2016

Community Health Needs Assessment

Longmont United Hospital
At a Glance: Community Health Needs Assessment
Longmont United Hospital

Area Served

Boulder, Weld and Larimer Counties

Priorities

- Behavioral Health
- Adult and Childhood Obesity
- Access to Care

Partners

- Boulder County Public Health
- The Longmont Community Foundation
- City of Longmont
- LiveWell Longmont
- Healthy Learning Paths
- The OUR Center
- Longmont Community Health Network
Executive Summary

The Patient Protection and Affordable Care Act, enacted March 23, 2010, added new requirements for nonprofit hospitals to maintain their tax-exempt status, including a requirement to conduct a Community Health Needs Assessment (CHNA) every three years to gauge the health needs of their communities and to develop strategies and implementation plans for addressing them. This CHNA was conducted in compliance with these new federal requirements and as an opportunity for Longmont United 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.”

CHNA Methodology and Process

Service Area Definition:
To define our community for the CHNA and to analyze demographic and health indicator data, we used the STARK-Law service areas, defined as the lowest number of contiguous ZIP codes that account for 75% of a hospital’s inpatient admissions. We used the main counties within the STARK-Law service area to analyze our health driver and health outcome data, as health outcome data was generally not available at the ZIP code level.

Qualitative and Quantitative Data Collection:
We began the data collection process by selecting quantitative indicators for analysis. Community Commons, a population health indicator data platform, was utilized throughout the quantitative data collection process. This platform compiles data from the US Census, the Behavioral Risk Factor Surveillance System, the CDC, the National Vital Statistics System, and the American Community Survey, among others. Specific health indicator data were selected, including community demographic information, behavior and environmental health drivers and outcomes indicators, as well as coverage, quality, and access data. These indicators were selected because they most accurately describe the community in terms of its demographics, disparities, population, and distinct health needs.

Additionally, we sought to engage our community in the qualitative data collection process. Once health needs were prioritized, we determined groups and individuals appropriate for focus groups, being sure to solicit input from underserved or minority groups within the communities we serve. These focus groups helped identify particularly important needs as seen by our communities, help us identify gaps in knowledge, and understand current external efforts around health needs that could be improved by healthcare participation.

Prioritization Process:
Longmont United Hospital created a CHNA subcommittee to review the qualitative and quantitative health data, prioritize health needs in our communities, and to develop implementation strategies to address the prioritized needs. This subcommittee was made up of both hospital staff and community stakeholders including representatives from local public health departments. We prioritized needs based upon quantitative public health and hospital data and qualitative data from community stakeholders representing those who are most affected by the health needs.
Prioritized Need: Behavioral Health

Behavioral health was prioritized as a health need due to the incidence and prevalence of issues related to behavioral health and the need for a more coordinated effort to ensure sufficient and coordinated resources to address the need.

To address behavioral health, we are partnering with the community to leverage the strengths of the hospital and community partners to fill gaps and meet the needs within the community. The strategies we will use to do this include the following:

1. Reduce the number of people inappropriately utilizing the LUH emergency room as the primary access point for behavioral health issues.

2. By December 31, 2017, train 50 Boulder County community members in Mental Health First Aid. (Mental Health First Aid USA is an international evidenced-based program managed, operated and disseminated by the National Council for Behavioral Health. The program is based on a standard curriculum designed to educate the general public about mental health, recognize individuals with mental health problems, and provide skills that students can use to help those who are having a mental health crisis access help.)

3. Increase access to psychiatric and counseling appointments for Boulder County residents.

Prioritized Need: Childhood and Adult Obesity

Longmont United Hospital identified obesity as an urgent issue in our community. As such, we have prioritized obesity and have developed an implementation plan to reduce childhood obesity and promote lifelong wellness strategies. The strategies we will use to do this include the following:

1. By December 31, 2016, have 100 elementary age children and his/her parents participate in the Healthy Learning Paths Be Well, Learn Well ™ curriculum.

2. Provide free health screenings for children and their families with a particular focus on weight and body mass index.

3. Reduce computer/TV screen time in elementary and middle-school children.

Implementation Planning Process:

The first step to developing our implementation plans was to present evidence-based practices focused on addressing Behavioral Health and Childhood Obesity to our hospital subcommittees. Next, we completed an environmental scan to determine which established efforts in Longmont United Hospital and our community we could leverage or build upon to meet the health needs. We then used the PEARL test to determine if a program or strategy would be effective and appropriate.

To create our implementation plan, we modified the CHAPS Action Plan, provided by CDPHE. For each health priority we created SMART goals, strategies, and metrics.

Once our community’s health needs were identified and prioritized, we began the process to develop an implementation plan to address behavioral health and childhood and adult obesity. The first step was to present evidence-based practices focused on Behavioral Health and Adult and Childhood Obesity to our hospital subcommittees. Next, we completed an environmental scan to identify those established efforts (in Longmont
United Hospital and our community) we could leverage or build upon to meet the health needs. We also considered the effectiveness and appropriateness of each strategy available to address these health needs.

**Implementation Plan Review and Approval:**

The final implementation plans were presented to and approved by the Longmont United Hospital Board on May 5, 2016.
Our 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.

Our Vision
Centura Health will fulfill a covenant of caring for our communities with excellence and integrity to become their partner for life.

Our Core Values
Compassion
  Respect
  Integrity
  Spirituality
  Stewardship
  Imagination
  Excellence
Introduction

Centura Health, Longmont United Hospital and Our Community

Background on the Community Health Needs Assessment

The evolving health care landscape has provided health systems throughout the country the opportunity to work with partners in their communities to improve and promote population health. The Patient Protection and Affordable Care Act, enacted March 23, 2010, added new requirements for nonprofit hospitals to maintain their tax-exempt status. One such provision requires nonprofit hospitals to conduct a Community Health Needs Assessment (CHNA) once every three years to gauge the health needs of their communities and to develop strategies and implementation plans for addressing them. This CHNA was conducted in compliance with these new federal requirements.

In addition to Affordable Care Act (ACA) compliance, the implementation of the CHNA furthers Centura Health’s and Longmont United Hospital’s mission and vision. As the region’s largest health care provider, Centura Health fulfills our 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. We honor our commitment to provide outstanding care to the communities we serve and to move upstream to manage health and positively impact our patients’ lives.
Our Goals for the Community Health Needs Assessment

The CHNA process gave Longmont United Hospital the opportunity to work closely with our community to identify existing and emerging health needs, understand community assets and gaps, and to implement strategies to improve health. This approach continues to strengthen partnerships between Longmont United Hospital, our local public health departments, community leaders, and stakeholders. Our goal is to build our organizational capacity in population health best practices and to better position Longmont United Hospital to provide sustainable, whole-person care to our patients and communities. The CHNA process provided valuable information to guide us in integrating our community health work with our hospital and strategic plans.

With this focus, we bring new dynamism to our historical legacy of addressing community needs. We are moving from the older model of simply caring for the sick to delivering and supporting the full spectrum of health, wellness and prevention resources the community depends upon in a world in which both acute and chronic health needs are prevalent and overwhelming. We specifically looked at factors that we know impact the social determinants of health. We recognize the important role that social factors such as housing, education, and employment play in affecting a wide range of health risks and outcomes and contributing to the disparities we see across race/ethnicity and geography. Health can be impacted by where we live, and we know that communities with unstable housing, high rates of poverty and crime, and substandard education have higher rates of morbidity and mortality. We looked at specific indicators representative of the social determinants of health in our prioritization process. Through the CHNA we sought to bring awareness to the importance of the social determinants, and work to promote and create social and physical environments that promote health equity and improve population health.

We seek to create efficiencies in our processes, community partnerships, and the delivery of care. We have continued to build upon existing relationships between Longmont United Hospital and the Boulder County Public Health Department. Together, we have taken great strides to create a model to which hospitals and health care systems around the nation can look to address their own community’s needs. By following the model of activating primary care networks, advancing evidence-based practices, and providing training for care teams and community providers, Longmont United Hospital is continuing to strengthen opportunities for optimal health and addressing the determinants of poor health in the communities we serve.

To more fully integrate a population health mindset throughout the Centura Health system, we leveraged existing data resources, internal expertise, and the strength of our network to design a system-wide CHNA process. This helped to assure key stakeholders’ increased knowledge of public health and to engage internal systems in population health data to help explain the drivers of emergency room and inpatient visits. The knowledge we gained from the CHNA process helped our hospitals more effectively lay out their strategic plan for addressing the health needs in their communities. Over the course of the year, this CHNA process facilitated collaboration within our family of hospitals, helping us build a stronger system in which our hospitals benefit from powerful learning networks and relationships, rather than function as separate entities.
Longmont United Hospital: Our Services and History

Since its foundation in 1959, Longmont United Hospital has provided Boulder County and the surrounding communities with compassionate, personalized, whole-person care. Longmont United Hospital is a full-service, award-winning, 201-bed hospital.

The Longmont Community Hospital Association was organized in 1955 by a group of business leaders and physicians with the express purpose of establishing a community hospital for the care and treatment of the sick. The citizens of the community raised the necessary funds to construct the hospital and it opened in 1959 with 50 beds and 19 physicians.

Longmont United Hospital is a formally designated Planetree Patient-Centered Hospital. The Planetree philosophy empowers patients and their families to be involved in decisions affecting their care. We listen to our patients and structure care around their needs and desires. Planning and developing our programs and services includes input from our communities, physicians, staff and patients. This input gives us the opportunity to increase the wellness of our communities and put the patient’s needs first.

Longmont United Hospital officially joined Centura Health in 2015, Colorado’s largest health network with 17 hospitals and a number of senior living communities, medical clinics, Flight for Life® Colorado, and home care and hospice services, Longmont United Hospital provides care that transcends the walls of the hospital to nurture the health of its communities.

Distinctive Services

Longmont United Hospital offers leading medical experts, cutting-edge technology, and a broad array of specialties and services. Our distinctive services include:

- Orthopedic Surgery
- Neurosurgery
- Women’s and Children’s Services
- Surgical Services
- Oncology Services
- Center of Excellence in Minimally Invasive Gynecology

Our expertise in these areas has earned us a number of awards and honors throughout the years. Longmont United Hospital is proud to have received the following awards and certifications:

- Consumer Choice #1 Award from National Research Corporation, 2012/2013
- Silver Beacon Award for Excellence earned by the Intensive Care Unit from American Association of Critical Care Nurses, 2015
- Outstanding Patient Care from Healthgrades, 2010-2011
- Outstanding Patient Experience Award, Top 10% in Nation from Healthgrades 2013
- The Joint Commission Gold Seal of Approval
- Center of Excellence in Minimally Invasive Gynecology
At Longmont United Hospital, the work we do outside of medical care is born out of the second part of our mission, “to nurture the health of the people in our communities.” From access for the uninsured, to strengthening community partnerships to build vibrant and healthy neighborhoods, Longmont United Hospital is a partner for life.

As a private, non-profit hospital, our dedication is solely to fulfilling our organizational mission by living out our core values and protecting the health and wellbeing of our communities. Our community benefit activities are integral to our religious mission and are the basis of our tax-exempt status. Throughout Centura Health, these community benefit activities include improving community health by providing services to low-income patients and connecting patients with services after discharge, community building, such as economic development and community health programs, subsidized health services like hospice, home care, research to advance the field, financial and in-kind contributions to the community, and community benefit planning.

In fiscal year 2015, Longmont United Hospital provided over $18,810,000 in total community benefit. Community services ranged from providing over $100,000 in support and donations to numerous nonprofit organizations throughout Longmont to donating over 200 bicycle helmets to local children through Bicycle Longmont. Longmont United Hospital provides a significant annual subsidy to Salud Family Health Centers. Salud serves much of the Longmont United Hospital service area and provides significant access to healthcare services for underserved populations. In 2015, the total subsidy amount provided to Salud was $161,762.

In addition to providing health information and services to the public at the hospital and other satellite offices, Longmont United Hospital takes these activities into the communities where patients live, work and play. By offering a variety of support groups, training sessions, educational programs and other community-based resources and activities, and collaborating with non-profit organizations and government entities, Longmont United Hospital has extended its mission to improving the health of our patients and communities we serve.
Our Community

To define our community for the CHNA and to analyze demographic and health indicator data, we used the STARK-Law service areas. The STARK-Law service area is defined as the lowest number of contiguous ZIP codes that accounts for 75 percent of a hospital’s inpatient admissions. These ZIP codes have a combined population of 146,924.

**The demographic makeup of these communities includes:**

Race: 87.68% White; .92% Black; 4.18% Asian; 0.52% Native American/Alaska Native; .05% Native Hawaiian; 3.67% Some other Race, 2.97% multiple races

Ethnicity: Hispanic 13.59%, Non-Hispanic 86.41%

Education Level: In our communities, 63.9% of the population has an Associate’s Degree or higher. CO average is 44.7%

Unemployment Rate: 3.5%; Colorado average is 4.0%

Population with Limited English Proficiency: 6%; Colorado average is 6.7%

High School Graduation Rate: 94%; Colorado average is 77.6%

Population Living in Households with Income Below 200% of Federal Poverty level: 14%; Colorado average is 29.6%
Population Demographics in Longmont United Hospital’s Service Area

Race

- White: 87.68%
- Black: 0.92%
- Asian: 4.18%
- Native American/Alaska Native: 0.52%
- Native Hawaiian/Pacific Islander: 0.05%
- Other: 3.67%
- Multiple races: 2.97%

Ethnicity

- Non-Hispanic: 86.41%
- Hispanic: 13.59%

Associate’s Degree or Higher

- Longmont Service Area: 63.9%
- State Average: 44.7%

High School Graduation Rate

- Longmont Service Area: 94%
- State Average: 77.6%

Limited English Proficiency

- Longmont Service Area: 6%
- State Average: 6.7%

Unemployment Rate

- Longmont Service Area: 3.5%
- State Average: 4.0%

Households Below 200% of Federal Poverty Level

- Longmont Service Area: 14%
- State Average: 29.6%
Our Approach to the Community Health Needs Assessment

In order to assess the needs of our community, we created a hospital subcommittee to solicit and take into account input from individuals representing the broad interest of our community. Our hospital subcommittee was made up of key stakeholders from Longmont United Hospital staff, The OUR Center, the City of Longmont, Longmont Community Foundation, and Healthy Living Paths, and LiveWell Longmont, representing the broader interests of our community.

Our subcommittee:

- Reviewed the quantitative data and provided insight;
- Prioritized health needs using the Centura Health Prioritization Method;
- Identified implementation strategies to maximize impact on a specific health need; and
- Coordinated and collaborated implementation strategies across prioritized needs.

Each subcommittee member was provided with a written description of his/her role. Our subcommittee met twice in 2015. Through mobilizing community partnerships, the subcommittee brought together over ten individuals, representing 7 agencies and dedicating approximately 40 collective hours.

Longmont United Hospital’s Partnerships with Public Health

Over the past several years Longmont United Hospital has partnered with Boulder County Public Health Department (BCHD) to focus our collective resources towards addressing the most pressing health needs in the community, and to provide services through program models that not only benefit children and families locally but will also lead to systemic change.

Additionally, in an effort to meet our goal to publically display our health data, we utilized BCHD’s dashboard of community health indicators. The dashboard is a user-friendly and interactive display using simple graphs and charts that can be understood among a wide range of viewers. The system is regularly updated to provide feedback and monitor performance and efforts to improve community health. The dashboard can be found here: http://www.bouldercountyhealthcompass.org/index.php#
Stage 1: Scanning the Data Landscape

The CHNA was conducted through a collaborative partnership between Longmont United Hospital teams, Boulder County Public Health Department, and community stakeholders. We used the main counties within the STARK-Law service area to analyze our health driver and health outcome data. Health outcome data was generally not available at the ZIP code level. Longmont United Hospital's main service area encompasses Boulder County, Weld County, and part of Larimer County. We used data from Boulder County for this process because the majority of Longmont United Hospital's service area lies in Boulder County. For areas of overlap in health priorities among Community Health Needs Assessments and Public Health Improvement Plans in Weld and Larimer Counties, we are committed to partnering on solutions when greater impact will be realized through such partnerships.

The subcommittee used both quantitative and qualitative data to gain a full understanding of our community and specific health needs. We began the data collection process by partnering with Boulder County Public Health Department’s (BCPH) Compass website. The website includes a dashboard of community health indicators. It also offers the great opportunity to collaborate with BCPH and reduce overall duplication of resources. The site is regularly updated to provide feedback and monitor performance and efforts to improve community health.

In this process, certain health indicator data were selected, including community and population demographic information, behavior and environmental health drivers and health outcomes indicators, as well as coverage, quality, and access data. These indicators were selected because they most accurately describe the community in terms of demographics, disparities, populations, and distinct health needs. These areas address the social determinants of health, quality of life, and healthy behaviors, all things that we know impact community health. To be sure we were measuring all determinants of health, we conducted a full legal and environmental scan of issues and policies impacting health in our community.
<table>
<thead>
<tr>
<th>Health Need</th>
<th>Indicator</th>
<th>Community Value</th>
<th>Colorado Value</th>
<th>Healthy People 2020 Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>Percentage of adults 18 and older who self report that they have ever been told by a health professional that they had asthma</td>
<td>14.6%</td>
<td>12.9%</td>
<td>N/A</td>
</tr>
<tr>
<td>Breast Cancer</td>
<td>Age adjusted death rate due to breast cancer</td>
<td>20.2</td>
<td>19.2</td>
<td>20.7</td>
</tr>
<tr>
<td>Cervical Cancer</td>
<td>Cases per 100,000 females per year, age adjusted</td>
<td>5</td>
<td>6.2</td>
<td>7.1</td>
</tr>
<tr>
<td>Colorectal Cancer</td>
<td>Cases per 100,000 population per year of colon and rectum cancer, age adjusted</td>
<td>33.2</td>
<td>36.9</td>
<td>38.7</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Percentage of adults aged 20 and older who have ever been told by a doctor that they have diabetes</td>
<td>5.5%</td>
<td>6.1%</td>
<td>N/A</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>Death rate due to coronary heart disease per 100,000 population</td>
<td>113.9</td>
<td>137.4</td>
<td>N/A</td>
</tr>
<tr>
<td>Homicide</td>
<td>Rate per 100,000 population</td>
<td>2 in 2011</td>
<td>3.7</td>
<td>5.5</td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>Chlamydia rate per 100,000 population</td>
<td>243.8</td>
<td>422.8</td>
<td>N/A</td>
</tr>
<tr>
<td>Lung Disease</td>
<td>Death rate due to chronic lower respiratory disease per 100,000 population</td>
<td>31.4</td>
<td>48.4</td>
<td>N/A</td>
</tr>
<tr>
<td>Maternal, Infant, and Child Health</td>
<td>Infant mortality rate per 1,000 births</td>
<td>6.3</td>
<td>5.5</td>
<td>6</td>
</tr>
<tr>
<td>Maternal, Infant, and Child Health</td>
<td>Teen birth rate per 1,000 female teens ages 15-19</td>
<td>10</td>
<td>22</td>
<td>N/A</td>
</tr>
<tr>
<td>Maternal, Infant, and Child Health</td>
<td>Percentage of low birth weight births</td>
<td>8.0%</td>
<td>8.8%</td>
<td>7.80%</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Percentage of adults who stated that they experienced eight or more days of poor mental health in the past month</td>
<td>13.1%</td>
<td>13.7%</td>
<td>N/A</td>
</tr>
<tr>
<td>Obesity/Overweight, Physical Activity and Nutrition</td>
<td>Adults (18 and over) who are Overweight (BMI between 25 and 29.9) or Obese (BMI&gt;=30)</td>
<td>45.2%</td>
<td>54.1%</td>
<td>N/A</td>
</tr>
<tr>
<td>Prostate Cancer</td>
<td>Cases per 100,000 males per year, age adjusted</td>
<td>127.9</td>
<td>147.6</td>
<td>N/A</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>Adults reporting heavy alcohol consumption</td>
<td>15.3%</td>
<td>17.6%</td>
<td>N/A</td>
</tr>
<tr>
<td>Suicide</td>
<td>Rate per 100,000 population</td>
<td>59 suicides (in 2009) 1 per 5,144 population</td>
<td>17.2</td>
<td>10.2</td>
</tr>
<tr>
<td>Unintentional Injury</td>
<td>Death rate due to unintentional injury (accident) per 100,000 population</td>
<td>46.7</td>
<td>45.1</td>
<td>36</td>
</tr>
</tbody>
</table>
Stage 2: Delving into the Data to Identify Priorities

Our Longmont United Hospital CHNA subcommittee was provided a health indicator data presentation compiled by the CHNA Steering Committee. The subcommittee identified and prioritized community health needs building upon long-standing relationships focusing on health among those serving on the CHNA subcommittee that have focused upon health for quite some time. They identified the most pressing needs in the Boulder County, Weld County and Larimer County communities based on health indicators, health drivers, and health outcomes. Longmont United Hospital prioritized Boulder County data as the majority of our service area falls in Boulder County.

Our subcommittee defined a health need as a poor health outcome and its associated health driver, or a health driver associated with a poor health outcome where the outcome has not yet arisen as a need. To fit the definition of a health need, the need must be confirmed by more than one indicator and/or data source, and must be analyzed according to its performance against the state benchmark or Healthy People 2020.

The CHNA subcommittee utilized the quantitative data from Boulder County and the hospital and ranked the health needs as a group. This process, complemented by the community conversations, led to the clear identification of the two areas of focus for our community.

Longmont United Hospital identified two needs as priority areas for which we have the ability to impact. These include:

1. Behavioral Health
2. Childhood and Adult Obesity

Stage 3: Engaging our Community to Understand and Act

We sought to engage our community in the qualitative data collection process. Once health needs were prioritized, the Subcommittee worked together to determine groups and individuals appropriate for focus groups, being sure to solicit input from those in the communities we serve who know experiences of the underserved, minority and aging populations best through personal experience or close work with them. Longmont United Hospital also held interviews with specific community representatives to gain input on areas including public health, minority and indigent populations, disparities in health care, social determinants of health and health and social services. The primary themes of these interviews revolved around behavioral health and childhood obesity as the most pressing needs to address. Recent well-publicized events in the Longmont community have placed a greater emphasis on the need for increased behavioral health services.

Next, the group identified questions to ask the focus group to gain a better understanding of Behavioral Health and Adult and Childhood Obesity. Specifically, we wanted to identify focus areas, gaps in knowledge, needs not met, or current external efforts around Behavioral Health and Adult and Childhood Obesity that could be improved by health care participation.

Our focus group was made up of community leaders who have a pulse on specific and critical needs of the community. Candidates were screened and selected to represent the demographics of the Longmont United Hospital service area. Many of these candidates also provide direct patient care on a regular basis and have first-hand knowledge of the needs of the area. These conversations also focused specifically on behavioral health and obesity. No other health issues were elevated during these conversations because of the community’s pressing need to improve health related to these two health needs.
### Table 2. Centura Health CHNA Prioritization Method: Sample Criteria Rating

<table>
<thead>
<tr>
<th>Rating</th>
<th>Size of Health Problem</th>
<th>Seriousness of Health Problem</th>
<th>Alignment</th>
</tr>
</thead>
<tbody>
<tr>
<td>9 or 10</td>
<td>&gt;25% /rate much higher than Colorado benchmark</td>
<td>Very Serious</td>
<td>Alignment with CHNA, CHIP, community groups, hospital and system strengths</td>
</tr>
<tr>
<td>7 or 8</td>
<td>10%-24.9% /rate somewhat higher than Colorado benchmark</td>
<td>Relatively Serious</td>
<td>Alignment with 3 of the following: CHNA, CHIP, community groups, hospital and system strengths</td>
</tr>
<tr>
<td>5 or 6</td>
<td>1%-9.9% /rate slightly higher than Colorado benchmark</td>
<td>Serious</td>
<td>Alignment with 2 of the following: CHNA, CHIP, community groups, hospital and system strengths</td>
</tr>
<tr>
<td>3 or 4</td>
<td>.1%-9% /rate same as Colorado benchmark</td>
<td>Moderately Serious</td>
<td>Alignment with 1 of the following: CHNA, CHIP, community groups, hospital and system strengths</td>
</tr>
<tr>
<td>1 or 2</td>
<td>.01%-0.9% /rate slightly lower than Colorado benchmark</td>
<td>Relatively Not Serious</td>
<td>Some alignment with 1 or two of the following: CHNA, CHIP, community groups, hospital and system strengths</td>
</tr>
<tr>
<td>0</td>
<td>&lt;.01% /rate lower than Colorado benchmark</td>
<td>Not Serious</td>
<td>No Alignment and/or no community gap in need being addressed</td>
</tr>
</tbody>
</table>

**Guiding Considerations**
- Size of Health Problem should be based on baseline data collected from the community
- Does it require immediate attention? What is the economic impact? What is the impact on quality of life? Is there a high hospitalization rate? Is there public demand?
- Is this health need being addressed by our last CHNA? Is this health need addressed in our last CHIP? Is this health need addressed by a local public health department’s CHIP? Is this health need addressed by a strong local community organization?
Stage 4: Developing the Implementation Plan

Once our community’s health needs were identified and prioritized, we began the process to develop an implementation plan to address Behavioral Health and Adult/Childhood Obesity. The first step was to present evidence-based practices focused on Mental Health and Adult and Childhood Obesity to our hospital subcommittees. Next, we completed an environmental scan to identify those established efforts (in Longmont United Hospital and our community) we could leverage or build upon to meet the health needs. We also considered the effectiveness and appropriateness of each strategy available to address these health needs.

On September 17, 2015, the CHNA hospital leads from each Centura Health hospital attended a panel at Porter Adventist Hospital. The panel featured local experts on mental health, healthy eating, and active living initiatives:

- Shannon Breitzman, Branch Director, Injury, Suicide and Violence Prevention, CDPHE
- Doug Muir, Director of Behavioral Health Service Line, Porter Adventist Hospital
- Sarah Kurz, VP of Policy and Communication, Livewell Colorado
- Kim Patton, HRSA, Acting Deputy Regional Administrator, Mental Health
- Reg Cox, Senior Minister, Lakewood Church of Christ
- Andrea Bon-Wilson, Psychological and Behavioral Counselor, Cardiac Rehabilitation and Health Wellness, HELP for Diabetes Program, St. Anthony Hospital

The panelists spoke about available resources and programs in their communities impactful and gaining traction locally, regionally, and/or statewide that address mental health and/or healthy eating and active living. They also spoke to current programming gaps that health care systems or hospitals can help to address.

To create our implementation plan, we modified the Colorado Health Assessment and Planning System Action Plan (CHAPS), provided by Colorado Department of Public Health and Environment. CHAPS provides a standard mechanism for assisting local public health agencies and the Colorado Department of Public Health and Environment in meeting assessment and planning requirements of the Public Health Act of 2008. For each health priority we created SMART goals, strategies, and metrics.

The Social-Ecological Model

The social-ecological model recognizes the complex interplay between individual, relationship, community, and societal factors. Individuals are responsible for making and maintaining lifestyle choices, such as healthy eating and active living. However, the ability to make these choices is determined largely by the social environment we live in (i.e., community norms, laws, policies). Barriers to healthy eating and active living are shared by the community, and removal of the barriers makes behaviors attainable and sustainable. The overlapping rings in the model illustrate how factors at one level influence factors at another level (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.

The following are examples of factors in the social-ecological model for the areas of priority for this Community Health Needs Assessment. To achieve long-term health outcomes among our communities, changes at every level of the model will both support people making the healthy choices and removing the barriers to making the healthy choices. The model makes it such that a person can leave the physician’s office and their community – people and environment – will support the person in the changes recommended by the physician. It also makes it possible for healthy choices to be supported in diverse communities or various income and race/ethnicity.
**Healthy Eating:**
Individual: Eat nine servings of fruits/vegetables daily

Interpersonal: When friends gather, there are fruits/vegetables served

Organizational: At work and in schools, vending machines and cafeterias offer fruits/vegetables

Community: Stores that sell fruits/vegetables are in all communities (e.g., food pantries, convenience stores and grocery stores)

Public policy: Women, Infants and Children Program for lower income moms can be used to purchase all healthy options within a store

**Active Living:**
Individual: Exercise for 150 minutes/week

Interpersonal: Friends and neighbors go for walks together as a part of their routines

Organizational: At work and in schools, there are daily opportunities to get up and move for longer periods of time (e.g., breaks and recess)

Community: There are places to walk in communities that support people safely walking where they would typically go (e.g., sidewalks to stores)

Public policy: Complete Streets policies guide cities and states to create sidewalks and bike lanes along with roads

**Behavioral Health:**
Individual: Sense of safety and security (e.g., shelter and safety from violence)

Interpersonal: Positive connections with peers and family

Organizational: Access to community activities, such as school clubs and recreation facilities, in which people have an awareness and understanding of behavioral health signs and symptoms through classes such as Mental Health First Aid

Hospital/HealthCare: Assess for risk factors associated with behavioral health issues to identify risk and early symptoms and referral to resources to meet basic needs (food, shelter) and health care services

Community: Create environments that encourage positive connections and in which there is decreased stigma associated with behavioral health

Public policy: Increase access to basic needs (e.g., affordable housing, Supplemental Nutrition Assistance Program enrollment) and behavioral health care providers through reducing shortages among those who accept Medicaid
Our Approach to the Community Health Needs Assessment

Figure 2. The Socio-Ecological Model

- Public Policy
  - Cultural values, norms
- Community
  - Environment, ethos
- Organizational
  - Social network
- Interpersonal
  - Knowledge, attitude, skills
- Individual
Identified Health Needs

In conducting our Community Health Needs Assessment, we identified the health needs of our community and then narrowed our focus to enable us to have the most impact. A community health need is defined as either:

- A poor health outcome and its associated health drivers
- A health driver associated with a poor health outcome, where the outcome itself has not yet arisen as a need

We used a specific set of criteria to identify the health needs in our communities. Specifically, we sought to ensure that the identified needs fit the above definition, and that the need was confirmed by more than one indicator and/or data source. We looked at demographics to describe our community, health drivers to look at our health behaviors and environmental factors, health outcomes to look at the main causes of illness and death in our community, and access data to analyze the availability of coverage and quality. Finally, we determined that the indicators related to the health need performed poorly against either the Colorado state average or the Healthy People 2020 benchmark.

The health needs identified in this CHNA included:

- Behavioral Health
- Childhood and Adult Obesity

Prioritized Health Needs

Longmont United Hospital prioritized behavioral health. Inadequate access to mental health services is also a concern in the communities we serve. Centura Health has recognized this gap and is currently working with mental health partners and providers to better integrate mental health services into our hospitals, clinics, and neighborhood health centers. At Longmont United Hospital, we are currently working with Mental Health Partners of Boulder County to provide mental health services to our patients and our communities.

A major initiative that Longmont United Hospital has undertaken is participation in the Colorado State Innovation Model (SIM) for the integration of behavioral health and primary care. Two Longmont United Hospital primary care clinics have integrated behavioral health and the early results have been positive. We would like to
expand this initiative to all Longmont United Hospital primary care clinics going forward.

There have been some recent events that occurred within Longmont that highlight the need for behavioral health awareness and resources. Various municipal officials and community agencies have begun to work collaboratively on increased resources and solutions. This awareness is a key first step in beginning to address a very urgent and complex issue.

In addition to Behavioral Health, our community decided to also focus on childhood obesity. Prevention of obesity with a focus on early childhood populations is a key health need for the communities served by Longmont United Hospital. Although Colorado is consistently recognized as one of the healthiest states, it also has one of the fastest growing rates of childhood obesity in the country. Much of this is among the Latino and low income populations and includes challenges such as lack of access to healthy foods, cultural influences and barriers to regular physical exercise.

An analysis of the environmental indicators for Boulder County revealed that our community has both opportunities and barriers to living a healthy and active lifestyle.

There are many opportunities for recreation and fitness, with over 21 fitness facilities per 100,000 individuals. The low-income population with low food access also stands at 3.66% compared to the state average of 6.39% and there are fewer liquor stores than the state average. Our community also has good access to grocery stores with 19 grocery stores per 100,000 individuals.

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<td>6.4</td>
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On the other hand, there are many opportunities to access unhealthy food in our community, with more fast food restaurants in our community than is average for the state of Colorado at 86.91 per 100,000 population. There are fewer WIC- and SNAP-authorized food stores in Boulder County than is average for Colorado, which may lead to food barriers for the most vulnerable members of our community.

Longmont United Hospital’s efforts to prevent childhood obesity involve strong partnerships with two significant community organizations, LiveWell Longmont and Healthy Learning Paths. Longmont United Hospital is the fiscal sponsor of LiveWell Longmont and works closely with the organization to further the Healthy Eating Active Living (HEAL) message. In addition, Longmont United Hospital strongly supports Healthy Learning Paths, an organization that empowers children and families to lead healthy lives by serving all children, with a focus on early childhood and families with low incomes. Longmont United Hospital physicians, nurses and other clinical staff teach the Be Well, Learn Well curriculum on a regular basis in the St. Vrain Valley School District. A particular focus is given to those schools with the greatest needs.

The Boulder Valley YMCA is a resource within the community that focuses heavily on obesity prevention. Longmont United Hospital has been a supporter of the YMCA and will continue to look at collaborative efforts to work together.
Longmont United Hospital also believes in our ability to create an environment supportive of health within our hospital setting. In 2015, we were awarded the Bronze Level of the Healthy Hospital Compact. In partnership with LiveWell Longmont, we will strive to achieve the Silver Level to increase healthy eating and physical activity choices within our hospital.

**Access to Care**

In addition to the above prioritized health needs, Centura Health and Longmont United Hospital recognize 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 has been a top priority for Centura Health throughout our history. Our founders recognized a community need for health care services and built the first hospitals to meet that need. More recently, we have proactively redesigned our core services and facilities to create low-cost healthcare options, including urgent care and neighborhood health centers, closer to our patient’s homes.

While not a driver of health outcomes, improving access to care is a critical factor in addressing the mental health and obesity needs identified in the CHNA process. As a nonprofit and faith-based hospital, Longmont United Hospital has a mission to understand all of the potential factors that prevent members of our community from accessing the care, both mental and physical, that they need. The rising costs of healthcare can prevent members of our communities from seeking care or from continuing with the care they need. 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.

Longmont United Hospital is assisting with access to care by providing Financial Assistance Counselors to help patients complete a Medicaid application, and gather necessary documentation to process the application. Often this involves assistance with submittal of the application as the technology required can be a barrier for some patients. In addition accounts of uninsured patients are monitored for eligibility for financial assistance. Longmont United Hospital is looking to expand financial assistance services by implementing Centura’s Community Health Advocate program that successfully enrolls eligible patients in Medicaid in a reduced period of time.

Longmont United Hospital has closely collaborated with Boulder County Housing and Human Services to target uninsured individuals who are high utilizers of healthcare services. This collaboration is part of an outreach effort to enroll as many uninsured individuals as possible into Medicaid. This larger effort resulted in 14,183 individuals being enrolled as of September 2014. This effort was repeated during the enrollment period in 2015.

Centura Health continually promotes programs and services to ensure that individuals in our communities can access the care they need. Throughout the organization, we engage Community Health Advocates (CHA’s) who 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 number who are uninsured. We identify uninsured patients in our Emergency Departments, our community-based partner organizations, and at local events to engage them with CHA’s 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.

In 2014, there were 90.2% adults who were insured in Boulder County. Of children in Boulder County, 97.1% were insured in 2014. There are 125 primary care providers (physicians) per 100,000 residents in Boulder County. This rate has been increasing over time. Complementary to the physician providers is the non-physician primary
care provider rate which is 83 per 100,000 population in Boulder. As health insurance rates increase, the demand for health care providers increases, and the non-physician providers provide the opportunity for people to access routine checkups and screenings. We as a community also need to focus on ensuring that people have access to a regular doctor or medical home.

Other Issues Impacting Health across the State and in Our Community

Smoking

The Colorado Clean Indoor Air Act is a state law limiting smoking in indoor areas and within 15 feet of building entryways. The law does not extend to outdoor areas. Many cities and counties in Colorado have enacted ordinances to make their smoking laws more stringent than state law. In many cases, cities and counties have extended their restrictions to widen the perimeter of restricted entryways and extend no smoking laws to outdoor areas like downtown areas, parks, transit waiting areas, and dining patios. Some and counties have also chosen to apply all of their existing smoking laws to the use of electronic cigarettes. Boulder County is one of the few counties or cities in Colorado with laws that do not allow smoking in attached bars or separately ventilated rooms and do not have size exemptions. The city of Boulder has imposed several measures to limit tobacco use in more ways than Colorado state law. For example, the city of Boulder extended all existing smoking bans to the use of electronic cigarettes and prohibits smoking in certain downtown areas, parks, and trails. The city of Lafayette extended all existing smoking bans to the use of electronic cigarettes as well. The city of Longmont has not extended Colorado law in regards to tobacco use.

SNAP and WIC Accepted at Farmer's Markets

Many Coloradans purchase their fresh fruits and vegetables from their local farmers’ market. Farmers’ markets are an excellent way for people to access nutritious, locally grown products. Ideally, farmers’ markets would be accessible to all Coloradans, regardless of income levels. Supplemental Nutrition Assistance Program (SNAP) payments are accepted at numerous farmers’ markets across the state. Women, Infants, and Children (WIC) payments are accepted only at 7 farmers’ markets.

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<tr>
<th>Health Factors (Percentage of importance in determining outcomes)</th>
<th>Health Outcomes</th>
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<td>Clinical Care (20%)</td>
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<td>Social and Economic Factors (40%)</td>
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<td>Health Behaviors (30%)</td>
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<td>Tobacco Use</td>
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<td>Diet and Exercise</td>
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<td>Alcohol and Drug Use</td>
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<td>Sexual Activity</td>
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<td>Access to Care</td>
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<td>Quality of Care</td>
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<td>Air and Water Quality</td>
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<td>Housing and Transit</td>
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Source: Robert Wood Johnson Foundation
across the state. Women, Infants, and Children (WIC) payments are accepted only at 7 farmers’ markets across the state. Boulder County residents who participate in the Supplemental Nutrition Assistance Program (SNAP) are able to buy twice as many fruits and vegetables when they use their benefits at the Boulder County Farmers’ Markets.

**Colorado’s Lack of Affordable Housing**

The average cost of rent in Colorado is growing three times faster than the national average. For a Coloradan to afford a median-priced rental in the state, the resident must make thirty-five dollars an hour, which is four times as much as Colorado’s minimum wage.

**High “Self Sufficiency Standard”**

The cost of living in Colorado has risen 32% from 2001 to 2015. Between 2001 and 2005, health care went up by 86%, food by 63%, child-care by 48%, and housing increased by 27%. The state’s minimum wage is insufficient to support families anywhere inside the state, and is only sufficient to support one-person households in Otero, Bent, and Custer Counties. 76% of workers in the most common occupations do not earn wages sufficient to support their families.

**Homelessness**

The Sturm College of Law at the University of Denver has conducted an extensive report addressing Colorado’s homelessness issues. Closely related to the issue of a shortage of affordable housing in many Colorado towns is a failure to address the needs of homeless residents. In Colorado’s 76 largest cities, there are 351 city ordinances in Colorado that criminalize life-sustaining behaviors for the homeless. These laws disproportionately impact homeless residents. Sturm College of Law at the University of Denver estimates that six Colorado cities spent at least $5 million enforcing fourteen anti-homeless ordinances between 2010 and 2014, and this is a conservative estimate. These funds could be better used to fund programs to rehabilitate and support the homeless, many of whom suffer from behavioral health issues.
Marijuana Legalization – Effect on Tourists

Out-of-state visitors to Colorado emergency rooms for marijuana-related symptoms accounted for 163 per 10,000 visits in 2014, up from 78 per 10,000 visits in 2012, according to research published by Dr. Howard Kim, a Northwestern research fellow and emergency medicine physician. The 109% increase far outpaced the 44% increase among Colorado residents since the state’s recreational marijuana sales began Jan. 1, 2014.7

Access to Care for Undocumented Individuals

Due to current laws and regulations, it is difficult for undocumented individuals to get health insurance.8 Also, families with both documented and undocumented individuals are apprehensive of applying for coverage even when they are eligible, out of fear that the undocumented members of their family will be reported to immigration authorities. However, there are currently strong legal protections against using information received through health insurance against an undocumented individual.9 Centura Health and other community organizations must educate the community regarding these rules to encourage more undocumented individuals to apply for coverage.

Preventable Motor Vehicle Accidents

Colorado is only one of fifteen states in the country with secondary safety belt laws – meaning that law enforcement drivers can only cite drivers for not wearing seat belts if they are stopped for another violation. Colorado safety belt usage is lower than the national average at 82.4% compared with 87% nationally. Also, it is not mandatory by law for motorcycle riders to wear helmets.10 Currently, it is legal for anyone over the age of 18 to use a phone while driving11.

Education

Coloradans with less education are more likely to live in poverty. A 2012 report shows that only 4.5% of Coloradans with a bachelor’s degree or higher lived in poverty, while 26.9% of Coloradans without a high school diploma or GED are living in poverty. Furthermore, the unemployment rate for Coloradans with a bachelor degree is 3.9%, which is significantly lower than the state average of 8%. 10.6% of Coloradans without a high school diploma or GED are unemployed. Education is strongly associated with higher earners. Coloradans with a bachelor's degree had a median income of $47,782, while those with only a high school education or GED had a median income of $28,486.

Civil Commitment Statute - Statewide

According to Colorado law, a person can be involuntary committed for psychiatric evaluation if they pose an “imminent danger” of harm to themselves or others.12 Spurred by the Aurora movie theater shooting in July 2012, there has been a contentious debate over this current law because it does not fall in line with 43 other states in which there is a lesser standard to involuntarily commit a person that poses a behavioral health risk to the public.13 Proposed bills to change this standard have been rejected as policymakers have shown hesitation to encroach on civil rights. Despite civil rights concerns, there are concerns that the current involuntary commitment standard is insufficient. Researchers at the School of Social Welfare at the University of California at Berkley reported in 2011 that broader commitment criteria are strongly associated with lower homicide rates.

Shortage of Mental Health Professionals

There is a shortage of mental health professionals in many Colorado counties.14 Colorado ranks near the bottom in psychiatric beds per capita. Also, Colorado ranks in the bottom half in per capita state and federal spending on mental-health.15 Despite the Affordable Care Act’s mandate that commercial insurers create “parity” between mental health care services and physical care services, insurers are still able to reimburse hospitals at a higher rate for physical healthcare than mental healthcare. Low funding and low reimbursement rates are leaving providers unable to invest in improving their behavioral health services.
Lack of Integration between Primary Care and Behavioral Healthcare

There is high demand for integration between behavioral health services and primary care. A 2014 study found that only 12% of patients who were referred to behavioral health therapy actually completed the treatment. Policy makers believe that if behavioral health treatment is integrated into primary care, the social stigma behind receiving behavioral healthcare will be eroded and patients will actually receive the treatment they need. There have been statewide attempts to integrate primary care and behavioral health services. Currently, the State is focusing on integrating the Accountable Care Collaborative efforts with the Colorado State Innovation Model and Behavioral Health Organization efforts. The goal of these efforts is to result in integration of physical and behavioral health services for Medicaid patients.

Also, Colorado has the seventh highest suicide rate in the nation. In the month before their deaths, a majority of people who have committed suicide were found to have visited a primary care physician. Increased integration of primary care and behavioral healthcare can result in improved detection tools and support for primary care physicians to identify mental illness and those at risk for suicide.

Bike Friendliness

Bike friendliness is an important function to encourage active lifestyles. Also, bike friendliness means creating roads that are cognizant of bicyclists, which leads to the reduction of unnecessary bike and car accidents. Colorado is currently named by The League of American bicyclists as a top 10 state for bike friendliness. Policies and laws can be enacted to increase bike friendliness and bike safety. The city of Boulder was one of five communities across the nation to receive a platinum rating from the League of American Bicyclists. Bike-friendly roadways are crucial in encouraging active lifestyles and preventing bike accidents. Boulder has numerous bike-friendly ordinances and 95% of its arterial roadways have bike lanes.

12. C.R.S. 27-65-105
13. http://www.denverpost.com/news/ci_25831191/debate%C2%AD-rages%C2%AD-colorado%C2%AD-over-involuntary%C2%AD-holds%C2%AD-mental%C2%AD-illness
Conclusion

Evaluation

Progress since our last CHNA

The following five needs were identified in the initial CHNA conducted in 2013. A brief summary of action taken in response follows each need.

• Improve healthcare access – The physician group employed by Longmont United Hospital has expanded not only the number of providers but also the overall patient base. Practices offer extended hours appointments for convenience and in effort to satisfy patient demand. In addition, Longmont United Hospital supports local organizations that improve access to care such as the Salud Clinic, Longmont Community Health Network, and The OUR Center.

• Increase availability of mental health services – Some of the steps taken include mental health counselors in the Emergency Department, building on strong working relationships between inpatient mental health facilities and establishing behavioral health professionals inside primary care clinics.

• Improve affordability of healthcare services – Pricing transparency and affordability continues to be one of Longmont United Hospital’s top strategic priorities. Centura Health is the regional leader in these areas and their progress in this area was of major importance when Longmont United Hospital was selecting a health system partner.

• Focus on preventative care and proactive management of chronic conditions – All of the Longmont United Hospital primary care clinics are designated as Patient Centered Medical Home Level III. This designation recognizes facilities that focus on preventive care, management of chronic conditions and an overall patient-focused approach.

• Reduce obesity and promote a lifelong wellness strategy – Longmont United Hospital is a very strong supporter of LiveWell Longmont and Healthy Learning Paths. Both of these organizations focus on the prevention of obesity, particularly in very young children, and the HEAL campaign, a partnership between LiveWell Colorado and the Colorado Municipal League (CML), the HEAL Cities & Towns Campaign provides training and technical assistance to help municipal officials adopt policies that improve access to healthy eating and active living (HEAL) in their communities.

Evaluating our Impact for this CHNA

To understand the impact we are having in our communities, we remain dedicated to consistently evaluating and measuring the effectiveness of our implementation plans and strategies. We will complete bi-annual assessments of core metric progress measures. Littleton Adventist Hospital will also track progress through annual community health improvement plans and community benefit reports.

Community Health Improvement Plans

The CHNA allows Longmont United Hospital to measurably identify, target, and improve health needs in our communities. From this assessment, we will generate annual Community Health Improvement Plans to carry out strategies for the advancement of all individuals in our communities. These plans detail the specifics of implementing the strategies from the CHNA, including the prioritized needs, partnerships in the community to address those needs, goals, initiatives, and progress to date.
Community Benefit Reports

As mentioned previously, a vital aspect of our non-profit and religious hospital status is the benefit we provide to the communities. Each fiscal year, we publish our annual community benefit report that details our communities by county, their demographics, the total community benefit that we provided, and the community benefit services and activities in which we engaged. These reports are an important way to visualize the work we do in our communities and to show the programs and services we offer along with the number of people reached through them. We will continue to use these reports to track our progress with the CHNA implementation strategies because they clearly demonstrate the number of people reached through our programs and services and the resources spent to achieve our goals.

Community Feedback

We welcome feedback to our assessment and implementation plan. Any feedback provided on our plan is documented and shared in future reports. No written feedback from the community was received on our last Community Health Needs Assessment. For comments or questions, please contact:

Peter Powers, Vice President, Operations  
(303) 651-5026 | peterpowers@centura.org

or

Monica Buhlig, Group Director of Community Health  
Mountain and North Denver Operating Group  
720-321-0028 | monicabuhlig@centura.org
Thank You and Recognition

Our Community Health Needs Assessment is as strong as the partnerships that created it. It is through these partnerships that we were able to ensure we were leveraging the assets in our communities, getting the voices of those who are experiencing challenges with their health and social determinants of health and making a plan to which both the community and hospital are committed. Thank you to the following people who committed their time, talent and testimony to this process.

- Add Namino Glantz, Health Planning & Epidemiology Manager, Boulder County Public Health Department
- Nancy Driscoll, Chief Nursing Officer
- Peter Powers, Vice President, Operations
- Reed Caldwell, MD, Emergency Department
- Darlene Savage, Director, Care Coordination
- Michelle Whitmore, Director, Patient Care
- Barb Turney, Marketing Manager
- Edwina Salazar, Executive Director, The OUR Center
- Dan Eamon, City of Longmont Emergency Manager, Longmont Community Health Network Coordinator
- Eric Hozempa, Executive Director, The Longmont Community Foundation
- Chris Marchioni, MD, Executive Director, Healthy Learning Paths

Longmont United Hospital and community members and leaders at large. Many of the hospital representatives and senior executives live in the community and represent the organization by serving on key not-for-profit Boards and organizations such as the Educational Foundation for the St. Vrain Valley, Longmont Area Economic Development Partnership, Via Mobility Services, LiveWell Longmont, Boulder County Public Health Public Health Improvement Process Steering Committee, A Woman's Work, Longmont Community Health Network, Tru Community Care, Rotary, Intercambio and the YMCA.
Appendix A: Data Sources

American Community Survey, 2008-12
Census Population Estimates, 2014
CMS, National Provider Identification file, 2015
Colorado Health and Hospital Association, 2010-12
County Health Rankings, 2008-2010
County Business Patterns, 2012
Dartmouth Atlas of Health Care, 2012
National Center for Education Statistics, 2012-2013
National Center for Education Statistics, 2008-2009
Behavioral Risk Factor Surveillance System, 2006-2012
Behavioral Risk Factor Surveillance System, 2005-09
Behavioral Risk Factor Surveillance System, 2006-2010
Behavioral Risk Factor Surveillance System, 2006-2012
Behavioral Risk Factor Surveillance System, 2011-2012
Federal Bureau of Investigation Uniform Crime Reports, 2010-12
Health Resources and Human Services Administration, Health Professional Shortage Areas, 2014
National Center for Chronic Disease Prevention and Health Promotion, 2012
National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, 2012
National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, 2010

National Environmental Public Health Tracking Network, 2008
National Vital Statistics System, 2006-2010
Small Area Health Insurance Estimates, 2012
State Cancer Profiles, 2007-2011
Area Health Resource File, 2012
US Department of Health & Human Services, Health Resources and Services Administration,
USDA Food Access Research Atlas, 2010