The Healthy Workplaces Healthy Communities Committee (HWHC) is a national employer-community collaboration initiative through the Health Enhancement Research Organization (HERO) that provides business and community leaders with practical tools and strategies for building support and investing in shared priorities. Since 2013, HERO has focused on building the business case for employer engagement in community-wide population health initiatives. With support from the Robert Wood Johnson Foundation, the Get-HWHC.org website was created to be a dynamic resource in defining the business case for employers to invest in community health improvement initiatives, sharing case studies and best practices and providing tools to assist in building multisector partnerships.

ORGANIZATIONAL INFORMATION

Name of Organization:	Intermountain Healthcare
Organization Description: (Mission/Vision)	Intermountain Healthcare is a Utah-based, not-for-profit system of 23 hospitals, 170 clinics, a medical group with some 2,300 employed physicians and advanced practice providers, a health plans division called SelectHealth, and other health services. Helping people live the healthiest lives possible, Intermountain is widely recognized as a leader in clinical quality improvement and in efficient healthcare delivery. Intermountain works with community non-profit agencies, government entities, and healthcare providers to improve the health of the uninsured and underserved. Intermountain operates a variety of community and school-based clinics to improve health and healthcare access in rural and underserved communities.
Contact Information:	Name of Primary Contact: Lisa Nichols Title: AVP Community Health Email address: Lisa.Nichols@imail.org
Website:	https://**intermountainhealthcare**.org/

COMMUNITY HEALTH ENHANCEMENT (CHE) STRATEGY

Title of CHE Strategy	Alliance for the Determinants of Health

Please list any implementation and funding partners	
Populations Served (e.g., employees, families, community participants, vulnerable populations)	A collaborative in Weber and Washington counties has been formed to address the social needs of our most vulnerable community members. The Alliance for the Determinants of Health (the Alliance) is a three-year demonstration project with support and participation from the public and private sectors. The Alliance will focus on SelectHealth Community Care (Medicaid) members of all ages.
Location(s) (city/town and state)	Weber and Washington counties in Utah.
What need/challenge are you addressing?	The cost of healthcare was the leading issue among Utah voters in 2018. Americans pay more for healthcare than any other county, and despite higher costs, we have shorter life expectancy and fare worse on many health indicators. Emerging evidence indicates that addressing the social determinants of health (SDoH) such as housing instability, utility needs, food insecurity, interpersonal violence, health behaviors, and transportation needs can improve health and well-being while simultaneously lowering healthcare costs. Addressing these social determinants requires innovative, comprehensive, and collaborative solutions from public and private sectors.
Goal(s) of CHE Strategy	The strategy is designed to decrease healthcare costs and improve healthcare outcomes by addressing the social needs of high risk Medicaid members. This requires a collaborative approach that eliminates the silos between healthcare and social services and bi-directional coordination through a digital platrom. Metrics include the number of emergency department visits for ambulatory care sensitive conditions, the rates of screening and engagement, and the number of community partners coordinating services through a bi-directional platform.

Description of strategy and tactics used for implementation	The framework for the Alliance is based on the Accountable Health Communities model currently being tested by the Center for Medicaid and Medicare Services. This framework includes awareness, assistance, and alignment. Awareness includes screening of high-risk individuals for social needs. Assistance includes navigation to services by a community health worker. Alignment includes developing shared goals with community partners, identifying and addressing gaps in community resources, and data sharing across organizations. A digital platform will be used to support the Alliance partners to coordinate social care. The platform will be utilized to screen members for unmet needs to electronically connect members to social service providers, to track progress and receive automated feedback from partners to ensure care and services are received, and to collect data to measure the network's impact.
Date of initial implementation for your CHE strategy?	In January 2019, we began operational testing in our care delivery partner sites including Federally Qualified Health Centers and Local Mental Health Authorities.
Is the CHE Strategy: • **In Process?** • **Complete**	The CHE is in process.
If CHE Strategy is complete, did you achieve what you set out to achieve? If no, state challenges or issues encountered.	The CHE is not complete.
Do these efforts tie into your corporate social responsibility standards or are they separate? Please explain.	These efforts tie into our corporate social responsibility standards as an anchor institution. As a large employer and healthcare system, Intermountain Healthcare could implement a community-level alliance to improve the health of Utahns through a deliberate focus on the alignment of provider, payer, and broader community resources. The Alliance will strive to demonstrably increase the health of our communities by going upstream to improve the health of specific populations and keep them well.

METRICS CAPTURED AND LESSONS LEARNED

How do you measure your success?	Success will be measured by a multitude of metrics including reduction in total cost of care, hospital readmissions, emergency department visits for avoidable needs, and improvements in addressing social needs. Intermountain has also created a long-term board goal that will be tracked over the three-year demonstration. This goal includes process measures related to the implementation of a digital platform to support better coordination of medical, behavioral, and social care plans across delivery systems and the creation, testing, and implementation of workflows and tools to support the coordination of social services in Intermountain Medical Group Clinics and Emergency Departments. This goal will help to create a scalable model that can support the achievement of value-based care.
Outcomes: What key metrics and areas of impact are being captured (e.g. stakeholder engagement, social, physical, environmental, including economic impact)	The Alliance has a robust evaluation plan including the use of a national research organization to perform an independent analysis of the demonstration. Once the national evaluator is selected, it is anticipated that additional metrics of evaluation will be created. Healthcare measures will become more specific and measurable. SDoH measures will be added through conversation with partners and in alignment with the selected interventions. Healthcare Metrics – 5% improvement year 2 over year 1 in the following Key Performance Indicators: • Total cost of care • Hospital readmissions • Avoidable emergency department visits SDoH Metrics - Improvements in addressing social needs: over three years, screen 50% of members and navigate 30% of those screened to social care.
Additional Lessons Learned	We often find what stands in the way is something that seems small but is not attainable for vulnerable populations. The members we serve are often seen in multiple settings across the medical and social continuum, because of this we see the need for operational alignment and integration across the system. We have found what seem to be easy solutions to these issues are hindered by regulatory and policy issues.

SUSTAINABILITY AND REPLICABILITY

Describe your sustainability plan	Concurrent with the Alliance initiative, Intermountain has teams tasked with developing a comprehensive, consistent and cohesive approach to SDoH across the continuum of care and across populations served by Intermountain, a caregiver health initiative, and a population health initiative for SelectHealth Community Care. As the work of the Alliance progresses, it will be necessary to ensure that all initiatives are aligned.
Please provide a few specific recommendations for replicating your CHE.	Health systems should rely on their community partner's experience and leverage the relationships they have with their patients/clients to get better engagement and higher acceptance of interventions. Our partner, providing the community health worker intervention and oversight, advised us from the beginning that they experienced more engagement during point-of-care screenings for SDoH or when an appointment or event prompted the introduction to the intervention. This has proven to be the case and has been a key factor in the FQHC increasing their volume of members who accept the intervention. The clinic point-of-care screenings allow their staff to endorse the intervention and it gives the patient a causal reason to engage. Another key has been leveraging the trust a patient has in the referring organization. For example, a patient of the FQHC was given the PRAPARE (Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences) Lite tool by the receptionist and marked that she had no social needs. Due to the existing relationship, the receptionist felt it was likely this patient had high social needs but was reluctant to ask for help. She sat down with the patient privately and shared how a community health worker had assisted her at one point in her life and how much she benefited from the help. The woman became emotional and said she did need help. The patient then proceeded to mark every box on the social determinant of health questionnaire. Because of a receptionist, who knew and cared about this patient, the patient accepted the offer to be connected to the community health worker.
Additional comments are encouraged and welcome! Please consider writing one to two paragraphs to accompany your case study that personalize your work or provide details not captured in the questions above.	The Alliance seeks to address social needs and to bridge the gap between social services and the healthcare system. The Alliance demonstration launched in January 2019 with testing and workflow refinement. To be successful in this initiative, we must redesign our current operational workflows to address the environmental, behavioral, and social factors that impact health. The complexity to achieve operational integration across multiple settings, both internal and external to Intermountain, is

	multifaceted. Intermountain will work with partners to ensure alignment with the model and the availability of identified resources. This includes supporting healthcare delivery partners such as Federally Qualified Health Centers and Local Mental Health Authorities in screening, awareness, and assistance likely through the support of Community Health Workers and Care Coordinators. It also includes working with non-healthcare delivery partners to build resources i.e. assisting food banks in ensuring fresh, healthy foods are available. Alignment will move beyond social needs to address integrated and coordinated delivery and payment.