2019 Community Health Implementation Plan
FY 2020–2022

St. Anthony Summit Medical Center
AT A GLANCE:

St. Anthony Summit Medical Center

AREA SERVED: SUMMIT COUNTY

PRIORITIES:

Mental Health for Families
Substance Abuse
Food Security and Health Equity

PARTNERS:

Summit County Public Health, Summit Community Care Clinic, Mind Springs Health, CHPG High Country Health Care, Family and Intercultural Resource Center, Summit County Community and Senior Center, Bristlecone Home Health, Ski Resorts, Summit County School District, Emergency Services, Summit County Community Care Clinic, Summit County Human Services, Summit County Sheriff, Advocates for Victims of Assault, Building Hope Summit County, Summit Foundation, Summit County Youth and Family Services, NWCCOG Alpine Area Agency for Aging, Town of Breckenridge, Kaiser Permanente, Summit County Government, Communities That Care, and Private Community Primary Care Practices.
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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 4, 2019, the St. Anthony Summit Medical Center Board of Directors approved the 2019 St. Anthony Summit Medical Center Community Health Needs Assessment (CHNA) priorities of Mental Health for Families, Substance Abuse, and Health Equity. 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 St. Anthony Summit 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 St. Anthony Summit Medical Center, local public health, community leaders, and partner organizations.

The St. Anthony Summit Medical Center 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 St. Anthony Summit 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.

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 St. Anthony Summit Medical Center, Food Security was embedded in our priority of Health Equity and Social Determinants of Health. We heard from our community that Food Security, along with other Social Determinants of Health, is a key component in addressing Health Equity, recognizing that race, ethnicity and income all impact a person’s access to healthy, affordable foods. Food Security is an essential building block toward health and well-being. It 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 Directors added this as a priority for St. Anthony Summit Medical Center. On October 1, 2019, our Board of Directors approved Food Security as a CHNA priority and our Community Health Improvement Plan for FY2020-FY2022.
MENTAL HEALTH FOR FAMILIES 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 increased awareness of behavioral health and reduced stigma associated with behavioral health.
• **Goal 3:** Increase people reporting access to behavioral health services by 40%.

SUBSTANCE ABUSE GOALS

• **Goal 1:** Reduce opioid prescription, misuse and abuse by 15%.
• **Goal 2:** Increase community awareness and education regarding opioid crisis, safe use, safe storage and overdose.

FOOD SECURITY AND HEALTH EQUITY GOALS

• **Goal 1:** Increase by 20% the number of produce sites which accept SNAP and WIC at point of purchase.
• **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/WIC by 60%.
• **Goal 4:** Increase community capacity to address the social determinants of health among community partners by 15%
• **Goal 5:** Deepen the community understanding of the complex needs of under-resourced populations by completing two community-wide training/presentations on health equity
Our Services and Community

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

St. Anthony Summit Medical Center has been Summit County’s primary health care resource for more than 40 years, offering the region’s highest level of emergency care. Its long legacy of care reflects its deep-seated commitment to building whole person care and flourishing communities. St. Anthony Summit Medical Center is a full-service, nationally recognized hospital and Level III trauma center. The 35-bed hospital is the mountain base of operations for Flight For Life Colorado and specializes in compassionate, personalized, whole-person care.

Founded in 1978, St. Anthony Summit Medical Center is the premier acute care provider servicing Summit County’s world-class mountain resort destinations, including Breckenridge, Keystone and Copper Mountain. Its Frisco hospital was built in 2005 and is consistently recognized as one of the best hospitals in the United States for patient experience.

Distinctive Services

St. Anthony Summit Medical Center offers leading medical experts, cutting-edge technology, and a broad array of specialties and services. Our distinctive services include:

- Emergency Care and Level III Trauma Center
- Cancer Care and Infusion Center
- Labor and Delivery
- Women’s Health and Breast Health
  - 3D mammography, ultrasound and MRI
- Mountain base of operations for Flight For Life Colorado

- Total Joint and Spine Program
- Comprehensive Orthopedic Trauma Care
  - The Joint Commission’s Gold Seal of Approval for Orthopedic Trauma
- Forensic Nurse Examiner Program
- Respiratory Diagnostic and Support Services

Our expertise in these areas has earned us several awards and honors throughout the years. St. Anthony Summit Medical Center is proud to have received the following awards:

Watson Health Honors

In 2018, St. Anthony Summit Medical Center was designated one of the nation’s 100 Top Hospitals by IBM Watson Health, a prestigious honor based on an objective analysis of publicly available clinical, operational and patient-satisfaction metrics and data. St. Anthony Summit was one of just 20 small community hospitals – and the only one in Colorado – to receive the designation.
OUR COMMUNITY

At Centura Health and St. Anthony Summit 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 Mental Health for Families, Substance Abuse, and Food Security and Health Equity for the next three years, we are excited to continue to live out our Mission, Vision, and Values every day.

To define St. Anthony Summit 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 St. Anthony Summit Medical Center 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 slightly more than 30,000 people, approximately half of whom live in unincorporated areas of the county. The largest incorporated town is Breckenridge, with 5,000 residents, followed closely by Silverthorne with 4,400 residents. Among Colorado’s 64 counties, Summit County is the 19th largest in terms of population, and the 55th largest county by land area, roughly half the size of Rhode Island. Approximately 80 percent of land in the county is federal public land. The demographic makeup of these communities is on the following page.
POPULATION DEMOGRAPHICS IN ST. ANTHONY SUMMIT MEDICAL CENTER’S SERVICE AREA

Race

- White 89%
- Black 1.2%
- Asian .9%
- Native American/Alaska Native 1%
- Native Hawaiian/Pacific Islander .2%
- Other 6.1%
- Multiple races 1.1%

Ethnicity

<table>
<thead>
<tr>
<th>Race</th>
<th>Non-Hispanic</th>
<th>Hispanic</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>83.89%</td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>16.11%</td>
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</table>

Associate’s Degree or Higher

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<tr>
<th>Race</th>
<th>St. Anthony Summit Service Area</th>
<th>State Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Hispanic</td>
<td>49%</td>
<td>44.7%</td>
</tr>
</tbody>
</table>

High School Graduation Rate

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<tr>
<th>Race</th>
<th>St. Anthony Summit Service Area</th>
<th>State Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Hispanic</td>
<td>82.6%</td>
<td>77.6%</td>
</tr>
</tbody>
</table>

Limited English Proficiency

- St. Anthony Summit Service Area: 3.3%
- State Average: 2.8% CO

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

- St. Anthony Summit Service Area: 4.0
- State Average: 4.5 CO

Unemployment Rate

- St. Anthony Summit Service Area: 2.9%
- State Average: 3.9% CO
Prioritized Needs and Plans

WORKING WITH COMMUNITY

St. Anthony Summit Medical Center collaborated with Summit County Public Health to do the Community Health Needs Assessment and Implementation Plan processes together and shared a Community Advisory Committee. We agreed to align community-based efforts in order to address community health holistically and to avoid duplication. We gathered and reviewed both qualitative and quantitative data together 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 St. Anthony Summit Medical Center’s subcommittee members. Our subcommittee:

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

After careful consideration of the available quantitative and qualitative indicators and our Centura Health Mission, Vision and Values, St. Anthony Summit Medical Center identified Mental Health for Families, Substance Abuse, and Food Security and Health Equity as priority focus areas.

We reviewed the assets and gaps identified by the community to develop the St. Anthony Summit 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 St. Anthony Summit 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 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.
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, St. Anthony Summit Medical Center identified Mental Health For Families, Substance Abuse, and Food Security and Health Equity as priority focus areas.

At St. Anthony Summit 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 Mental Health For Families, Substance Abuse, and Food Security and Health Equity will have the greatest impact on our organizational commitment to whole person health.
Prioritized Need: Mental Health for Families

In the St. Anthony Summit Medical Center service area, 21 percent of residents reported that they have symptoms of depression and or anxiety. Thirty-five percent of residents reported that someone in their household wanted or needed help for anxiety, which was more common than any other mental issue. Also, 66 percent of residents know someone who is struggling with mental health or substance abuse and 1 in 4 Summit High School students report feeling sad or hopeless almost every day for more than 2 weeks. Anxiety and depression are linked to suicide. Twenty-two percent of local suicides in the community coincided with issues regarding anxiety and 47 percent with depression. The practitioners in the community see depression as the most impactful problem among their clients. When it occurs, it is seen as the mental health issue most likely to have major or catastrophic effects on the client.

Mental health issues have significant impacts on people, and the community wants more attention focused on this issue. Mental health was addressed in the 2016 CNHA under behavioral health, but only 52 percent of respondents felt enough is being done. This was significantly lower than all the other areas tested in the assessment. The public feels uncomfortable advising others to seek help for mental health issues unless those issues are a path to harming oneself or others or if they are affecting a person’s ability to hold a job. They would like to see routine screenings in the health care system to provide this sort of advice. Among those with a household member who had experienced a mental health issue, only 59% received care. However, among those who did receive care, all said that it was helpful. Even so, around half of those who received help said that it was difficult for them to find the health care they needed. The Spanish speaking respondents want to see more family-oriented community mental health programs and additional resources for the Spanish speaking elderly population in the county.

A diagnosis of mental illness in one family member affects the whole family. In addition to the effects on the individual, it may cause tension in relationships and impact the other family members. These effects can lead to fractures in families, serious disagreement, and sometimes estrangement. These are not intentional but arise because of differences in understanding what a mental illness is and how to address it. These indicators caused us to look deeper into mental health issues for families in our community. St. Anthony Summit Medical Center believes that a family-based approach that builds on existing strengths and fosters new skills in families with an overall goal of family empowerment is ideal.

To address mental health for families, St. Anthony Summit Medical Center will partner with Summit County Public Health, Building Hope Summit County and Mind Springs Health to enhance the continuum of available services and resources to address varying levels of mental health needs. The hospital will work with our partners to improve and enhance the skill sets of families to improve family wellness outcomes through implementation of evidence-based mental health initiatives. We will seek to improve the continuum of strategies that increase protective factors and improve overall family wellness. This will be done by reaching out to parents and youth in community-based settings where they already assemble. The hospital will also collaborate with the health care community to screen patients and clients for behavioral health issues.
**Goal 1: Reach 80% of school-aged youth with a social cohesion and/or resiliency strategy.**

<table>
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<tr>
<th>Strategy</th>
<th>Target Population</th>
<th>Action Plan Activity</th>
<th>Metrics</th>
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<tbody>
<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/Summit 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>
</tr>
<tr>
<td>Work with state and local officials to support social cohesion and resiliency policies to sustain programming to support youth.</td>
<td>School-age youth</td>
<td>• Develop a list of policy solutions related to youth resiliency and social cohesion. • Work with community partners to identify the best policies for our community.</td>
<td>• Policies passed to reach children and sustain best practices. • Increase in 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 increased awareness of behavioral health and reduced stigma associated with behavioral health.**

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</table>
| Develop a community strategy for MHFA to reach youth and other identified target populations. | Community members | • 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. | • # of people working with youth who receive MHFA training  
• # of people not working with youth who receive MHFA training |
| Work with state and local leaders to create a sustainable model for MHFA. | Local and State Leaders Community Members | • Meet with key coalitions to identify policy strategy for MHFA.  
• Identify barriers and opportunities related to providing MHFA within Summit County.  
• Develop strategy for sustained MHFA within the community. | Policies passed to sustain MHFA (organizational, state or local policies) |
| Integrate Let’s Talk Stigma Campaign messaging into all work related to behavioral health. | Community Members | • Integrate messaging into Centura Health communications.  
• Integrate messaging through coalitions.  
• Use messaging with decision-makers.  
• Develop a plan to sustain stigma campaign for 3-5 years. | • State survey of stigma associated with behavioral health  
• # of people reached with messaging |
### Goal 3: Increase people reporting access to behavioral health services by 40%.

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| Implement SBIRT and/or MAT in Emergency Department to identify people with behavioral health needs. | Hospital patients with Mental Health or Substance Use Disorder Diagnosis           | • Evaluate resource requirements for SBIRT/MAT in ED.  
• Establish plan for implementation of SBIRT/MAT in ED along with key partnerships for follow-up treatment.  
• Establish Adolescent Intensive Outpatient Program (IOP).  
• Establish a half day Psychosocial Rehab Program.                                                                 | # of people screened and referred to Tx |
| Develop care program for patients with MH or SUD Dx (primary or secondary) that involves a collaborative discharge planning process with the RAE or consent to notify RAE within one business day. | Hospital patients with Mental Health or Substance Use Disorder Diagnosis           | • Map out process for patients identified with MH/SUD Dx with RAE.  
• Identify how to efficiently and effectively transition patients from hospital to RAE and BH services.                                                                 | # of people referred to mental health services  
% of people connected to mental health services |
| Map behavioral health system of care within the community and develop a system to help people navigate through the system of care. | Community members with behavioral health needs                                      | • Engage partners in resource mapping process.  
• Identify opportunities to support people in the community (vs. hospitals) and ways to navigate them to the right treatment at the right time.                                                                 | Behavioral Health screening, referral and access map developed  
% of people connected to mental health services |
| Track and share data: mental health service needs within the community with state and local leaders to identify systems to increase access. | Policy makers  
Community members with MH/ SUD Dx | • Develop policy strategy for Behavioral Health with local and state coalitions.  
• Work with local communities to identify policy priorities.                                                                 | % of people connected to mental health services  
Systems established with state agencies to sustain effective mental health programming |
PRIORITIZED NEED: SUBSTANCE ABUSE

The Centers for Disease Control and Prevention has classified prescription drug abuse as an epidemic. Nationally in 2017, more than 72,000 people died of drug overdoses; 66 percent of these involved an opioid. Data from the National Survey on Drug Use and Health (NSDUH) show that nearly one-third of people age 12 and over who use drugs for the first time began using a prescription drug non-medically. Drug overdoses have become the leading cause of death for those under age 50. Though the overdose deaths for Colorado are lower than the national average, 16.6 vs 19.8 per 100,000, Colorado ranks second worst among all states for prescription drug misuse.

Opioid abuse is a significant problem in Summit County. In 2015, Summit County ranked 11th in the state in opioid deaths. Combined prevalence and impact are powerful in the community. One in 25 households is affected. Four percent of residents said that someone in their household had wanted or needed help with opioid prescription drug dependence. Experts and practitioners see it as one of the most impactful problems among their clients. According to them, opioid prescription drug dependence falls into a group of substance abuse issues that represent a powerful combination of both prevalence and high impact on affected persons.

Opioids have the public’s attention. When focus group participants were asked to name the most pressing substance abuse issue in the county, prescription opioids were the second-most-cited issue, following only alcohol. Long acting opioids are prescribed more in Summit County than in the state on average. Time scheduled opioids are associated with greater total average daily dosages and increased risk for long term use. In Summit County, 52% of opioids are of the long-duration variety given to opioid-naïve patients, versus a corresponding figure of 14% statewide. Ten percent of Summit High School students report using a prescription drug that was not prescribed for them.

St. Anthony Summit Medical Center believes the best ways to prevent opioid overdose deaths are to improve opioid prescribing, reduce exposure to both prescription and illicit opioids, prevent misuse, and treat opioid use disorder. In working with our Public Health Department and our community partners, we will increase the number of community resources to support those struggling with opioid dependence. We will also limit the number of opioid prescriptions available for diversion, misuse and abuse. We will encourage provider and prescriber education on CDC guidelines, Opioid Alternatives (ALTO), Medication Assisted Treatment (MAT) and availability of Naloxone. We will also work with our community partners to increase community awareness and the education regarding opioid crisis, safe use, safe storage, overdose prevention, and establish additional Take-Back locations.
### Goal 1: Reduce opioid prescription, misuse and abuse by 15%.

<table>
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</table>
| Increase the number of community resources to support those struggling with opioid dependence while also limiting the number of opioid prescriptions available for diversion, misuse and abuse. Strategy will include the following: 1) Provider and prescriber education on CDC guidelines, Opioid Alternatives, Medication Assisted Treatment (MAT) and availability of Naloxone 2) Community input 3) Method for evaluation of success | Community members | • Convene stakeholders to develop comprehensive plan.  
• Provider and prescriber training on ALTO.  
• Establish baseline data metrics.  
• Assess opioid prescription practices at SASMC.  
• Implement ALTO in SASMC ER.  
• Screening for substance abuse and mental health issues in healthcare setting and other related community settings.  
• Reach out to pharmacists regarding opioid prevention efforts. | • SASMC opioid prescription data report  
• # of providers and prescribers attending training  
• # of facilities screening  
• # of pharmacist meetings and # of brochures distributed |
| Establish MAT Site.                                                       | Community members | Identify and recruit two providers to provide MAT services.                          | • # of clinical sites providing MAT services  
• # of clients served |
| Establish Additional Drug Take-Back Locations.                           | Community members | • Identify additional site for drug Take-Back box location.  
• Explore alternative take-back services.                                | • # of Take-Back site established  
• # pounds of medication recovered  
• Alternative take-back services |

### Goal 2: Increase community awareness and education regarding opioid crisis, safe use, safe storage and overdose.

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<tr>
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<th>Target Population</th>
<th>Action Plan Activity</th>
<th>Metrics</th>
</tr>
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</table>
| Work with community partners on funding requirements and secure funding. | Community members | • Identify locations and events where safe use, safe storage and safe disposal information can be distributed.  
• Utilize existing marketing campaign that targets the general public and overcomes existing obstacles about opioids.  
• Availability of Naloxone.  
• Provide community awareness presentations on opioid epidemic and efforts to address it.  
• Provide education to students and parents about the opioid epidemic and risks or misuse of opioids. | • Funding secured  
• # of location and events where information is distributed  
• # of ads on buses, radio stations, newspaper ads and articles etc.  
• # of community awareness presentations  
• # of Events conducted  
• # of community members reached |
PRIORITIZED NEED: FOOD SECURITY AND HEALTH EQUITY

According to The World Health Organization (WHO), health equity “implies that ideally, everyone should have a fair opportunity to attain their full potential and that no one should be disadvantaged from achieving their potential.” Conversely, equity is undermined when preventable and avoidable systemic conditions constrain life choices. Systemic conditions are largely the social and economic factors known as the social determinants of health. The WHO defines the social determinants of health as the circumstances in which people are born, develop, live, and age. They include income and income distribution, early life, education, housing, food security, employment and working conditions, unemployment and job security, social safety net, social inclusion and exclusion, and health services. Addressing social determinants of health is important for achieving greater health equity. The presence of health disparities is well established in the United States. Longstanding research has consistently identified disparities experienced by racial and ethnic minorities, low-income, and other vulnerable communities.

Summit County recognizes that within a seemingly affluent community, there are pockets of need where our residents may not have opportunities to attain their full potential. These populations are disproportionately affected by health issues, which are impacted by differences in key determinants of health such as race/ethnicity, education, employment, socioeconomic status, and housing. Achieving health equity defined by Healthy People 2020 as the highest level of health for all people will require addressing these social and environmental determinants through both broad population-based and targeted approaches focused on disadvantaged communities.
Unfortunately, many of the households that are eligible for assistance are not receiving it. Possible reasons for this could be lack of awareness, language issues, or stigma attached assistance, but the bottom line is that programs that could help the quality of life of lower-income households are not being fully utilized. Only 17% of those eligible for Colorado Child Care Assistance Program benefits are enrolled. Nineteen percent of those eligible for Supplemental Nutrition Assistance program benefits are enrolled. Only 24% of those eligible for Colorado Works benefits are enrolled. Fifty-four percent of those eligible for WIC (Special Supplemental Nutrition Program for Women, Infants, and Children) benefits are enrolled. And only 77 percent of those eligible for Medicaid benefits are enrolled. Lower-income households report a lower quality of life in Summit County. One in five households say that their personal financial situation is not good, and anxiety is more common among lower income households.

St. Anthony Summit Medical Center believes that the most well-intentioned effort to reducing disparities is less likely to succeed if it is not part of a broader culture of equity. Therefore, it is essential to ensure that disparities are openly recognized by community partners, and that they are committed to reduce them. Moreover, by being culturally responsive, agencies working with various populations can better understand an individual’s diverse values, beliefs, and behaviors, and customize services and resources to meet social, cultural, and linguistic needs. Currently, there is no coordinated effort to educate community partners on health equity and cultural responsiveness and address the needs of under-resourced populations, and little that includes this population in any leadership capacity. In working with our community partners, we will create a community-wide system of equity to address the needs of under-resourced populations. We will work to improve community awareness of health equity and cultural responsiveness, increase the number of providers who screen for Social Determinants of Health, and increase enrollment in existing programs that address determinants of health.
### CHNA PRIORITY: FOOD SECURITY AND HEALTH EQUITY

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

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<th>Action Plan Activity</th>
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<tbody>
<tr>
<td>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</td>
<td>SNAP and WIC eligible community members</td>
<td>• 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.</td>
<td>• Strategy to increase SNAP and WIC acceptance in community • Community map of food resources and SNAP/WIC participation</td>
</tr>
<tr>
<td>Implement strategy to increase SNAP and WIC within Y2 and Y3.</td>
<td>SNAP and WIC eligible community members</td>
<td>To be included after strategy designed for Y2 and Y3.</td>
<td>• # of SNAP and WIC sites within community • Ability of SNAP and WIC participants to purchase fruits and vegetables</td>
</tr>
<tr>
<td>Integrate food access strategies into St. Anthony Summit Medical Center community partnerships.</td>
<td>Partner Organizations Business Partners</td>
<td>• Integrate SNAP and WIC EBT use into partnerships in community. • Identify key locations for food distribution partnerships to increase access.</td>
<td>• % of sponsorships/partnerships that increase food access through location and/or SNAP/WIC acceptance</td>
</tr>
<tr>
<td>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.</td>
<td>SNAP and WIC eligible community members</td>
<td>• Develop a list of policy solutions related to SNAP and WIC sales. • Work with community partners to identify the best policies for our community.</td>
<td>• Policies passed to increase access to healthy, affordable foods through SNAP and WIC • SNAP/WIC purchases for fruits/vegetables</td>
</tr>
</tbody>
</table>
### Goal 2: Increase number of sources of healthy affordable food within the community by decreasing the number of food deserts by 20%.

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Target Population</th>
<th>Action Plan Activity</th>
<th>Metrics</th>
</tr>
</thead>
</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 |
| 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 | • 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 |

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

<table>
<thead>
<tr>
<th>Strategy</th>
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<th>Metrics</th>
</tr>
</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 practice. | • % 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 Summit Healthcare Collaborative to address social determinants of health. | • # of groups and meetings attended  
• Policies adopted at state and local levels to increase access |
### Goal 4: Increase community capacity to address the Social Determinants of Health among community partners by 15%.

<table>
<thead>
<tr>
<th>Strategy</th>
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<th>Metrics</th>
</tr>
</thead>
</table>
| Partner with community agencies to increase number of providers who screen for SDoH and increase trust among disparate populations. | Minority and underserved populations | • Identify funding requirements and secure funding.  
• Identify community partners.  
• Develop standardized process for resource referral to bolster enrollment and participation in programs.  
• Identify agencies/health navigators to use screening tool.  
• Develop scope and plan for community health worker model.  
• Identify partners for and organize a Spanish-language Community Health Fair. | • Process monitoring to determine progress and completion of activities  
• # of agencies using screening tool  
• Enrollment rates in programs  
• # of outreach events  
• Funding for community health worker model established and worker/s hired and trained  
• # of participants in health fair |

### Goal 5: Deepen the community understanding of the complex needs of under-resourced populations by completing two community-wide training/presentations on Health Equity.

<table>
<thead>
<tr>
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<th>Metrics</th>
</tr>
</thead>
</table>
| Partner with community to increase awareness, understanding and ways to address the needs of under-resourced population in our community. | | • Identify funding requirements and secure funding.  
• Engage community partners in Health Equity trainings.  
• Community-wide training/assessment of organizational leadership and practices in addressing needs of under-resourced populations.  
• Engage community partners in creating and implementing health equity roadmap. | • Process monitoring to determine progress and completion of activities  
• # of attendees at trainings  
• # of trainings  
• # of organizations assessed  
• # of organizations participating in implementation |
Conclusion

On June 4, 2019, the St. Anthony Summit Medical Center Board of Directors, a board made up of community members, approved our Community Health Needs Assessment. On October 1, 2019, the Board of Directors approved Food Security as a priority and our Community Health Implementation Plan. The CHNA process presents an opportunity for St. Anthony Summit 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>
</tr>
</thead>
<tbody>
<tr>
<td>Summit County Youth and Family Services</td>
<td>Robin Albert</td>
</tr>
<tr>
<td>The Summit Foundation</td>
<td>Jeanne Bistranin</td>
</tr>
<tr>
<td>Consultant</td>
<td>Gini Bradley</td>
</tr>
<tr>
<td>St. Anthony Hospital Centura Health</td>
<td>Monica Buhlig</td>
</tr>
<tr>
<td>High Country Health Care</td>
<td>Corrie Burr</td>
</tr>
<tr>
<td>Building Hope Summit County</td>
<td>Betsy Casey</td>
</tr>
<tr>
<td>Summit Community Care Clinic</td>
<td>Cassie Comeau</td>
</tr>
<tr>
<td>St. Anthony Summit Medical Center</td>
<td>Paul Chodkowski</td>
</tr>
<tr>
<td>County Commissioner</td>
<td>Thomas C. Davidson</td>
</tr>
<tr>
<td>Family and Intercultural Resource Center</td>
<td>Casey Donohoe</td>
</tr>
<tr>
<td>Family and Intercultural Resource Center</td>
<td>Tamara Drangstveit</td>
</tr>
<tr>
<td>Kaiser Permanente</td>
<td>Susan Fairweather</td>
</tr>
<tr>
<td>NWCCOG Alpine Area Agency for Aging</td>
<td>Erin Fisher</td>
</tr>
<tr>
<td>Summit County Sheriff</td>
<td>Jaime Fitzsimons</td>
</tr>
<tr>
<td>County Commissioner</td>
<td>Dan Gibbs</td>
</tr>
<tr>
<td>Communities That Care</td>
<td>Kelly Glynn</td>
</tr>
<tr>
<td>Town of Breckenridge</td>
<td>Shannon Haynes</td>
</tr>
<tr>
<td>Summit County Public Health-Environmental</td>
<td>Dan Hendershott</td>
</tr>
<tr>
<td>Summit County Public Health-WIC</td>
<td>Whitney Horner</td>
</tr>
<tr>
<td>Mind Springs Health</td>
<td>Sonia Jackson</td>
</tr>
<tr>
<td>Summit County Public Health</td>
<td>Sara Lopez</td>
</tr>
<tr>
<td>Summit School District</td>
<td>Julie McCluskie</td>
</tr>
<tr>
<td>Advocates for Victims of Assault</td>
<td>Rob Murphy</td>
</tr>
<tr>
<td>St. Anthony Summit Medical Center</td>
<td>Tema Nnamezie</td>
</tr>
<tr>
<td>Community Member</td>
<td>Don Parsons, MD</td>
</tr>
<tr>
<td>Summit Community Care Clinic</td>
<td>Helen Royal</td>
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<tr>
<td>Summit County Human Services</td>
<td>Joanne Sprouse</td>
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<tr>
<td>County Commissioner</td>
<td>Karn Stiegelmeier</td>
</tr>
<tr>
<td>St. Anthony Summit Medical Center</td>
<td>Trixie VanderSchaff</td>
</tr>
<tr>
<td>St. Anthony Summit Medical Center</td>
<td>Sam Weller</td>
</tr>
<tr>
<td>Summit County Community and Senior Center</td>
<td>Lorie Williams</td>
</tr>
<tr>
<td>Summit County Public Health</td>
<td>Amy Wineland</td>
</tr>
</tbody>
</table>