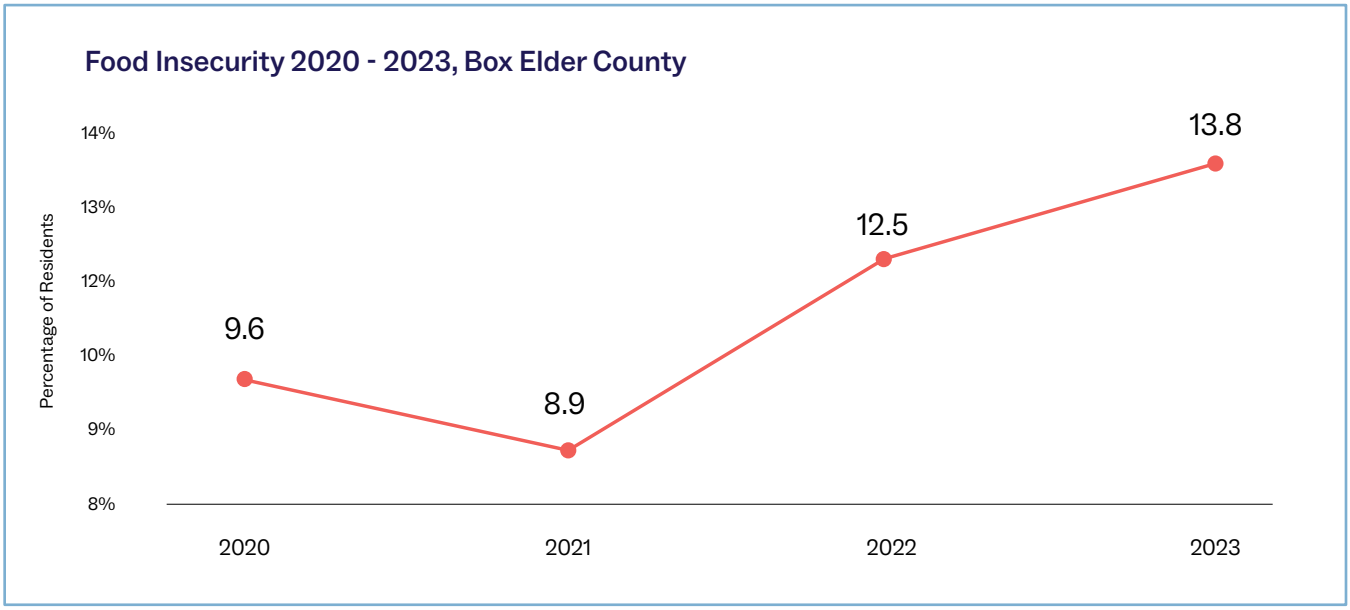
- Available high-quality behavioral health providers that offer community and care management services with adjustable income-based fees.
- Alignment with public health agencies and other health systems on behavioral health as a significant health need.
- Sustaining and expanding current community collaborations and programming from previous Implementation Strategy to address behavioral health.

APPENDIX: RESOURCES TO ADDRESS SIGNIFICANT HEALTH NEEDS

Invest in Social Drivers of Health

The 2025 CHNA prioritizes investing in social drivers of health as a significant health need through addressing financial security, food security, and housing stability. This unifies the preliminary health needs identified during data collection and prioritization under Social Drivers of Health.

"It's difficult to separate the effects of affordable housing from broader health outcomes. When families are burdened by high housing costs, both parents often have to work multiple jobs just to make ends meet. This leads to increased stress, less time for healthy meal preparation, and fewer opportunities for preventive healthcare." *— Community Stakeholder*



Data source: Feeding America: Map the Meal Gap

The rate of food insecurity was between 9% to 10% in 2020 and 2021, then sharply increased to almost 14% in 2023. The rate is highest among Hispanic/Latino residents at 23%.

DISPARITIES, HEALTH EQUITY & SOCIAL DRIVERS OF HEALTH

Financial Security

The public survey respondents rated trouble finding stable employment as the highest household need.

The poverty rate is highest for residents who are Hispanic/Latino or Black.

Food Security

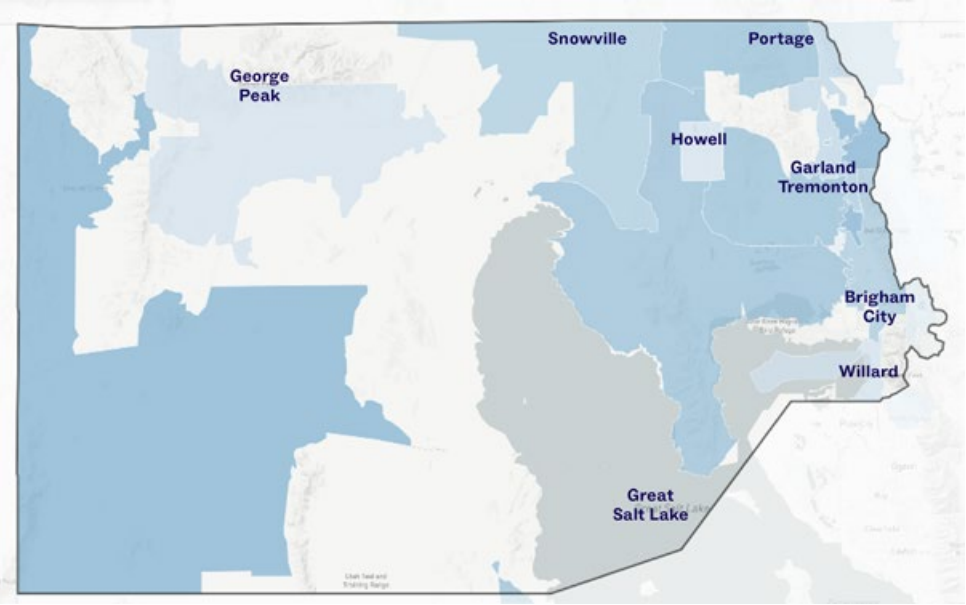
Food insecurity affects 12% of residents in the service area and 23% of Hispanic/Latino residents.

Housing Stability

The percentage of households spending more than 30% of their income on rent has been increasing steadily from 27% in 2010 to 38% in 2023.

Invest in Social Drivers of Health

Housing Insecurity | 2022
Box Elder County: **11.0%**
±1.1% of adults



Metopio | Ties © Mapbox, Data source: Centers for Disease Control and Prevention (CDC) PLACES, BRFSS

About one in ten residents in the service area reported being unable to pay a mortgage, rent, or utility bill in the past 12 months, which is one data method used to measure housing insecurity for the CHNA report.

There is little variation across the county. The areas with the highest housing insecurity are Honeyville/Madsen, Wheelon/Collinston at 12%.

7.8% **12.2%**

COMMUNITY STRENGTHS

- An existing collaborative network of community-based organizations that support service coordination and resource sharing across sectors.
- Family- and service-oriented with a strong community identity.
- Low unemployment and crime rates, outdoor recreation, and strong economy promote economic stability.
- Responsive to social issues and needs with a history of volunteerism and charitable giving.

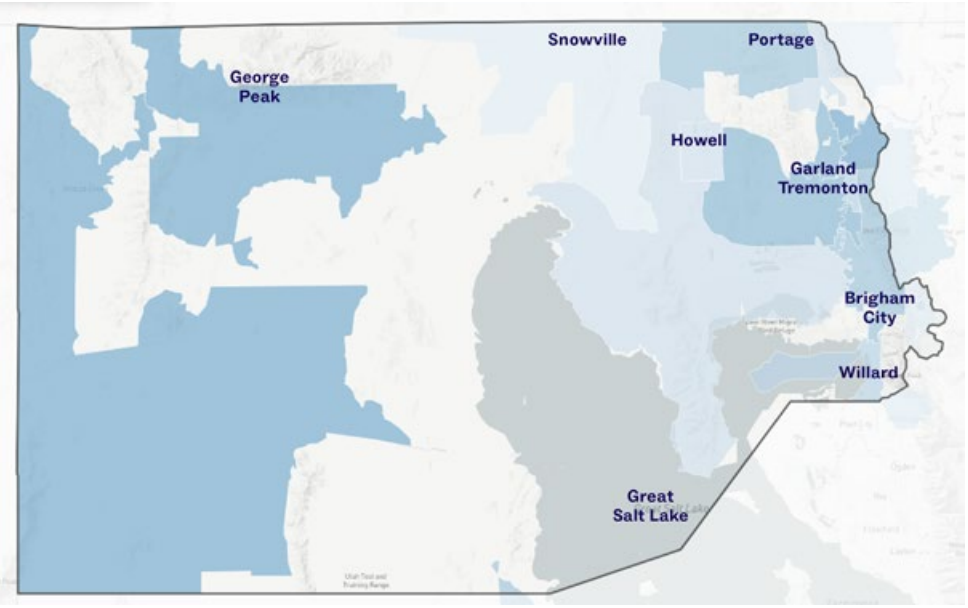
APPENDIX: RESOURCES TO ADDRESS SIGNIFICANT HEALTH NEEDS

Increase Access to Care

The 2025 CHNA prioritizes addressing access to care as a significant health need based on data-driven needs specific to the service area.

"We lack reliable transportation options in this area, and that significantly limits people's ability to access healthcare, especially specialized services that aren't available locally." *— Community Stakeholder*

Uninsured Rate | 2019-2023
Box Elder County: **7.9%**
±0.8% of adults



In the service area, 8% of residents are uninsured and rates are over 25% in Fielding and the rural areas in the north and western corners of the county.

Metopio | Ties © Mapbox, Data source: Centers for Disease Control and Prevention (CDC) PLACES, BRFSS

DISPARITIES, HEALTH EQUITY & ACCESS TO CARE

Utah has double the family medicine providers per capita compared to the service area.

8% of the service area are uninsured, but rates are higher among residents who are Hispanic/Latino, Asian, Pacific Islander, and adults ages 18 to 39 years.

11% of residents are covered by Medicaid, with rates increasing to 15% for children ages 0 to 17 years.

COMMUNITY STRENGTHS

- Federally Qualified Health Centers, community clinics, and other community-based health organizations offer access to comprehensive, culturally appropriate care with with adjustable income-based fees.
- Collaboration opportunities with community-based organizations that have trusted relationships with residents experiencing access needs.
- Existing navigation and benefits programs inform and assist residents in accessing coverage and benefits.
- Diverse population with unique perspectives and skills that strengthen cultural capabilities.

APPENDIX: RESOURCES TO ADDRESS SIGNIFICANT HEALTH NEEDS

Prevent Childhood Injury and Illness

Proactively addressing children's health can have an upstream and life-long impact. Intermountain Health prioritized preventing childhood injury and illness as a significant health need through addressing child abuse/neglect and injury prevention. Using child-specific morbidity and mortality data and community input, the CHNA identified and prioritized health needs that differ from the adult population.

"I think educating, like the parents, in society that mental health is a real thing... because I've seen people my age go to adults who they trust and are being told that it's not actually happening. We need people, adults, who we can go to when we are struggling."

— Youth Community Member

TOP CAUSES OF INJURY-RELATED DEATH IN CHILDREN (2019-2023)

Injuries are the leading cause of mortality and disability among children (ages 0 to 18 years). Injuries are classified by their intent: unintentional, suicide or intentional self-harm, and homicide/assault

Ages 0 to 1 year	Ages 1 to 4 years	Ages 5 to 9 years	Ages 10 to 14 years	Ages 15 to 19 years
Unintentional • Suffocation (sleep related)	**Unintentional** • Drowning • Suffocation • Motor vehicle accidents	**Unintentional** • Motor vehicle accidents • Drowning **Homicide or Assault** • Firearms	**Unintentional** • Motor vehicle accidents **Homicide or Assault** • Firearms **Suicide** • Asphyxia	**Unintentional** • Motor vehicle accidents • Drug overdose • Drowning **Homicide or Assault** • Firearms **Suicide** • Firearms • Asphyxia • Drug overdose

DISPARITIES, HEALTH EQUITY & CHILDHOOD INJURY

Utah children living in rural and frontier counties are more likely to die by suicide, motor vehicle crashes, and firearms compared to children living in urban counties.

American Indian/Alaska Native and Black/African American children in Utah are twice as likely to have an injury-related death compared to all races and ethnicities in the state.

Young women are more likely to attempt suicide; young men are more likely to die by suicide.

Firearms are the leading cause of death for ages 13 to 18 years in Utah.

COMMUNITY STRENGTHS

- Children's hospitals and specialty clinics with expertise to address the specialized health needs of infants, children, and youth in the services area.
- Family-focused communities and a readiness to collaborate on issues relating to children's health.
- The state ranks high for safety rates and low for crime rates compared to the U.S.

APPENDIX: RESOURCES TO ADDRESS SIGNIFICANT HEALTH NEEDS

Evaluation of Prior CHNA

The previous CHNA was conducted in 2022, and the significant health needs were identified as improving mental well-being, improving chronic and avoidable health outcomes, and addressing and investing in social determinants of health. A companion Implementation Strategy was also developed to address these health needs identified among the medically underserved, low- income, and minority residents in the CHNA data. Notable outcomes from those activities are below.

2023 - 2025 Implementation Strategies and Outcomes

Significant Health Need	Strategies	Outcomes 2023-2025*
 **Mental Well-Being**	• Reduce suicide deaths • Reduce frequent mental distress, including anxiety and depression • Decrease opioid misuse and prevent opioid overdose deaths	• Led or provided funding for 407 community suicide prevention trainings for 15,922 Utah residents. • Distributed 17,766 gunlocks along with mental health pamphlets tailored with community resources. • Funded 32 mental health organizations to serve 3,655 uninsured or underinsured people providing access to 13,122 mental health encounters. • Developed and distributed public education for adult and youth mental health and resource navigation. • Distributed 3,860 naloxone kits at 135 public events in Utah.
 **Chronic and Avoidable Health Outcomes**	• Prevent or delay the onset of type 2 diabetes and high blood pressure • Improve immunization rates • Decrease unintentional injuries and vaping for children and youth	• Led or provided funding for 5,177 prediabetes screenings and 27 prediabetes prevention classes for 141 participants. • Provided funding for enrollment in an evidence-based diabetes health coaching program for 109 patients at Utah community clinics. • Supported the Utah Immunizations Community Collaborative, which helped increase the state HPV immunization rate from 55% in 2022 to 61% in 2024. • Distributed 9,444 safety devices to prevent childhood injury, including car seats, bike helmets, life jackets, and others. • Conducted 1,434 car seat checks for proper installation and fit throughout Utah. • Trained staff from three Utah school districts, who instructed over 5,000 students with Catch My Breath curriculum, a vaping prevention program.
 **Social Determinants of Health**	• Improve individual- and community-level social determinants of health • Build community capacity to address social needs	• Provided 68 community organizations with diagnostic vouchers for uninsured and low-income patients to access 34,048 diagnostic services. • Funded the launch of a statewide social care referral platform that has onboarded 467 community organizations with 952 programs in Utah. • Implemented interpersonal violence screenings in 22 Intermountain clinics with 280 providers and connected individuals to community resources. • Invested $40 million in place based investing to create 299 affordable housing units and improved the financial wellness for 187 people.

* Totals as of April 2025

Conclusion

Intermountain is grateful for the support of community members and organizations for their valuable participation in the CHNA process. Their community voices offered a deeper understanding of unique local needs and health disparities identified through the CHNA data. Intermountain leverages this valuable input to develop an Implementation Strategy in collaboration and alignment with the community to create equitable opportunities for health.

Intermountain caregivers from Community Health and Consumer Experience worked with the Utah CHNA Collaboration to lead the 2025 CHNA process. We recognize the value of working alongside the Collaborative, which resulted in a more comprehensive, inclusive, and impactful CHNA. Intermountain will conduct the next CHNA in 2028 and looks forward to continuing collaborations to improve the health of our communities.

For additional information about the CHNA, contact:

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To submit written comments on this CHNA or request a paper copy, please email IH_CommunityHealth@imail.org

Appendices

Intermountain Health

CHNA Glossary

Term	Definition
Activity or Program	Evidence-based actions to address each significant health need.
Community Health Needs Assessment (CHNA)	Tri-annual review and analysis of unmet or significant health needs in the communities served by Intermountain Health; it informs the development of the Implementation Strategy and all of Intermountain Health's Community Health work.
Evaluation	Assessment of results from actions taken to address significant health needs.
External Stakeholder	Organizations, government agencies, individuals, and other entities outside Intermountain Health that will be influential in the success of or impacted by the CHNA and Implementation Strategy.
Health Disparity	Data-identified and preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health experienced by communities.
Health Equity	Foundational and embedded across Intermountain Health's approach to health improvement is the principle of pursuing the highest possible standard of health by focusing on improving the well-being of our most vulnerable communities.
Health Needs	Unmet community health needs identified during the CHNA.
Health Indicators	Specific health discrepancies identified by data within the health needs (i. e. , frequent mental distress as an indicator within behavioral health).
Health Outcome	Anticipated impact of strategies on significant health needs.
Implementation Strategies (IS)	A written plan to address health needs prioritized in the CHNA; it includes activities, collaborations, resources, funding, and the anticipated impact on data-driven needs.
Internal Stakeholder	Departments, teams, and other functions of Intermountain Health that will be influential in the success of or impacted by CHNA and Implementation Strategy.
Primary Data	Information gathered directly from sources including stakeholder and resident surveys, interviews, and community and stakeholder meetings.
Secondary Data	Information gathered by third parties, typically public health agencies, government agencies, or large studies.
Significant Health Needs	Community health needs prioritized during the CHNA that are addressed in the Implementation Strategy.

CHNA Participants

Utah Community Health Needs Assessment Collaborative

Bear River Health Department	Beaver Valley Hospital	Blue Mountain Hospital
Central Utah Public Health Department	Comagine Health	CommonSpirit Health
Davis Behavioral Health	Davis County Health Department	Division of Public Health, School of Medicine, University of Utah
Get Healthy Utah	Huntsman Cancer Institute	Intermountain Health
Kem C. Gardner Policy Institute	Milford Valley Memorial Hospital	MountainStar Healthcare
One Utah Health Collaborative	Salt Lake County Health Department	San Juan Public Health Department
Southeast Utah Health Department	Southwest Utah Health Department	Summit County Health Department
Tooele County Health Department	Tri-County Health Department	Uintah Basin Healthcare
Utah County Health Department	University of Utah	Utah Hospital Association
Wasatch County Health Department	Weber-Morgan Health Department	

Community Input Participants

Bear River Association of Governments	Bear River Health Department	Bear River Hospital
Bear River LGBTQ+ Community Coalition	Box Elder School District	Brigham City Suicide Prevention Coalition
Intermountain Health	New Hope Crisis Center	Northern Box Elder County Suicide Prevention Coalition
Tremonton City	United Way	Utah Department of Health and Human Services

CHNA Methodology

Persons Involved in Data Collection and Analysis

Organization	Name, Credentials	Title	Responsibilities
Intermountain Health	Kathryn Barker, MPH	Community Health Manager	Support secondary data analysis and evaluation
Intermountain Health	Chris Grosh, PhD	Strategic Research Senior Consultant	Gather and analyze data from public and stakeholder surveys and interviews

Methodology: Secondary Data

Secondary Data Sources

Unless noted otherwise, CHNA secondary data sources are accessible in the Metopio database at this link.

Data Source	Year(s)	Indicators
U.S. Census Bureau: American Community Survey (ACS)	2019-2023 Five-Year File 2023 One-Year File	Population (B01001), High school graduation (B15002), Poverty rate (B17001), Median household income (B19013), Uninsured rate (B27001/C27001), Spanish primary language (B16002), Limited English proficiency (B16004), No computer or smartphone (B28001), Below 150% of poverty level (C17002), Unemployment rate (B23025, B23001, C23002), Housing cost burden (B25070/B25091)
Centers for Disease Control and Prevention (CDC): National Vital Statistics System-Mortality (NVSS-M)	2019-2023	Mortality rates: breast cancer, colorectal cancer, drug overdose, firearms, lung cancer, infant, motor vehicle traffic accidents, suicide
CDC WONDER and WISQARS online databases	2019-2023	Leading causes of death, Firearm-related deaths; Accessible at this link
University of Wisconsin-Madison, Neighborhood Atlas	2022	Area Deprivation Index (ADI)
Area Health Resources Files	2021-2022	Family medicine providers per capita
KIDS COUNT	2020-2022	Low birth weight
diversitydatakids.org, Boston University	2021	Child Opportunity Index 3.0
PLACES, Behavioral Risk Factor Surveillance System (BRFSS)	2022	Diagnosed stroke, Have ever had cancer, Mammography use, Visited dentist, Self-reported poor physical health, Self-reported poor mental health, Depression, Cigarette smoking, Coronary heart disease, Current asthma, Colorectal cancer screening, Binge drinking, Visited doctor for routine checkup, Housing insecurity, Diagnosed diabetes
Health Professional Shortage Areas (HPSA)	2024	Provider ratios
Map the Meal Gap from Feeding America	2022	Food insecurity
National Center for Education Statistics: Common Core of Data	2023	Free school lunch eligibility
National Provider Identifier Files (NPI)	2021-2024	Mental health providers per capita
National Low Income Housing Coalition	2024	Fair market rental cost with minimum wage
Utah Child Fatality Review, Annual report	2021	Injury-related mortality rates for children; Accessible at this link
Utah Office of the Medical Examiner, Fatal Drug Overdose Report	2023	Drug overdoses involving fentanyl; multiple substances; Accessible at this link
Utah Office of the Medical Examiner, Suicide among Youth in Utah	2016-2021	Youth suicide attempts; Accessible at this link
Utah Student Health and Risk Prevention (SHARP) Survey	2023	Considered suicide among students (grades 6, 8, 10, 12); Accessible at this link

Methodology: Primary Data

Community Input Inventory

Input Types and Dates	Sample	Method	Topics Covered	Community Representation
Public Survey 1/6 - 2/3/2025	n=1,081 50 reside in service area	Web-based survey through email	• Health and well-being • Health insurance status • Health care access • Unmet social needs • Community concerns • Community strengths	• 12% Ages 18 – 24 • 30% Ages 25 – 39 • 44% Ages 40 – 59 • 14% Ages 60 or older • 0% American Indian/Alaska Native • 4% Asian • 4% Black/African American • 4% Hispanic/Latino • 0% Native Hawaiian/Pacific Islander • 92% White, Non-Hispanic/ Latino • 58% Female • 42% Male • 8% LGBTQIA affiliation • 44% Child living in household • 52% Disability in household • 12% Unemployed
Stakeholder Survey 1/21 - 2/14/2025	n=238 21 serve the service area	Web-based survey through email	• Community demographics • Community health focus • Community concerns • Community priorities • Community strengths	• Community-based organization representative (nonprofits, community groups) • Education/youth serving representative (teachers, school administrators, youth program coordinators) • Elected official (city council members, state legislators) • Faith-based organization representative (clergy, church leaders) • Healthcare administrator (hospital administrators, clinic managers) • Medical professional serving adults (doctors, nurses, physician assistants) • Medical professional serving children (pediatric doctors, nurses, physician assistants) • Mental/behavioral health representative (psychologists, social workers, counselors) • Public health worker (public health nurses, health educators) • Youth representative (youth leaders, student council members)
Community Input Meetings 4/21/2025	n=17	In-person meeting	• Primary and secondary data review • Discussion of preliminary health needs and community impact • Identification of additional community health needs	• Community-based organizations • Education and government • Health care organizations • Older adult serving organizations • Private sector • Public health departments • Youth-serving organizations

Summary of Primary Data Findings

Input Type	Findings
Public Survey	• Top Reported Unmet Health Needs in Service Area – Dental care, 22% – Specialty healthcare, 14% – Prescription medications, 14% – Mental healthcare, 14% – Primary care, 10% • Children with Unmet Healthcare Needs, 0% • Top Reported Household Needs for Service Area – Trouble finding employment, 22% – Food insecurity, 20% – Unreliable transportation, 14% – Social isolation, 14% – Housing instability, 12% – Overwhelmed by caregiving, 12% – Utilities being shut off, 12% • Top Reported Community Concerns for Service Area – Health insurance costs, 42% – Pollution (air, ground, water), 30% – Financial insecurity, 28% – Childhood bullying, 28% – Quality education, 24% – Mental health, 24% – Aging needs, 24% – Affordable housing, 20% – Gun safety, 20% – Suicide, 16%
Stakeholder Survey	• Top community concerns ranked in order were mental health, housing instability, financial insecurity, substance use/addiction, health insurance costs, suicide, food insecurity, healthcare access, child abuse, and access to public transportation. • Top health needs that should be prioritized were mental health issues including suicide and substance use/addiction, financial insecurity including housing instability and food insecurity, community safety, child abuse, healthcare access, and health insurance costs.
Stakeholder Interviews	• Identification of community strengths and resources to address Significant Health Needs identified in 2025 CHNA. • Current community efforts to address Significant Health Needs identified in 2025 CHNA. • Opportunities for on-going or potential collaboration with stakeholders to address Significant Health Needs identified in 2025 CHNA.

Community Resources

Resources to Address Significant Health Needs

Significant Health Need	Organization	Summary of Resources
Improve Behavioral Health	Local Mental Health Authorities	Mental health therapy, case management, group therapy, and trainings. Individual and group services on a sliding fee scale that support access for low-income individuals.
	Substance Use Disorder Treatment Centers	Organizations that provide Medication Assisted Treatment (MAT) programs for individuals with substance use disorder.
	County Public Health Departments	Provide prevention programming and harm reduction.
	Peer-Support Substance Use Organizations	Peer recovery coaching, family support services, and social supports.
Invest in Social Drivers of Health	Nonprofit Housing Organizations	Housing and utility assistance, emergency and respite shelter, case management, and workforce development.
	Housing Authorities	Affordable housing and support, case management, and transition services.
	County and State Government Agencies	Local workforce centers, government programs like Women, Infants and Children (WIC), and collaboration on economic stability strategies.
	Nonprofit Food Organizations	Community-based organizations that provide food assistance programs, local food banks, and pantries.
	Nonprofit Employment and Economic Stability Organizations	Community-based organizations that provide training programs leading to employment pathways, financial literacy education, and wrap-around support for people experiencing poverty.
Increase Access to Care	Federally Qualified Health Centers	Community-based organizations that provide comprehensive primary medical, dental, and behavioral healthcare regardless of ability to pay and insurance status.
	Safety Net Clinics	Community and school based primary care services including medical, behavioral health, and dental for low-income and uninsured residents.
	Nonprofit Community Organization	Navigation and application assistance for public programs, including government and other health insurance.
	Nonprofit Transportation Organization	Transportation services that improve access to care.
	Government Agencies	Enrollment assistance for numerous types of public benefits related to access, income, and insurance coverage.
	Law Enforcement and Corrections	Connection to medical, behavioral health, and social support services.
Prevent Childhood Injury and Illness	Early Childhood Government Agencies	In-home services, health and wellness support, and child protection.
	Nonprofit Community-Based Organizations	Assistance in connecting children and families experiencing poverty, abuse, neglect, or crisis to social services and other community resources. Supervision and programs for children focused on safety, health, learning, and development.
	Child Behavioral Health Organizations	Specialized pediatric behavioral health providers who serve children and youth.
	Education Organizations and Schools	Youth mental health resources, promotion of injury prevention and mental well-being, and career pathways leading to economic stability.

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