2019 Community Health Implementation Plan
FY 2020–2022
St. Thomas More Hospital
AT A GLANCE:

St. Thomas More Hospital

AREA SERVED: FREMONT COUNTY

PRIORITY:
- Behavioral Health
- Food Security
- Lung Disease

PARTNERS:
Fremont County Department of Public Health and Environment, Fremont County Department of Human Services, Upper Arkansas Area Council of Governments, Fremont County Homeless Coalition, Southern Colorado Regional Emergency Medical and Trauma Advisory Council, Senior Resource Agency, Solvista Health, Health Solutions, Rocky Mountain Behavioral Health, Community Health Collaborative, Health Colorado, ValleyWide Community Health Center, Regional Health Connector, and Loves & Fishes Ministry of Fremont County
# 2019 Community Health Needs Assessment

**St. Thomas More Hospital**

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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

[Centura Health logo]
Executive Summary

On August 2, 2019, the St. Thomas More Hospital Board of Directors approved the 2019 St. Thomas More Hospital Community Health Needs Assessment (CHNA) priorities of Behavioral Health, Heart Disease and Lung Disease. 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. Thomas More Hospital 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. Thomas More Hospital, local public health departments, community leaders, and partner organizations.

The St. Thomas More Hospital 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. Thomas More Hospital 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. Thomas More Hospital, the issue related to Food Security was originally identified as Heart Disease. While Heart Disease 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 Directors added Food Security as a health priority instead of Heart Disease for St. Thomas More Hospital. On October 4, 2019, our Board of Directors approved Food Security as a CHNA priority and our Community Health Improvement Plan for FY2020-FY2022.
BEHAVIORAL HEALTH GOALS

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

• **Goal 2:** Increase capacity of community to support Behavioral Health needs through increased awareness of Behavioral Health and reduced stigma.

• **Goal 3:** Increase people reporting access to Behavioral Health services by 40%.

FOOD SECURITY GOALS

• **Goal 1:** Increase by 20% number of produce sites which accept SNAP/WIC.

• **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%.

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

LUNG DISEASE GOALS

• **Goal 1:** Work with community partners to promote tobacco cessation efforts.

• **Goal 2:** Collaborate with youth serving agencies/organizations to increase protective factors to discourage tobacco use among youth and decrease use among youth.

• **Goal 3:** Collaborate with Agencies that work with pregnant women to decrease tobacco use during pregnancy and postpartum.
Our Services and Community

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

Nestled in the foothills of the Sangre de Cristo Mountains in Cañon City, St. Thomas More Hospital’s rich history of providing comfort and healing began in 1938 when a halfdozen Benedictine nuns opened its doors. Today, the hospital plays a pivotal role in this rural community by providing emergency services, rehabilitation, joint replacement, surgical services, critical care, digital mammography and a birthing center to Fremont County residents, neighboring communities and the many visitors who flock to the area.

Distinctive Services  Noteworthy areas of care include:

Hospital Services
• Patient Safety Excellence Award 2017-2018
• Named among the top 10% in the Nation for Patient Safety 2017-2018

The Birth Center
• Five-Star Recipient for Vaginal Delivery 2015-2017

Cardiac Rehabilitation
• AACVPR Certified

Healthgrades Honors

St. Thomas More Hospital is a recipient of the Healthgrades 2018 Patient Safety Excellence Award™, a designation that recognizes superior performance of hospitals that have prevented the occurrence of serious, potentially avoidable complications for patients during hospital stays. St. Thomas More Hospital has received Five-Star Ratings from Healthgrades in hip fracture treatment, total knee replacement, and treatment of sepsis.

Patient & Community Resources

St. Thomas More Hospital offers community outreach, education and health screenings. Also offered is the Forensic Nurse Examiner (FNE) program, Chronic Disease Self-Management program and the Care Transitions hospital-to-home program. Support groups found at the hospital include classes for diabetes, tobacco cessation, weight loss and sleep health. Wellness classes are also offered, along with a membership to the hospital’s fitness center.
At Centura Health and St. Thomas More Hospital 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 Lung Disease for the next three years, we are excited to continue to live out our Mission, Vision, and Values every day.

To define St. Thomas More Hospital’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. Thomas More’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 44,691. The demographic makeup of these communities is on the following page.
POPULATION DEMOGRAPHICS IN ST. THOMAS MORE HOSPITAL’S SERVICE AREA

Race

- White 88.8%
- Black 4%
- Asian 1.3%
- Native American/Alaska Native 1.7%
- Native Hawaiian/Pacific Islander .1%
- Other 1.9%
- Multiple races 2.2%

Ethnicity

- Non-Hispanic 86.3%
- Hispanic 13.7%

Associate’s Degree or Higher

- St. Thomas More Service Area: 24.9%
- State Average: 44.7%

High School Graduation Rate

- St. Thomas More Service Area: 23.2%
- State Average: 77.6%

Limited English Proficiency

- 1.9%
  - St. Thomas More Service Area

Unemployment Rate

- 6.2%
  - St. Thomas More Service Area

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

- 4.2
  - St. Thomas More Service Area

Unemployment Rate

- 3.9%
  - St. Thomas More Service Area
Prioritized Needs and Plans

WORKING WITH COMMUNITY

St. Thomas More Hospital collaborated with Fremont County Department of Public Health & Environment, 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 St. Thomas More Hospital’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, St. Thomas More Hospital identified Behavioral Health, Food Security, and Lung Disease as priority focus areas.

After identifying our priorities, we reviewed the assets and gaps identified by the subcommittee to develop the St. Thomas More Hospital 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. Thomas More Hospital 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.

FIGURE 1: Centura’s Role

HOW WE INVEST IN COMMUNITY HEALTH

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.
PRIORITIZED NEEDS AND PLANS

After careful consideration of the available quantitative and qualitative indicators and our Centura Health Mission, Vision, and Values, St. Thomas More Hospital identified Behavioral Health, Food Security, and Lung Disease as priority focus areas.

At St. Thomas More Hospital, 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 Lung Disease will have the greatest impact on our organizational commitment to whole person health.
PRIORITIZED NEED: BEHAVIORAL HEALTH

St. Thomas More prioritized Behavioral Health as the top community health need. Behavioral Health encompasses mental health and substance use, excluding tobacco, which will be covered under the prioritized health need of lung disease. Although Behavioral Health was identified as a health need for Fremont County in the 2016 CHNA, St. Thomas More is elevating the health need to be a top prioritized health need for the 2019 CHNA. Fremont County, like the rest of the state of Colorado, has experienced significant increases in substance use and mental health conditions in the last few years. During the CHIP, community members reported substance use and mental health as their top two health concerns for the county.

St. Thomas More reports 2,883 mental health hospitalizations per 100,000 hospitalizations, compared to 2,833 mental health hospitalizations per 100,000 hospitalizations across Colorado. Fremont County has a slightly higher rate of suicide per 100,000 residents (21) than the Colorado average of 20 per 100,000 residents; however, the county has more than double the number of suicide hospitalizations (110) per 100,000 residents compared to the statewide average (52). Over 14% of new moms in Fremont County report post-partum depressive symptoms, compared to 9.6% statewide.

Fremont county is served by two main behavioral health providers: Solvista, the community mental health center and Rocky Mountain Behavioral Health. Solvista is actively working with the community to improve access to behavioral health care and engage in population health efforts to reduce the stigma of those services. St. Thomas More partners with both behavioral health providers to facilitate smooth transitions of care for patients with a behavioral health condition.
## Goal 1: Reach 80% of school-aged youth with a social cohesion / resiliency strategy.

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<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/St. Thomas More 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>
</tr>
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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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| 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 CO.  
• 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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</table>
| 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.                                                                                                                                                                                                                                             | # 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 re: 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: FOOD SECURITY

Heart disease was originally identified as a priority for St. Thomas More because in Fremont County, 5.1% of adults have heart disease, compared to 2.7% of adults in Colorado. Additionally, 34.4% of adults in our community have high blood pressure, higher than the 25.7% of adults in the state. We also have issues with high cholesterol, with 35.4% of adults having high cholesterol, compared to 31.9% of adults in the state. People in our community are dying from heart disease at a rate of 227.9 per 100,000, compared to 176.0 per 100,000 in the state.

Heart disease was a prioritized health need for our 2016 CHNA. Preventing and treating heart disease is something that St. Thomas More strives to accomplish. We are working with our community on numerous efforts to prevent heart disease before it happens. One of our goals is to stem the rate of obesity in the community. We recognize that poor nutrition and inactivity leads to overweight and obese residents. In Fremont County 22.8% of residents are obese compared to 20.2% statewide. Eighty percent of adults in Fremont County report eating less than 5 fruits and vegetables daily, compared to 75% statewide.

Food Security and access to healthy foods were reported by community members as one of the top social determinants of health in the county. These issues impact heart health. Fremont county has higher rates of poverty than most other communities in the state with 56% of children living in the county are eligible for free or reduced-price lunch, compared to 42% statewide. Community groups reported that multiple schools in the county have 70-80% of their children that are eligible for free or reduced lunch.

Community organizations, including St. Thomas More, are collaborating on many initiatives to provide families with access to healthy food and opportunities to engage in physical activities to try to curb the rates of obesity which have led to the high rates of heart disease in the county. Cañon City and Florence both have food pantries and several healthy food initiatives. However, transportation is a barrier to access healthy foods with most of the community grocery stores located on the outskirts of town.
**CHNA PRIORITY: FOOD SECURITY**

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

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

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</tr>
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<tbody>
<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</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Ability of SNAP and WIC participants to purchase fruits and vegetables.</td>
</tr>
<tr>
<td>Integrate food access strategies into St. Thomas More Hospital's community partnerships.</td>
<td>Partner Organizations Business Partners</td>
<td>• Integrate SNAP and WIC EBT use into partnerships in community.</td>
<td>% of sponsorships/partnerships that increase food access through location and/or SNAP/WIC acceptance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Identify key locations for food distribution partnerships to increase access.</td>
<td></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.</td>
<td>• Policies passed to increase access to healthy, affordable foods through SNAP and WIC</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Work with community partners to identify the best policies for our community.</td>
<td>• 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>
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</tr>
</thead>
<tbody>
<tr>
<td>Identify locations at which affordable food access needs to be increased based upon race/ethnicity and income to increase access for food insecure communities.</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 sites</td>
</tr>
<tr>
<td></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></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 deserts within the community.</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 passed to increase access to healthy, affordable foods</td>
</tr>
<tr>
<td></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 production processes.</td>
<td>Centura 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></td>
<td></td>
<td>Pounds and nutrient value of food distributed to community</td>
<td></td>
</tr>
<tr>
<td>Explore Centura Health and community land use opportunities for local food production and identify how to increase production of locally sourced fruits and vegetables.</td>
<td>Centura Health Food Insecure Community Members Hospital Community</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>
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<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></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 gardens</td>
</tr>
</tbody>
</table>
### Goal 3: Decrease the number of community members who are eligible but not enrolled in SNAP by 60%.

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<tbody>
<tr>
<td>Screen households for food insecurity and refer them to food resources in their communities, including identifying eligibility for all available public assistance programs.</td>
<td>SNAP and WIC eligible community members Food Insecure Patients</td>
<td>• 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.</td>
<td>• % of patients screened for food insecurity • % of patients screened successfully referred to community resources</td>
</tr>
<tr>
<td>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.</td>
<td>Decision Makers at State and Local Levels</td>
<td>• 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.</td>
<td>• # of groups and meetings attended • Policies adopted at state and local levels to increase access</td>
</tr>
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### Goal 4: Increase use of locally sourced healthy, affordable food within Centura Health by 50%.

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<tbody>
<tr>
<td>Implement food procurement practices to prioritize local food sourcing.</td>
<td>Centura associates Hospital community</td>
<td>• 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.</td>
<td>% of locally sourced food used by Centura Health</td>
</tr>
</tbody>
</table>
PRIORITIZED NEED: LUNG DISEASE

St. Thomas More prioritized lung disease as a top community need in the 2016 CHNA. Local providers and community organizations have significantly decreased the rate of adult smokers in Fremont County, from 29.1% in 2016 to 19.5% in 2019. However, Fremont County still has a tobacco problem. According to the Fremont County Department of Public Health and Environment, 37% of mothers use tobacco at time of pregnancy, 14.8% use tobacco during the pregnancy, and 50% go back to using tobacco after birth. The mortality rate for lung disease in our community is 65.6 per 100,000, higher than Colorado’s rate of 46.8. This is likely due to the higher rates of smoking in our community.

We currently offer support groups at the hospital for tobacco cessation and provide tobacco cessation support and education at local health fairs and at schools. We are also partnering with the Fremont County Department of Public Health and Environment to increase community knowledge of resources available for tobacco cessation and to encourage people to engage in treatment. We are working together with the community to increase referral rates to tobacco cessation services, with an emphasis on youth and pregnant women populations.

In recent years, the community has turned its attention to prevention efforts among youth population and pregnant women. Increased youth vaping was identified in community discussions as a top concern. The county has engaged in education campaigns with teachers and students but indicate that education is now needed for parents. Parents often give their children vape pens as presents as early as fourth grade. Many residents don’t believe that vaping has health consequences.

The Fremont County Department of Public Health and Environment recently hired a tobacco cessation specialist to ramp up efforts around tobacco cessation, with a special focus on teen vaping in Fremont county. These efforts, which include high schools are beginning to adopt the 2nd Chance Program for tobacco cessation, which has proven effective within the criminal justice system. Community organizations are engaging in numerous efforts to try to curb the tobacco rates in the county. St. Thomas More has a department dedicated to tobacco cessation and provides education to children (and their parents) starting as early as elementary school.
### CHNA PRIORITY: LUNG DISEASE

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

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Target Population</th>
<th>Action Plan Activity</th>
<th>Metrics</th>
</tr>
</thead>
</table>
| Work with community partners to promote tobacco cessation efforts. | Partner Organizations FCDPHE | • Identify community partners invested in tobacco cessation.  
• Increase access to cessation resources.  
• Engage and inform the community on education related to tobacco and tobacco cessation. | • # of groups and meetings attended  
• Policies adopted at state and local levels to increase access to resources |
| Collaborate with youth serving agencies/organizations to increase protective factors to discourage tobacco use among youth and decrease use among youth. | Partner Organizations FCDPHE | • Provide education and support for policies and regulations that promote tobacco free environments.  
• Engage youth in tobacco use.  
• Develop and deliver parent/guardian focused messages to influence beliefs and attitudes to discourage tobacco use. | Plan to reach youth with appropriate social cohesion and/or resiliency strategies |
| Collaborate with agencies that work with pregnant women to decrease tobacco use during pregnancy and post-partum. | Partner Organizations FCDPHE | • Partner with agencies to promote evidence-based cessation programs.  
• Utilize community partners to increase access and education for healthy lifestyles. | • # of people referred to cessation programs  
• % of people connected to cessation services |
Conclusion

On August 2, 2019, the St. Thomas More Hospital Board of Directors, a board made up of community members, approved Food Security as a priority to address Heart Disease, and our Community Health Needs Assessment. On October 4, 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. Thomas More Hospital 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>Fremont County Department of Public Health &amp; Environment</td>
<td>Emma Davis</td>
</tr>
<tr>
<td>Fremont County Department of Public Health &amp; Environment</td>
<td>Amanda Apodaca</td>
</tr>
<tr>
<td>Upper Arkansas Area Council of Governments – Lead Ombudsman</td>
<td>Terri Gerstmeyer</td>
</tr>
<tr>
<td>Health Colorado (interim) RAE</td>
<td>Jason Chippeaux</td>
</tr>
<tr>
<td>Fremont County Department of Human Services</td>
<td>Stacie Kwitek-Russell</td>
</tr>
<tr>
<td>ValleyWide</td>
<td>Lindsey Sykora</td>
</tr>
<tr>
<td>Solvista</td>
<td>Brian Turner</td>
</tr>
<tr>
<td>Regional Health Connector</td>
<td>Mike Orrill</td>
</tr>
<tr>
<td>Upper Arkansas Area Council of Governments</td>
<td>Judy Lohnes</td>
</tr>
<tr>
<td>Loves &amp; Fishes Ministry of Fremont County</td>
<td>DeeDee Clement</td>
</tr>
<tr>
<td>Department of Human Services</td>
<td>Kelly Broomfield</td>
</tr>
<tr>
<td>Southern Colorado RETAC</td>
<td>Brandon Chambers</td>
</tr>
<tr>
<td>Rocky Mountain Behavioral Health</td>
<td>Ray Moore</td>
</tr>
<tr>
<td>St. Thomas More – CEO</td>
<td>Kristy Olson</td>
</tr>
<tr>
<td>St. Thomas More – Wellness</td>
<td>Nikki Teigen</td>
</tr>
<tr>
<td>St. Thomas More – Trauma</td>
<td>Nancy Bartkowiak</td>
</tr>
<tr>
<td>St. Thomas More – Admin</td>
<td>Kristi Swett</td>
</tr>
<tr>
<td>St. Thomas More – Marketing</td>
<td>Jillian Maes</td>
</tr>
<tr>
<td>St. Thomas More – Quality/Case management</td>
<td>Dawn McWilliams</td>
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</tbody>
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