AT A GLANCE:

Penrose-St. Francis Health Services

AREA SERVED: EL PASO COUNTY

PRIORITIES:

Behavioral Health
Food Security
Access to Care

PARTNERS:

# 2019 Community Health Needs Assessment

## Penrose-St. Francis Health Services

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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 13, 2019 the Penrose-St. Francis Health Services Board of Trustees approved the 2019 Penrose-St. Francis Health Services’ Community Health Needs Assessment (CHNA) priorities of Behavioral Health, Healthy Lifestyles and Access to Care. 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 Penrose-St. Francis Health Services 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 Penrose-St. Francis Health Services, local public health departments, community leaders, and partner organizations.

The Penrose-St. Francis Health Services Community Health Implementation Plan (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.

The strategies Penrose-St. Francis Health Services 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.

As Centura Health looked across our system of care throughout Colorado and western Kansas at the health issues rising to the top as potential priorities, we recognized every hospital community had a need related to food security, or access to healthy, affordable foods. At Penrose-St. Francis Health Services, the needs identified related to food security were originally identified as Healthy Lifestyle. While the need for a healthy lifestyle is important, we heard from our community that in order to impact this issue, we must first address Food Security. This Social Determinant of Health is an essential building block toward health and well-being. Food security enables people with limited income to focus on healthy eating by removing cost and transportation barriers related to purchasing healthy food. Additionally, it removes the stressor of whether and how food will be on the table. As a result, our Board of Trustees added this as a priority for Penrose-St. Francis Health Services. On November 7, 2019, our Board of Trustees approved Food Security as a CHNA priority as the focus of the Healthy Lifestyles priority and our Community Health Improvement Plan for FY2020-FY2022.
BEHAVIORAL HEALTH GOALS

• **Goal 1:** Increase access to behavioral health services and providers.

• **Goal 2:** Develop screening tool and mechanism for identifying depression in postpartum women.

• **Goal 3:** Strengthen and expand community partnerships to provide care for those presenting with behavioral health diagnoses.

FOOD SECURITY GOALS

• **Goal 1:** Increase use of locally sourced healthy, affordable food within Centura Health by 50%.

• **Goal 2:** Increase 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%.

ACCESS TO CARE GOALS

• **Goal 1:** Increase the number of primary care providers.

• **Goal 2:** Strengthen and expand partnerships to increase transportation, increase education and awareness of available resources in the community, develop and increase the number of access points.
Our Services and Community

CENTURY LONG LEGACY OF AWARD WINNING SERVICES TO HEAL, INSPIRE AND CONNECT OUR COMMUNITY.

Penrose Hospital is the anchor hospital of Penrose-St. Francis Health Services. Penrose Hospital provides secondary and tertiary (high tech) medical-surgical services with emphasis on elective and outpatient care. Penrose Hospital is a major health treatment and referral center, specializing in cancer care, cardiac care, emergency trauma care and physical rehabilitation. St. Francis Medical Center, also part of Penrose-St. Francis, is the only full-service hospital in Northern Colorado Springs and features a modern Birth Center, Level III Neonatal Intensive Care Unit, Pediatric Care Unit, Emergency Department, Level III Trauma Center, Imaging Services, Surgical Services and Critical Care Unit. SFMC is the home base for Flight For Life Colorado air ambulance helicopter service.

Distinctive Services Noteworthy areas of care include:

- The Penrose Cancer Center brings leading-edge, compassionate cancer care to the people of southern Colorado.
- Penrose-St. Francis’ acclaimed heart program consistently achieves outcomes that exceed national benchmarks.
- St. Francis Medical Center is the home to the new Total Joint and Spine Center, a 33-bed state-of-the-art unit that caters to patients who have undergone joint or spine surgery. Our expert surgeons, fully coordinated team of clinical staff, physical therapists and nurse navigators provide a full continuum of care from diagnosis to rehabilitation.
- St. Francis Medical Center specializes in maternal-child health with a state-of-the-art birthing center, a Level IIIA Neonatal Intensive Care Unit and northern Colorado Springs’ only dedicated pediatric unit.
- The PSF Laboratories provide a comprehensive range of tertiary care anatomic and clinical diagnostic services ranging from bedside point of care chemistries to electron microscopy and molecular testing.
- Penrose’s Center for Behavioral Health helps businesses retain healthy and productive employees.

Penrose-St. Francis Health Services

- Catholic Health Initiatives TAVR Center of Excellence 2018-2019
- Blue Cross Blue Shield – Blue Distinction Centers for Cardiac Care 2019
- Own the Bone Star Performer, Outstanding Quality in Fragility Fracture Care 2019, American Orthopedic Association

Penrose Hospital

- ACS Level I Trauma Verification
- Level II State Trauma Designation

St. Francis Medical Center

- Commission on Accreditation of Rehabilitation Facilities (CARF), Inpatient Rehab Facility
- CARF Stroke Specialty Program 3-Year Certification
OUR COMMUNITY

At Centura Health and Penrose-St. Francis Health Services, 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 Behavioral Health, Food Security and Access to Care for the next three years, we are excited to continue to live out our Mission, Vision, and Values every day.

To define Penrose-St. Francis Health Care Services’ 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 Penrose-St. Francis Health Services’ 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 692,540. The demographic makeup of these communities is on the following page.

Honors

Penrose-St. Francis Health Services is proud to be named One of America’s 50 Best Hospitals™ for 10 years in a row (2008 - 2017) by Healthgrades®, one of only six hospitals in the country to receive this award. When it comes to your health care, you should never compromise. Both Penrose Hospital and St. Francis Medical Center worked to collectively be recognized with this distinction.
### POPULATION DEMOGRAPHICS IN PENROSE-ST. FRANCIS HEALTH SERVICES SERVICE AREA

**Race**

<table>
<thead>
<tr>
<th>Race</th>
<th>Penrose-St. Francis Service Area</th>
<th>State Average</th>
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<tbody>
<tr>
<td>White</td>
<td>78.5%</td>
<td>74.7%</td>
</tr>
<tr>
<td>Black</td>
<td>6.3%</td>
<td>71%</td>
</tr>
<tr>
<td>Asian</td>
<td>2.8%</td>
<td>75.1%</td>
</tr>
<tr>
<td>Native American/Alaska Native</td>
<td>1.0%</td>
<td>77.3%</td>
</tr>
<tr>
<td>Native Hawaiian/Pacific Islander</td>
<td>0.4%</td>
<td>4.3%</td>
</tr>
<tr>
<td>Other</td>
<td>5.5%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Multiple races</td>
<td>5.6%</td>
<td>4.5%</td>
</tr>
</tbody>
</table>

**Ethnicity**

| Ethnicity         | Non-Hispanic (83.1%) | Hispanic (16.9%) |

**Some College**

<table>
<thead>
<tr>
<th>Some College</th>
<th>Penrose-St. Francis Service Area</th>
<th>State Average</th>
</tr>
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**High School Graduation Rate**

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<thead>
<tr>
<th>High School Graduation Rate</th>
<th>Penrose-St. Francis Service Area</th>
<th>State Average</th>
</tr>
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</table>

**Limited English Proficiency**

- **Penrose-St. Francis Service Area**: 1.4%
- **State**: 2.8% CO

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

- **Penrose-St. Francis Service Area**: 4.3
- **State**: 4.5 CO

**Unemployment Rate**

- **Penrose-St. Francis Service Area**: 4.6%
- **State**: 3.9% CO
Prioritized Needs and Plans

WORKING WITH COMMUNITY

Penrose-St. Francis Health Services, collaborated with the El Paso County Public Health Department with their representation on our Advisory Subcommittee. In addition to serving on our Advisory Subcommittee, we agreed with the public health department 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, to ensure greater movement toward same goals with complementary efforts.

We created a hospital subcommittee to solicit and take into account 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 Penrose-St. Francis Health Services’ 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, Penrose-St. Francis Health Services originally identified Behavioral Health, Healthy Lifestyles and Access to Care as priority focus areas.

After identifying our priorities, we reviewed the assets and gaps identified by the subcommittee to develop the Penrose-St. Francis Health Services Community Health Implementation Plan (CHIP). This process led to a better understanding of how to focus our efforts related to Healthy Lifestyle and to modify this priority to be Food Security, recognizing that access to healthy, affordable food is essential for a healthy lifestyle. 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 Penrose-St. Francis Health Services 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.
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 integrated in 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.

FIGURE 1: Centura’s Role

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.

**FIGURE 2: Socioecological Model for Whole Person Health**

**PRIORITIZED NEEDS AND PLANS**

After careful consideration of the available quantitative and qualitative indicators and our Centura Health Mission, Vision, and Values, Penrose-St. Francis Health Services identified Behavioral Health, Food Security, and Access to Care as priority focus areas.

At Penrose-St. Francis Health Services, 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 Behavioral Health, Food Security, and Access to Care will have the greatest impact on our organizational commitment to whole person health.
PRIORITIZED NEED: BEHAVIORAL HEALTH

Colorado ranks 43rd in the country for mental health, according to a 2018 index created by Mental Health America. In 2017, the Colorado Health Access Survey revealed that 12% of El Paso County residents, aged 5 years or older, reported poor mental health (eight days or more of poor mental health in the previous month). In Colorado, there were 1,175 deaths by suicide during 2017, the highest rate of suicide ever recorded in Colorado. In El Paso County, 163 residents died by suicide in 2017, and working aged men accounted for 75 percent of those deaths. Suicide is also a growing epidemic among our younger populations and is now the leading cause of death for youth ages 10 to 17 in Colorado. Based on review by the Child Fatality Review Team in 2016, over half of all child fatalities among youth under 18 in El Paso County were due to suicide.

Community partners indicate that social isolation, especially among seniors, low-income, homeless and other vulnerable individuals may be a driving factor for mental health problems in El Paso County. Partners suggested that social media, electronics and technology is resulting in a lack of connectedness among the youth population as well as suicidal ideation. Trauma was also cited during community meetings as a cause for mental health issues. Adverse childhood experiences (stressful or traumatic events including abuse and neglect) can result in a range of health, social, and behavioral health problems.

Penrose-St. Francis identified youth suicide as a top health need in our 2016 CHNA. Since then we have implemented screening tools for youth at high risk for suicide across our PSF affiliated physician and inpatient programs. We have worked with community partners to conduct a gap analysis of referral resources for high risk youth and disseminated a resource referral tool to assist clients with timely and appropriate referrals to social services and partnering networks in order to support and treat high-risk youth with suicidal ideations.
Penrose-St. Francis also sponsors Teen Suicide Prevention education programs held twice a year, with pre-post testing to measure level of awareness for those at risk of committing suicide.

The El Paso County Youth Suicide Prevention Workgroup, which includes more than 60 multidisciplinary partner agencies, is working to identify community needs and assets, improve community networking and partnerships, and create an action plan for Countywide activities. PSF will remain an active participant in this important work. The El Paso County Public Health, El Paso County Coroner’s Office, Sheriff’s Office and National Alliance on Mental Illness are partnering on a new Man Therapy campaign to promote resources that provide men and their loved ones with the education, tools and community connections needed to empower them to take control of their overall wellness and mental health. The County has also received grant funding for a new co-responder program in El Paso County, which pairs Sheriff’s Office personnel with mental health professionals when responding to mental-health related calls for service.

Penrose-St. Francis will also continue our efforts to reduce the stigma around mental illness and educate the community. PSF community training and education efforts include quarterly adult and youth MHFA (Mental Health First Aid), and ACE (Adverse Childhood Experiences) trainings at Penrose-St. Francis, schools, community and faith-based partnering sites. These trainings teach community members how to learn the signs of a person in mental distress and how to get the affected person the help they need.

El Paso County is a designated medical shortage area for behavioral health professionals which creates significant challenges in addressing mental health problems in our community. Penrose-St. Francis offers integrated physical and behavioral health care in our in-patient settings and at our Centura Health Physician Group neighborhood clinics. Our behavioral health services include drug and alcohol treatment programs, neuropsychological testing, dementia assessment, and outpatient counseling for children and adults of all ages. Additionally, we are working with our community partners to expand access to behavioral health care in El Paso County. These efforts will be discussed in the Access to Care section of this CHNA.
## CHNA PRIORITY: BEHAVIORAL HEALTH (BH)

Key: Mental Health (MH) and Substance Use Disorder (SUD)

### Goal 1: Increase the number of behavioral / mental health care providers and access points.

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<th>Strategy</th>
<th>Target Population</th>
<th>Action Plan Activity</th>
<th>Metrics</th>
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| Increase the number of behavioral health care providers in the Penrose-St. Francis Health Services service area and surrounding community. | Community members, current and perspective patients Providers | • Collect baseline data re: services provided and target population needs.  
• Employ and contract with an increased number of providers.  
• Explore broadening insurance and charity care options.  
• Assess transportation access and map availability relative to physician location.  
• Explore providing care in pre-existing community-based organizations. | # of providers and access points |
| Create community collaborative approach expanding resources and minimizing over-utilization of one existing resource. | Community-based organizations Existing coalitions | • Convene community partners.  
• Present at existing coalitions.  
• Create a continuum of care flow with existing resources.  
• Develop plan to address gaps; collect baseline data, mid-point data and ongoing assessments. | • Creation of master resource list  
• Accepted and adopted patient flow plans and care plans |
| Explore and expand specific methods of treatment such as SBIRT, MAT, and ALTOs. | Existing coalitions First responders | • Work with providers and first responders on best practices.  
• Convene health care organizations in service area.  
• Evaluate what currently exists and identify gaps.  
• Develop plan to address gaps; collect baseline data, mid-point data and ongoing assessments. | • Accepted and adopted patient and community flow plans and care plans  
• Reduction of admissions, ED visits and readmissions |
| Collaborate with community-based organizations such for the prevention and education on Suicide Ideation. | Providers Local school districts First responders Community-based organizations | • Engage with organizations already working towards prevention and education.  
• Expand services and connect with internal resources.  
• Develop and distribute education materials.  
• Develop plan to address gaps; collect baseline data, mid-point data and ongoing assessments. | • Creation of master resource list  
• Reduction in Suicide Ideation admissions and ED visits |
### Goal 2: Develop screening tool and method for identifying depression in postpartum women.

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| Prevent, screen and intervene when postpartum women present with and/or identify signs of depression. | Postpartum women Providers | • Develop evidence-based screening tool to identify those with signs of depression.  
• Create process and care plan for implementation.  
• Implement referral process.  
• Develop data collection system and establish baseline. | • Number of referrals  
• Referral results |

### Goal 3: Strengthen and expand community partnerships to provide care and resources for those presenting with behavioral health diagnoses.

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<th>Strategy</th>
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</table>
| Identify community partners with aligned vision, mission and values to develop programs and solutions that meet the identified needs. | Community-based organizations Vulnerable populations Providers | • Convene target population.  
• Create master list of resources and identify methods of distribution.  
• Education and awareness session for target population in how to utilize resources for access to care.  
• Identify care gaps and develop collaborations and programs to address those gaps with a community collaborative approach. | • Behavioral Health Task Force established  
• % of people reporting access to needed behavioral health services |
PRIORITIZED NEED: FOOD SECURITY

The priority of Food Security originated as Healthy Lifestyle in the 2019 CHNA process and then changed to focus on Food Security based upon the data and what we learned in the CHNA process. In 2016, 35.6% of the adult population in El Paso County was overweight, and 23.6%, or one in five adults, was obese. Disparities exist for people who are obese based on gender, age, and race and ethnicity. In El Paso County, there is a higher prevalence of obesity among Black/African American (35.9%) and Hispanic (33%) populations. Obesity is a serious concern because it is associated with poorer mental health outcomes, reduced quality of life, and the leading causes of death in the U.S. and worldwide, including diabetes, heart disease, stroke, and some types of cancer. El Paso County ranks 35 of 58 counties in Colorado for health outcomes and 32 in health factors, which include adult obesity, smoking, inactivity, excessive drinking, and the food environment. The County has higher rates of high blood pressure, high cholesterol and heart disease than the statewide average.

El Paso County community members suggest that food insecurity, or access to healthy foods, is one of the top social determinants of health in the County and is especially prevalent in a few contiguous zip codes within the County where many low-income and minority residents live. Quantitative data confirms that in El Paso County today, 14.7% of the County’s population suffers from food insecurity, compared to 12.9% statewide. Access to and availability of fresh, affordable fruits and vegetables are different based on where you live. Many
low-income families may not have access to a full-service grocery store or market that sells fresh fruits and vegetables. El Paso County community partners indicate that both food deserts (urban areas in which it is difficult to buy affordable or good-quality fresh food) and food swamps (areas flooded with unhealthy, highly processed, low-nutrient food) are found in El Paso County. In 2014, El Paso County scored 7.0 on the Food Environment Index of factors that contribute to a healthy food environment—defined as the availability of economical, close and nutritious food options in a community—ranking it the lowest among peer counties across Colorado and below Colorado and the National benchmark. Nearly nine percent of the population in El Paso County lacks access to healthy food, compared to 5.9% statewide. Furthermore, El Paso County also reports higher rates of adult inactivity (15%) compared to the statewide average (14%). Recreation and fitness facility access of 9 per 100,000 population is also lower than the Colorado average of 10.8.

Penrose-St. Francis prioritized obesity as a top community health need in our 2016 CHNA. We have worked to connect patients with local resources to address obesity; partnered with community organizations to develop new initiatives to connect patients with healthy food and physical activity opportunities; and established our own programs to address obesity. During this process, we learned of the importance of addressing Food Security to truly impact Obesity and of the many resources in our community which, collectively, can impact Food Security. Resources available to address Food Security in Colorado Springs and surrounding areas are local farms, comprehensive food banks, free school breakfast/ lunch programs, free cooking classes and SNAP/WIC programs. PSF provided input for the 2018 El Paso County Public Health Food System Assessment, which was designed to identify prospects for policies and priorities for capacity building, innovation and investment in order to address challenges and capitalize on opportunities in our food system (considering roles for both public and private sectors and non-profit partners). Though our collaborative CHIP and CHNA work, Penrose-St. Francis, EPCPH and the HCC will continue to partner to provide new opportunities for El Paso County residents to live healthy lifestyles, including Food Security.
CHNA PRIORITY: FOOD SECURITY

Key: Supplemental Nutrition Assistance Program (SNAP), Women Infants and Children (WIC) and Electronic Benefits Transfer (EBT)

Goal 1: Increase use of locally sourced healthy, affordable food within Centura Health by 50%.

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<tr>
<th>Strategy</th>
<th>Target Population</th>
<th>Action Plan Activity</th>
<th>Metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement food procurement practices to prioritize local food sourcing.</td>
<td>Centura associates and volunteers Hospital community</td>
<td>• Review current Centura Health food procurement practices and identify food sources.</td>
<td>% of locally sourced food used by Centura Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Review best practices related to local food procurement and identify local food sources.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Establish plan for Centura Health implementation of local food procurement for hospital facility.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Implement local food procurement purchasing practices.</td>
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</table>
**Goal 2: Increase number of sources of healthy affordable food within the community by decreasing number of food deserts by 20% in order to reach vulnerable populations and associates/volunteers.**

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

<table>
<thead>
<tr>
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<th>Action Plan Activity</th>
<th>Metrics</th>
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</thead>
</table>
| 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 |
PRIORITIZED NEED: ACCESS TO CARE

In addition to the above prioritized health needs, Penrose –St. Francis Health Services recognizes that access to care is a critical factor to assess, screen, and provide treatment that improves and maintains health. We have a primary duty to ensure we address barriers to access and link our communities to the care they need. Access to care was a prioritized need in our 2016 CHNA and since that time the rate of uninsured adults in the County has dropped to 12.4% among adults and 5.1% among children in 2018. Both rates are below the statewide average. However, Robert Wood Johnson’s County Health Rankings for 2019 indicate that there are still 41,408 uninsured individuals living in El Paso County. Additionally, the recent expansion of Medicaid has greatly increased the number of patients in our communities seeking specialty care. This increased demand has led to access barriers for our Medicaid populations who are typically the most vulnerable and underserved members of our community.

Penrose-St. Francis engages Community Health Advocates (CHA) to work with uninsured individuals or those without a primary care doctor to enroll them into coverage and link them with providers. Our goals are to increase the number of patients in our communities who have a designated primary care medical home and to decrease the numbers who are uninsured. We identify uninsured patients in our Emergency Departments, our community-based partner organizations, our Neighborhood Nurse Centers and at local events to engage them with CHAs to guide them through the insurance enrollment process and navigation to the appropriate source of care. Once they have received the coverage they need, our advocates refer the patients to providers so they may begin to receive high-quality and consistent medical care.
## CHNA PRIORITY: ACCESS TO CARE

### Goal 1: Increase the number of primary care providers and health care access points.

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Target Population</th>
<th>Action Plan Activity</th>
<th>Metrics</th>
</tr>
</thead>
</table>
| Increase the number of primary care providers in the Penrose-St. Francis Health Services service area and surrounding community. | Community members, Current and perspective patients, Providers and primary care practices | • Survey the identified target population and demographic needs.  
• Employ and contract with an increased number of providers.  
• Explore broadening insurance and charity care options.  
• Assess transportation access and map availability relative to physician location.  
• Explore providing care in pre-existing community-based organizations. | • Number of providers and access points |

### Goal 2: Strengthen and expand partnerships to include transportation, increased awareness and education of available resources in the community.

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Target Population</th>
<th>Action Plan Activity</th>
<th>Metrics</th>
</tr>
</thead>
</table>
| Identify community partners with aligned vision, mission and values to develop programs and solutions that meet the identified needs. | Community-based organizations, Vulnerable populations | • Convene target population.  
• Create master list of resources and identify methods of distribution.  
• Education and awareness session for target population in how to utilize resources for access to care.  
• Establish Access to Care Task Force with community. | • Creation of Access to Care taskforce  
• Programs developed |
Conclusion

On June 13, 2019, the Penrose-St. Francis Health Services Board of Trustees, a board made up of community members, approved our Community Health Needs Assessment. On November 7, 2019, the Board of Trustees approved Food Security as a priority and our Community Health Implementation Plan. The CHNA process presents an opportunity for Penrose-St. Francis Health Services 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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</thead>
<tbody>
<tr>
<td>Penrose-St. Francis</td>
<td>Dr. Brian Erling, CEO</td>
</tr>
<tr>
<td>PSF</td>
<td>Patrick Ballard</td>
</tr>
<tr>
<td>PSF</td>
<td>Heather Weaver</td>
</tr>
<tr>
<td>PSF</td>
<td>Erin Heberlein</td>
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<tr>
<td>PSF</td>
<td>Gail Decker</td>
</tr>
<tr>
<td>Centura Health</td>
<td>Carl Patten</td>
</tr>
<tr>
<td>El Paso County Public Health</td>
<td>Robin Johnson, Susan Anthony, Mina Liebert</td>
</tr>
<tr>
<td>Colorado Community Health Alliance</td>
<td>Amy Yutzy</td>
</tr>
<tr>
<td>Aspen Pointe</td>
<td>Tyler Carpenter</td>
</tr>
<tr>
<td>Peak Vista Community Health Centers</td>
<td>Louis Larimer, Barb VerCandel, Pam McManus</td>
</tr>
<tr>
<td>YMCA of the Pikes Peak Region</td>
<td>Gloria Winters</td>
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<tr>
<td>Community Health Partnership</td>
<td>Aimee Cox</td>
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<tr>
<td>Catholic Charities</td>
<td>Andy Barton</td>
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<tr>
<td>The Resource Exchange</td>
<td>Camille Blakely</td>
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<tr>
<td>RISE Coalition</td>
<td>Joyce Salazar</td>
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<tr>
<td>Colorado Springs Rescue Mission</td>
<td>Steve Self, Jackie Jaramillo</td>
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<tr>
<td>Penrose-St. Francis Foundation</td>
<td>Mary Coleman</td>
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<tr>
<td>Woodmen Valley Chapel</td>
<td>Niki Scott</td>
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<tr>
<td>University of Colorado, Denver</td>
<td>Erick Wallace</td>
</tr>
<tr>
<td>Colorado Springs Conservatory</td>
<td>Heather Steinman, Amy Husted</td>
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<tr>
<td>Colorado Springs Osteopathic Association</td>
<td>Doris Ralston</td>
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<tr>
<td>LiveWell Colorado</td>
<td>Gabriel Guillaume</td>
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<tr>
<td>Pikes Peak Hospice</td>
<td>Gloria Brooks</td>
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<tr>
<td>TESSA Colorado Springs</td>
<td>Sherrylynn Boyles</td>
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<tr>
<td>Wounded Warrior Project</td>
<td>David Griego</td>
</tr>
<tr>
<td>Community Partnership for Child Development</td>
<td>Noreen Landis-Tyson</td>
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</tbody>
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