AT A GLANCE:

Mercy Regional Medical Center

AREA SERVED: ARCHULETA AND LA PLATA COUNTIES

PRIORITIES:

- Mental Health
- Substance Use Disorder
- Healthy Living: Nutrition and Food Security
- Adult Oral Health

PARTNERS:

Axis Health Systems (integrated federally qualified health center), Southwest Area Health Education Center, Community Health Action Coalition (local grassroots organization), and the Southern Ute Indian Tribe, Mercy Regional Medical Center’s Community Benefit Advisory Council
# 2019 Community Health Needs Assessment

**Mercy Regional Medical Center**

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OUR MISSION, OUR VISION, AND OUR VALUES

**Mission**
We extend the healing ministry of Christ by caring for those who are ill and by nurturing the health of the people in our communities.

**Vision**
Every community, every neighborhood, every life – whole and healthy.

**Values**
- Compassion
- Respect
- Integrity
- Spirituality
- Stewardship
- Imagination
- Excellence
Executive Summary

On June 7, 2019, the Mercy Regional Medical Center Board of Directors approved the 2019 Mercy Regional Medical Center Community Health Needs Assessment (CHNA) priorities of 1) Mental Health; 2) Substance Use Disorder; 3) Healthy Living: Nutrition; and 4) Adult Oral Health. The CHNA was the third iteration of our process to strategically ignite whole person health in each community we touch. At Centura Health, we are a diverse community of caregivers connected and fueled by our individual passions and purposes to change the world around us. While individually inspired, we are collectively unified by our Centura Health mission. The CHNA process presents an opportunity for Mercy Regional Medical Center to fulfill our commitment to our organizational mission to extend the healing ministry of Christ by caring for those who are ill and by nurturing the health of the people in our communities. Based upon the input we received during the CHNA process and by reviewing community assets and gaps, we developed our Community Health Implementation Plan (CHIP), setting our path forward to building wholeness and flourishing communities. This plan is designed to continue to amplify meaningful collaboration among Mercy Regional Medical Center, the local public health department, community leaders, and partner organizations.

Mercy Regional Medical Center’s Community Health Implementation Plan (CHIP) recognizes the health needs prioritized in our Community Health Needs Assessment (CHNA) as difficult health issues that cannot be solved by any single organization. To positively impact the health priorities requires a collaborative and strengths-based approach. Strategies in the CHIP are more likely be to successfully executed when working in collaboration with community partners. The strategies Mercy Regional Medical Center plans to use to address the health priorities leverages our role as a large business and employer, a health care organization and a nonprofit hospital partner. Like our approach toward medicine, we are committed to using evidence-based strategies to address the health needs of the community.

On October 4, 2019, our Board of Directors approved Food Security as a priority and Mercy Regional Medical Center’s Community Health Improvement Plan for FY2020-FY2022.
MENTAL HEALTH GOALS

• **Goal 1:** Reach 80% of school-aged youth with a social cohesion and/or resiliency strategy.

• **Goal 2:** Increase capacity of our community to support behavioral health needs through a sustainable approach toward Mental Health First Aid and a Stigma Reduction Campaign.

• **Goal 3:** Increase people reporting access to behavioral health services by 40%.

SUBSTANCE USE DISORDER (SUD) GOALS

• **Goal 1:** Identify and screen patients for substance abuse and connect them to appropriate treatment.

HEALTHY LIVING: NUTRITION AND FOOD SECURITY GOALS

• **Goal 1:** Increase by 20% the number of produce sites which accept SNAP and WIC at point of purchase.

• **Goal 2:** Increase the number of sources of healthy affordable food within the community by decreasing the number of food deserts by 20%.

• **Goal 3:** Decrease the number of community members who are eligible but not enrolled in SNAP by 60%.

• **Goal 4:** Increase use of locally sourced healthy, affordable food within Centura Health by 50%.

ADULT ORAL HEALTH GOALS

• **Goal 1:** Address oral health needs among vulnerable populations in our service area.
Our Services and Community

COMMITTED TO IMPROVING THE HEALTH AND WELLNESS OF THE COMMUNITIES WE SERVE.

Mercy Regional Medical Center is an 82-bed, acute-care hospital in Durango, Colorado. Mercy was founded in 1882 and has grown to become Southwest Colorado’s largest and most technologically advanced medical facility. It is the only hospital in the Four Corners region to receive a five-star rating for overall hospital quality from the Centers for Medicare and Medicaid Services. Mercy’s areas of specialty include orthopedic and spine surgery, cardiology, emergency and trauma care, cancer care, and more.

Distinctive Services  Noteworthy areas of care include:

**Hospital Services**
- 5-star rating for overall hospital quality
- Centers for Medicare & Medicaid Services
- Top Rural Hospital – Leapfrog Group

**Cardiology Services**
- Top 10% in nation for Cardiology Services – Healthgrades 2018
- American College of Cardiology’s NCDR ACTION Registry Platinum Performance Achievement Award

**Home Health**
- Top Agency of the HomeCare Elite

**Oncology Services**
- Quality Oncology Practice Initiative Certification Program
  (affiliate of American Society of Clinical Oncology)

**Spine Center of Excellence**

**Orthopedic Center of Excellence**

**Healthgrades Honor**

Mercy Regional Medical Center received the Healthgrades Top 5% in the nation for Outstanding Patient Experience Award™. This distinction recognizes Mercy among the top 15 percent of hospitals nationwide, according to Healthgrades. Mercy is the only hospital in the Four Corners region to receive the award for the last 10 years in a row (2009-2018).
OUR COMMUNITY

At Centura Health and Mercy Regional Medical Center, we remain committed to advancing vibrant and flourishing communities.

The CHNA and CHIP help to fuel our caregivers to continuously engage with, understand, and contribute to whole person health in our shared neighborhoods. By focusing on 1) Mental Health; 2) Substance Use Disorder; 3) Healthy Living: Nutrition and Food Security; and 4) Adult Oral Health for the next three years, we are excited to continue to live out our Mission, Vision, and Values every day.

To define Mercy Regional Medical Center’s service area for the CHNA, we followed a process focused on ensuring that the defined service area was inclusive of medically underserved, low-income and minority populations in the geographical areas from which the hospital draws its patients. We considered four factors:

• Opportunities to viably expand outreach of programs to medically underserved populations

• Inpatient admissions

• Coverage of the County by another Centura facility

• Opportunities for collaboration among facilities and with community-based organizations

After considering the factors above, we compared the defined geographical service area of the 2016 CHNA to this one to ensure no disadvantaged populations included in the 2016 CHNA were excluded in the 2019 CHNA.

To understand the profile of MRMC’s community we analyzed the demographic and health indicator data of the population within the defined service area. The service area has a total population of 69,931. The demographic makeup of these communities is on the following page.
POPULATION DEMOGRAPHICS IN MERCY REGIONAL MEDICAL CENTER’S SERVICE AREA

Race

- White 88.2%
- Black .5%
- Asian .6%
- Native American/Alaska Native 5.2%
- Native Hawaiian/Pacific Islander 0%
- Other 3.4%
- Multiple races 2.1%

Ethnicity

- Non-Hispanic 86.5%
- Hispanic 13.5%

Associate’s Degree or Higher

- Mercy Regional Service Area 73.1%
- State Average 71%

High School Graduation Rate

- Mercy Regional Service Area 80.9%
- State Average 77.6%

Limited English Proficiency

- Mercy Regional Service Area 1.5%
- CO 2.8%

Ratio of households in the 80th percentile to income at the 20th percentile

- Mercy Regional Service Area 4.2
- CO 4.5

Unemployment Rate

- Mercy Regional Service Area 3%
- CO 3.9%
Prioritized Needs and Plans

WORKING WITH COMMUNITY

Mercy Regional Medical Center collaborated with San Juan Basin Public Health (SJBPH). In addition to serving on our Advisory Subcommittee, we agreed to align community-based efforts in order to address community health holistically and to avoid duplication. We leveraged their qualitative data collected through focus groups to inform our CHNA. We have intentionally aligned strategies, as applicable, so we can work in collaboration with one another to address some of the most challenging health issues affecting our community.

We created a hospital subcommittee to solicit input from individuals and organizations representing the broad interest of our community to assess the needs of our community. Please see Appendix A for a list of Mercy Regional Medical Center’s subcommittee members. Our subcommittee:

- Reviewed the quantitative data and provided insight; and
- Prioritized health needs using the Centura Health Prioritization Method;

Our subcommittee met three times for two hours each meeting in order to rank and prioritize health needs, assets and gaps and to design the overarching strategies to be used to address the health needs. After careful consideration of the available quantitative and qualitative indicators and our Centura Health Mission, Vision and Values, Mercy Regional Medical Center identified 1) Mental Health; 2) Substance Use Disorder; 3) Healthy Living: Nutrition and Food Security; and 4) Adult Oral Health as priority focus areas.

After identifying our priorities, we reviewed the assets and gaps identified by the subcommittee to develop the Mercy Regional Medical Center Community Health Implementation Plan (CHIP). The CHIP recognizes the health needs prioritized in our CHNA as tough health issues that cannot be solved by any single organization on its own. To positively impact the health priorities requires a collaborative and strengths-based approach. The CHIP elevates those strategies a hospital can implement on its own and with community partners to impact community health.

HOW WE MAKE A DIFFERENCE

The strategies Mercy Regional Medical Center will use to address the health priorities leverages our role as a large business and employer, a health care organization and a nonprofit hospital partner. (See Figure 1) Like our approach toward medicine, we are committed to using evidence-based strategies to address the
health needs of the community. Our intent in every strategy is to leverage our strengths and community partnerships, fill gaps and use strategies that catalyze community change.

Our CHNA and CHIP processes are integrated within the Colorado Hospital Transformation Program (HTP) Community and Health Neighborhood Engagement process. We value the time and voices of our community. We also believe our community health priorities and strategies should align with and complement HTP clinical strategies to yield the greatest outcomes for those in our communities. To that end, there are HTP metrics included in our CHIP to leverage our role as a health care provider to impact community health priorities.

In order to support whole person health, we recognize that health is more than the choices an individual makes. Rather, a person’s health is their community, requiring a healthy ecosystem to supporting the mind, body and spirit of individuals.

We use the socioecological model to address the health of our communities. This model recognizes the complex interplay between individual, relationship, community and societal factors. Individuals are responsible for making and maintaining lifestyle choices, such as eating healthy foods and refraining from substance use. However, the ability to make these choices is determined largely by the social environment in which we live (e.g., community norms, laws and policies). It is important to be surrounded by a community supportive of a person’s overall wellbeing. Communities should not have barriers to being healthy based upon a person’s race, ethnicity, income, or where they live, work, play or learn.

Each part of the wheel illustrates the contributing factors to whole person health, each factor influencing the others. Without all portions, the wheel does not smoothly move in a positive direction for whole person health. (See Figure 2). Therefore, the most effective approach to impacting health outcomes is a combination of efforts at the individual, interpersonal, organizational, community and public policy levels.
PRIORITIZED NEEDS AND PLANS

After careful consideration of the available quantitative and qualitative indicators and our Centura Health Mission, Vision, and Values, Mercy Regional Medical Center identified 1) Mental Health; 2) Substance Use Disorder; 3) Healthy Living: Nutrition and Food Security; and 4) Adult Oral Health as priority focus areas.

At Mercy Regional Medical Center, we are collectively unified by our Centura Health Mission: We extend the healing ministry of Christ by caring for those who are ill and by nurturing the health of the people in our communities. This Mission guides and inspires our shared desire to make a difference – one whole person and one healthy neighborhood at a time. We believe that our focus on 1) Mental Health; 2) Substance Use Disorder; 3) Healthy Living: Nutrition and Food Security; and 4) Adult Oral Health will have the greatest impact on our organizational commitment to whole person health.
PRIORITIZED NEED: MENTAL HEALTH

Inadequate access to mental health services is a concern in the communities we serve. Centura Health has recognized this gap and has been working with mental health partners and providers to better integrate mental health services into our hospitals, clinics and neighborhood health centers. At Mercy, we have been working with Axis Health System to provide mental health services to our patients and our communities. As part of new Hospital Transformation Program (HTP), we have had some conversations with community partners and our Regional Accountable Entity (RAE) in Region 1 to explore additional resources we need in our community and region to improve access to behavioral health services. Rocky Mountain Health Plan (RMHP) recently conducted focus groups for providers and clients to identify barriers to behavioral health services and potential resources that could close gaps in care. We expect that there will be a plan from RMHP outlining action steps they will take in the foreseeable future to address this need in our service area and region.

Some challenges include not having enough providers who accept Medicaid and not having timely access to behavioral health services. Individuals in our service area typically wait several weeks or months to get an appointment for therapy or psychiatry. Mercy will continue to serve on the SJBPH’s Suicide Prevention Steering Committee in our ongoing efforts with community partners to reduce the rate of suicide in our service area. With the recent adoption of the collective impact framework and additional funding and resources coming to our area in recent months, we are optimistic that we will be see a significant reduction in suicide rates in our area.

Though the area is still understaffed, we are making strides toward improving access to behavioral health services for our patients who need these services. We created a behavioral health carve out from our high utilization program, LINK (Life Interruptions Need Kindness). This enables us to provide on-going behavioral health services to high utilizers enrolled in LINK who have behavioral health needs. Depression, Anxiety, and PTSD are leading drivers of ED utilization among LINK participants and creating this carve out from the LINK program will help us further meet this need in our hospital and community. We will continue to partner with Axis Health System to explore ways we can work together to improve access to behavioral health services.
## Goal 1: Reach 80% of school-aged youth with a social cohesion and/or resiliency strategy.

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<th>Strategy</th>
<th>Target Population</th>
<th>Action Plan Activity</th>
<th>Metrics</th>
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<tr>
<td>Develop with the school district and partners a plan to support youth resiliency and social cohesion within the school setting, Pre-K-12. Strategy will include the following: 1) Stakeholder engagement 2) Policy strategy 3) Specific plan for Y2 and Y3 4) Community input 5) Role of Centura Health/Mercy Regional Medical Center 6) Method for evaluation of success</td>
<td>School-age youth</td>
<td>• Convene stakeholders to develop comprehensive plan. • Develop 3-5 year plan for school and community.</td>
<td>Plan to reach youth with appropriate social cohesion and/or resiliency strategies</td>
</tr>
<tr>
<td>Implement strategy to reach youth with social cohesion and resiliency strategy for Y2 and Y3.</td>
<td>School-age youth</td>
<td>To be included after strategy designed for Y2 and Y3.</td>
<td># of youth reached through resiliency and social cohesion programs • Measure of youth resiliency and/or behavioral health status</td>
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## Goal 2: Increase capacity of our community to support behavioral health needs through a sustainable approach toward Mental Health First Aid and a Stigma Reduction Campaign.

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<td>Develop a community strategy for MHFA to reach youth and adolescents.</td>
<td>Youth &amp; Adolescents</td>
<td>• Review current MHFA plan for community and identify populations of focus for community. • Identify MHFA trainers within community and coordinate outreach. • Develop outreach strategy to reach key audiences for MHFA training. • Provide MHFA training to people serving youth within community.</td>
<td># of people working with youth who receive MHFA training # of youth/adolescents trained in MHFA</td>
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**Goal 3: Increase people reporting access to behavioral health services by 40%.**

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| Development of a collaborative discharge planning or notification process with the appropriate RAE’s for eligible patients with a diagnosis of mental illness discharged from the hospital or emergency room. | Patients 18 years and older discharged from the hospital or emergency room with a principal or secondary diagnosis of mental illness | • Map out identification process for patients diagnosed with a primary or secondary diagnosis of mental illness.  
• Identify how to efficiently and effectively transition patients from hospital/ED to the RAE for care coordination. | Percentage of eligible patients 18 years or older discharged from the hospital or emergency room with a principal or secondary diagnosis of mental illness with collaborative discharge planning or notification of the RAE within 1 business day (HTP measure SW-BH1) |
PRIORITIZED NEED: SUBSTANCE USE DISORDER

Alcohol use was identified as a significant health concern by MRMC’s Community Benefit Advisory Council, SJBPH’s most recent community health needs assessment, and our RAE in Region 1. Liquor store access is higher in our service area versus Colorado. It is easy for individuals to access alcohol and is widely accepted as part of our culture. Homeless individuals and individuals with PTSD, depression, and anxiety tend to self-medicate with alcohol. Alcohol use is the primary driver of ED utilization with patients enrolled in LINK. SUD was identified as a health need in MRMC’s 2016 Community Health Needs Assessment, and the LINK program was implemented in the fall of 2016 to help address ED and hospital utilization associated with alcohol use, mental health issues, and unmanaged chronic conditions. We have successfully connected patients with inpatient residential treatment outside of our service area as well as outpatient services in La Plata County to help them achieve sobriety and stop the cycle of visits to the ED and detox. RAE Region 1 is currently exploring the creation of an intensive outpatient day treatment program in La Plata County because this is currently lacking in our community. We have two Medication Assisted Treatment Programs (MAT) in La Plata County; however, individuals who have utilized these services in the past for their alcohol use shared that the medication they are given makes them feel ill. Axis Health System provides outpatient substance use treatment services; however, some individuals find their program rigid, and as a result, will not engage in these services.
A challenge we have in our community is the lack of sober living homes for individuals who have achieved sobriety but may need housing, employment, and other support services to help them become self-sufficient. We have one sober living home in Durango with three rooms; therefore, there is little turnover, making it difficult to access. Individuals who achieve sobriety who remain homeless or unstably housed have a higher chance of relapsing. There is a need in the service area to create more affordable housing so we can help individuals stabilize and work toward becoming self-sufficient. We don’t know yet what our role will be in addressing the lack of affordable housing in Durango; however, the faith-based community will develop a plan to address this issue in Durango. We know that there is a strong correlation between homelessness, mental health issues, substance use disorders, and high ED utilization. We will continue to remain engaged with our community partners and RAE Region 1 to further define our role in addressing SUDs, primarily alcohol use.

We will explore creating a carveout from the LINK program that will focus on patients whose primary driver of ED utilization is substance use. While our LINK program currently serves patients with SUDs, creating a substance use focus within the program will enable us to provide intensive services so we can help patients achieve long-term sobriety.

In December 2018, our ED implemented the ALTO (Alternatives to Opioids) in an effort to reduce opioid use and overdoses in our community. We have heard from law enforcement that the use of cocaine, heroin, and methamphetamine is increasing because it is very cheap to purchase. We will continue to monitor the use of these drugs entering our ED and hospital.
Goal 1: Identify and screen patients for substance abuse and connect them to appropriate treatment.

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| Development of a collaborative discharge planning or notification process with the appropriate RAE’s for eligible patients with a diagnosis of substance use disorder (SUD) discharged from the hospital or emergency room. | Patients 18 years and older discharged from the hospital or emergency room with a principal or secondary diagnosis of SUD (HTP) | • Map out identification process for patients diagnosed with a primary or secondary diagnosis of SUD.  
• Identify how to efficiently and effectively transition patients from hospital/ED to the RAE for care coordination. | Percentage of eligible patients 18 years or older discharged from the hospital or emergency room with a principal or secondary diagnosis of SUD with collaborative discharge planning or notification of the RAE within 1 business day (HTP measure SW-BH1) |
| Screening, Brief Intervention, Referral, Treatment | ED patients 12 years and older                          | Identify/develop resource in the ED to conduct SBIRT screening on all patients 12 years and older. | Percent of ED patients age 12 years and older who are screened for alcohol or other substance use and the percent of those who screen positive who received a brief intervention (HTP measure LM-BH1) |
PRIORITIZED NEED:
HEALTHY LIVING: NUTRITION AND FOOD SECURITY

Mercy Regional Medical Center’s Community Benefit Advisory Council again prioritized Healthy Living through Nutrition and Physical Activity to address obesity. Although La Plata and Archuleta counties’ obesity rates are better than the state average, the Council recognized that trends are going in the wrong direction with overweight adults in MRMC’s service area exceeding the state average. If MRMC can positively affect overweight and obesity rates, this will likely result in less diabetes along with its associated complications, fewer abnormal birth weights, less heart disease, cancer and other co-morbidities.

Food insecurity is defined as the state of being without reliable access to a sufficient quantity of affordable, nutritious food. This priority will focus on removing barriers that create food insecurity. In Colorado, 12.9% of our community experiences food insecurity. Only 60% of Coloradans who are eligible for Supplemental Nutrition Assistance Program benefits are enrolled. As a result, Colorado loses out on is at $235.2M of grocery sales and an economic stimulus of $421M. Addressing food insecurity is essential to addressing Nutrition/Obesity/Healthy Living/Active Lifestyles because vulnerable populations need to be able to access the right kind of food to improve their health.

Food Security, a Social Determinant of Health, has been identified as a priority for Centura Health as a health system serving much of Colorado and western Kansas. As we listened to our communities, we heard frequently the barriers people face related to meeting their basic needs and the impacts on people’s health and well-being. Addressing Food Security will also address health equity because an essential tool in improving the health status of populations is providing access to healthy food. As a large employer and a nonprofit health system, we can impact access to healthy, affordable foods as an anchor institution whose mission and vision includes our communities.

Potential resources include:

- MRMC Diabetes Education Program
- MRMC Sports Medicine Program
- MRMC Wellness and Nutritional Therapy Program
- MRMC Cardio and Pulmonary Rehab Program
- Breast Feeding and Lactation Program, Family Birth Center, MRMC
- WIC (Women, Infants & Children)

- Health & Human Services Supplemental Nutrition Assistance Program
- Nurse Family Partnership
- Manna Soup Kitchen
- Cooking Matters
- Garden Project of the Southwest

In addition to the potential resources listed above, culinary medicine classes and cooking demonstrations were added in 2019. Other discussions include the possibility of providing outreach services for diabetes education in Archuleta County. We will explore tele-health as an option to expand our services to outlying communities.
### CHNA PRIORITY: HEALTHY LIVING: NUTRITION AND FOOD SECURITY

#### Goal 1: Increase by 20% the number of produce sites which accept SNAP and WIC at point of purchase.

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| Develop a strategy to increase SNAP and WIC acceptance in the community within Year 1. Strategy will include the following:  
1) Stakeholder engagement  
2) Policy strategy  
3) Specific plan for Y2 and Y3  
4) Community input  
5) Role of Centura Health/MRMC | SNAP and WIC eligible community members                                                                  | • Map food source locations and those which accept SNAP and WIC.  
• Convene stakeholders to identify strategies to address gaps within community and key stakeholders to engage.                                                                                              | • Strategy to increase SNAP and WIC acceptance in community  
• Community map of food resources and SNAP/WIC |
| Implement strategy to increase access to SNAP and WIC within Y2 and Y3.                          | SNAP and WIC eligible community members                                                                  | To be included after strategy designed for Y2 and Y3.                                                                                                                                                                | • # of SNAP and WIC sites within community  
• Ability of SNAP and WIC participants to purchase fruits and vegetables |
| Integrate food access strategies into Mercy Hospital community partnerships.                       | Partner Organizations Business Partners                                                                | • Integrate SNAP and WIC EBT use into partnerships in community.  
• Identify key locations for food distribution partnerships to increase access.                                                                             | % of sponsorships/partnerships that increase food access through location and/or SNAP/WIC acceptance                                                      |
| Work with state and local officials to identify policies to increase and sustain number of SNAP and WIC sale sites and ability to purchase fruits/vegetables through SNAP/WIC. | SNAP and WIC eligible community members                                                                  | • Develop a list of policy solutions related to SNAP and WIC sales.  
• Work with community partners to identify the best policies for our community.                                                                              | • Policies passed to increase access to healthy, affordable foods through SNAP and WIC  
• SNAP/WIC purchases for fruits/vegetables |
### Goal 2: Increase number of sources of healthy affordable food within the community by decreasing the number of food deserts by 20%

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<tbody>
<tr>
<td>Identify locations at which affordable food access needs to be increased</td>
<td>Low-income community members living in food deserts</td>
<td>• Map food source locations and those which accept SNAP and WIC by race/ethnicity and income.</td>
<td>• Community map of food resources and SNAP/WIC</td>
</tr>
<tr>
<td>based upon race/ethnicity and income to increase access for food insecure</td>
<td></td>
<td>• Identify ways to add access to healthy, affordable food in food deserts.</td>
<td>• # of produce distribution sites and food distribution sites within community by race/ethnicity and income</td>
</tr>
<tr>
<td>communities.</td>
<td></td>
<td>• Work with partners to eliminate food deserts through identified strategies.</td>
<td></td>
</tr>
<tr>
<td>Work with state and local officials to identify strategies to reduce food</td>
<td>Low-income community members living in food deserts</td>
<td>• Develop a list of policy solutions related to SNAP and WIC sales.</td>
<td>Policies adopted to increase access to healthy, affordable foods</td>
</tr>
<tr>
<td>deserts within the community.</td>
<td></td>
<td>• Work with community partners to identify the best policies for our community.</td>
<td></td>
</tr>
<tr>
<td>Increase access to healthy, affordable food through Centura Health food</td>
<td>Centura/Mercy associates Food Insecure Community Members</td>
<td>Review hospital food production processes and identify ways to distribute safe, unused food into community.</td>
<td>Policies and processes developed</td>
</tr>
<tr>
<td>production processes.</td>
<td></td>
<td></td>
<td>• Pounds and nutrient value of food distributed to community</td>
</tr>
<tr>
<td>Explore Centura Health and community land use opportunities for local</td>
<td>Food Insecure Community Members Mercy’s Service Area</td>
<td>• Conduct assessment of Centura Health land and community land and ability to grow food on identified locations</td>
<td>• # of Centura Health facilities producing food</td>
</tr>
<tr>
<td>food production and identify how to increase production of locally sourced</td>
<td></td>
<td>• Identify locations where gardening is possible on Centura Health land and community land.</td>
<td>• # of new community gardens</td>
</tr>
<tr>
<td>fruits and vegetables.</td>
<td></td>
<td>• Work with state and local policy makers to address barriers to gardening on Centura and community land, as necessary</td>
<td>• Pounds and nutrient value of food distributed to community from Centura Health gardens</td>
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### Goal 3: Decrease the number of community members who are eligible but not enrolled in SNAP by 60%.

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| Screen households for food insecurity and refer them to food resources in their communities, including identifying eligibility for all available public assistance programs. | SNAP and WIC eligible community members Food Insecure Patients | • Update Centura’s Electronic Health Record to assist in identifying Social Determinants of Health, including food insecurity.  
• Train associates on Social Determinant of Health screening and referral process.  
• Implement screening for Social Determinants of Health within hospital/ambulatory practices. | • % of patients screened for food insecurity  
• % of patients screened successfully referred to community resources |
| Partner with community to increase awareness of impact of hunger on whole person health and identify state and local policies to increase access to SNAP and WIC. | Decision Makers at State and Local Levels | • Participate in state and local coalitions addressing food insecurity.  
• Participate in Metro Denver Partnership for Health to address social determinants of health.  
• Implement Blueprint to End Hunger strategies applicable to health care. | • # of groups and meetings attended  
• Policies adopted at state and local levels to increase access |

### Goal 4: Increase use of locally sourced healthy, affordable food within Centura Health by 50%. (Systemwide)

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| Implement food procurement practices to prioritize local food sourcing. | Centura associates Hospital community | • Review current Centura Health food procurement practices and identify food sources.  
• Review best practices related to local food procurement and identify local food sources.  
• Establish plan for Centura Health implementation of local food procurement for hospital facility.  
• Implement local food procurement purchasing practices. | % of locally sourced food used by Centura Health |
PRIORITIZED NEED: ADULT ORAL HEALTH

Adult Oral Health was identified as a community health need for this CHNA. Just over 11% of adults in MRMC’s service area have poor dental health compared to 10% of adults in Colorado. The service area lacks dentists who accept Medicaid, and it can take up to one year for adults, particularly those on Medicaid, to receive preventative dental care. Axis recently expanded the number of adult oral health providers accepting Medicaid in La Plata County. Medicare does not cover the cost of dental services for seniors and many are unable to afford dentures. The MRMC Community Benefit Advisory Council recently met with the Chair of the Oral Health Coalition to explore ways MRMC can support community efforts to improve access to dental care services.

Potential resources include:

• Partnering with San Juan Basin Public Health Department’s Oral Health Coalition

• Collaborating with dentists and dental hygienists in our service area

• Educate primary care offices that accept Medicaid/Medicare about new dental benefits and Axis Health Systems expanded access

• Grant funding to address gaps in dental health services

There are several significant barriers that must be overcome to address adult oral health. This is a highly stigmatized issue, and sometimes people feel embarrassed by “their mouths” so they don’t seek care until their condition is very advanced. Transportation is also a significant issue. Veterans can also struggle to obtain quality oral health care services. If they are covered by the VA at 100% (meaning no supplemental insurance), there is no dental coverage and the nearest Vet clinic is in Albuquerque so that means transportation barriers. A van operated by volunteers provides transportation to ABQ. There is a dearth of oral care in nursing homes in the service area. Finally, the closing of the Head Start Center in Ignacio will eliminate a point of delivery of dental care for 65 families.
Goal 1: Address oral health needs among vulnerable populations in our service area.

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Target Population</th>
<th>Action Plan Activity</th>
<th>Metrics</th>
</tr>
</thead>
</table>
| Increase funding resources to address gaps in oral health & dental programs that impact health in our service area. | Uninsured adults and/or seniors with Medicare & no dental benefits | • Partner with Mercy foundation to identify funding resources for oral health.  
• Collaborate with Axis Health System to pursue grants to address oral health needs in our service area. | • # of uninsured adults and/or seniors who received financial support for oral health needs  
• Amount of dollars secured to address oral health needs in our service area |
| Provide education about the impact of oral health on physical health.    | Mercy staff                                      | Invite a dentist to speak at our annual health care conference in May 2020.          | # of staff who attend Mercy’s Health Care Conference in May 2020         |
Conclusion

On June 7, 2019, Mercy Regional Medical Center Board of Directors, a board made up of community members, approved our Community Health Needs Assessment. On October 4, 2019, the Board of Directors approved our Food Security as a priority and our Community Health Implementation Plan. The CHNA process presents an opportunity for Mercy Regional Medical Center to fulfill our commitment to Centura’s organizational mission to extend the healing ministry of Christ by caring for those who are ill and by nurturing the health of the people in our communities. The Community Health Implementation Plan (CHIP), sets our path forward to building wholeness and flourishing communities.

We look forward to reporting back annually on the work we do to improve the health of our communities. Together, we can realize our Centura Health Vision that every community, every neighborhood, every life is whole and healthy.
## APPENDIX A: LIST OF SUBCOMMITTEE MEMBERS

<table>
<thead>
<tr>
<th>Organization</th>
<th>Name of Representative</th>
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<tbody>
<tr>
<td>Community Health Action Committee</td>
<td>Pattie Adler</td>
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<tr>
<td>Axis Health System</td>
<td>Stephanie Allred</td>
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<tr>
<td>Mercy Regional Medical Center</td>
<td>Jolie Ensign</td>
</tr>
<tr>
<td>Southwest Health Education Council</td>
<td>Mary Frey</td>
</tr>
<tr>
<td>Centura Health</td>
<td>Tina Gallegos</td>
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<tr>
<td>CHPG and Mercy Regional Medical Center</td>
<td>Gwen Heller</td>
</tr>
<tr>
<td>Mercy Regional Medical Center</td>
<td>Elsa Inman</td>
</tr>
<tr>
<td>Mercy Regional Medical Center</td>
<td>Joshua Magyar</td>
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<tr>
<td>Mercy Regional Medical Center</td>
<td>Scott Mathis</td>
</tr>
<tr>
<td>Area Health Education Council</td>
<td>Kathleen McInnis, RN</td>
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<tr>
<td>Mercy Regional Medical Center Foundation</td>
<td>Karen Midkiff</td>
</tr>
<tr>
<td>Chair, Sub-Committee Obesity and Healthy Living, CHNA Sub-Committee</td>
<td>Marge Morris</td>
</tr>
<tr>
<td>Mercy Regional Medical Center</td>
<td>Jane Strobel</td>
</tr>
<tr>
<td>San Juan Basin Public Health</td>
<td>Laura Warner, MD</td>
</tr>
<tr>
<td>Mercy Regional Medical Center</td>
<td>Linda Young</td>
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