Community Health Needs Assessment
Parker Adventist Hospital
Priorities

- Mental Health/Suicide Prevention
- Healthy Eating
- Active Living/Obesity
- Access to Care
- Equestrian Safety

Partners

- Town of Parker (government)
- Doctor’s Care (clinical partner)
- Tri-County Health Department (clinical partner)
- Parker Police (city government)
- Parker Chamber of Commerce (city government)
- The Crisis Center (clinical partner)
- Colorado Wellness Connection / 9Health Fair (wellness partner)
- New Day Seventh Day Adventist Church (church partner)
- South Metro Health Alliance (mental health partner)
- John Christie, Licensed Professional Counselor (mental health partner)
- Parker Pediatrics (clinical partner)
- NAMI – National Alliance on Mental Illness (mental health partner)
- Colorado Crisis Services (mental health partner)
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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) 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 and as an opportunity for Parker Adventist 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:
Parker Adventist 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 health needs in our community using the Centura Health prioritization method, adapted from the Hanlon Method for Prioritizing Health Problems. First, members of the hospital subcommittee individually rated each identified need against the size of the problem, the seriousness of the problem, and how much the need already aligned with Centura Health and the community’s existing efforts. Based on the criteria rankings assigned to each health need, we calculated priority scores using the formula: $D = C[A + (2B)]$, where:

- $D =$ Priority Score
- $A =$ Size of health need ranking
- $B =$ Seriousness of health need ranking
- $C =$ Alignment ranking
After calculating priority scores for each identified health need, we gave the need with the highest score a rank of 1, with the next highest score receiving a rank of 2, and so forth. This helped us identify the health needs in our community.

**Prioritized Need: Mental Health/Suicide Prevention**

The health need mental health/suicide prevention for Parker Adventist Hospital was prioritized because the health indicators for mental health were either higher than surrounding county and state average data, or not meeting the goal of Healthy People 2020. Parker Adventist Hospital’s service area’s suicide rate is 15.2 per 100,000 compared to Colorado’s 17.2. This is higher than the Healthy People 2020 goal of 10.2 per 100,000. Douglas County had higher suicide rates in 2013 than both Arapahoe and Jefferson Counties, the closest surrounding areas. Additionally, 16.5% of individuals in our service area reported a lack of social or emotional support. Roughly, 14% of Douglas County adolescents considered suicide in the past 12 months, the same alarmingly high rate as the state.

Several hospital activities and initiatives are available to address this need. Mental Health training programs are offered to both associates and community members in order to raise the competency levels of people who deal with mental health issues. These programs include Mental Health First Aid and Youth Mental Health First Aid (Y/MHFA), Crisis Prevention Institute Training, Applied Suicide Intervention Skills Training (ASIST), and Assessing and Managing Suicide Risk (AMSR).

**Prioritized Need: Healthy Eating Active Living/Obesity**

This was identified as a health need because 36.9% of adults in our service area were overweight, compared to the state average of 35.3%. Additionally, 75.8% of adults reported eating less than 5 fruits or vegetables per day, and 14.6% reported getting no leisure time physical activity. Our focus groups confirmed that healthy eating active living/obesity is a high priority need in our community. Our participants stated this issue disproportionately affected vulnerable populations, such as those with low incomes, the elderly and minorities. We felt it was imperative that we worked to remove barriers to healthy eating and increase opportunities for active living in our community.

Programs at the hospital to address obesity include the Pathways to Health and Wellness (PHW), CafeWell, CREATION Health, and Weigh and Win.

**Prioritized Need: Access to Care**

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, Parker Adventist 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. In our community, 24% of adults had no dental exam in the past year, and 7% have poor dental health. In 2012, 16.8% of adults and 8.2% of children under 19 were uninsured.

Access to care programs are designed to increase enrollment in insurance programs and connection to primary care homes. These programs enable low income residents to obtain health services, which was one of the top concerns of people in the food bank focus groups. Programs at the hospital include Centura Community Health Advocates and Eligibility Specialists that assist with insurance enrollment; and Centura Health Physician Group that connects patients to primary care homes.
Implementation Planning Process:
The first step to developing our implementation plans was to present evidence-based practices focused on addressing mental health, healthy eating active living/obesity, equestrian safety, and access to care to our hospital subcommittees. Next, we completed an environmental scan to determine which established efforts in Parker Adventist 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 of developing an implementation plan to address mental health/suicide, healthy eating active living/obesity, and access to care. The first step was to present evidence-based practices focused on mental health/suicide, healthy eating active living/obesity, and access to care to our hospital subcommittees. Next, we completed an environmental scan to identify those established efforts (in Parker Adventist 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. Our last step was to hear from a panel of experts on mental health, healthy eating, and active living, before we created our plans.

Implementation Plan Review and Approval:
The final implementation plans were presented to and approved by the Parker Adventist Hospital Board on March 16, 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, Parker Adventist 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 Parker Adventist 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 within our hospital walls and to move upstream to positively impact our patients’ lives.
Our Goals for the Community Health Needs Assessment

The CHNA process gave Parker Adventist 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 Parker Adventist 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 Parker Adventist 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 delivery of care. We have continued to build upon existing relationships between Parker Adventist Hospital and the Tri-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, Parker Adventist Hospital is continuing to strengthen opportunities for good 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 assure increased public health knowledge of key stakeholders and engaged internal systems in population health data that helps 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 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.
Parker Adventist Hospital:
Our Services and History

Since its foundation in 2004, Parker Adventist Hospital has provided people throughout the south Denver region and the surrounding communities compassionate, personalized, whole-person care. Parker Adventist Hospital is a full-service, award-winning, 170 bed hospital that specializes in advanced surgery, complex medicine, and life-saving emergency care.

Twelve years ago, Parker Adventist Hospital joined the Parker community. Ranked among the top hospitals in the nation for patient satisfaction, we offer comprehensive health care services, including the most complex surgeries and medical treatments available. Some of these include: neurosurgery, wound care, spine surgery, joint replacement, stroke care, bariatric surgery, and comprehensive cancer care. With access to more than 1,100 providers in 55 specialties, you can rest easy knowing that the healthcare needs for your entire family are minutes from your home.

As part of Centura Health, 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, Parker Adventist Hospital provides care that transcends the walls of the hospital to nurture the health of its communities.

Distinctive Services

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

- Emergency Services & Level II Trauma Center
- Joint Replacement Program
- Cancer Center
- The BirthPlace & NICU
- Neuroscience & Surgical Spine Program
- Bariatric Weight Loss Surgery

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

- 2015 - The Center for Bariatric Surgery at Parker Adventist Hospital has received the Center of Excellence designation by OptumHealth (a division of UnitedHealth Group)
- 2013 - Commission on Cancer (CoC) accreditation with eight commendations by the American College of Surgeons
- 2015 – Chest Pain Center with PCI Accreditation from the Society of Cardiovascular Patient Care (SCPC)
- 2015 - Anthem BlueCross BlueShield Blue Distinction® Centers for Knee & Hip Replacement and Blue Distinction® Centers for Spine Surgery
- 2015 - American Heart Association & American Stroke Association’s, “Get with the Guidelines” Stroke GOLD PLUS Achievement Award
Commitment to Our Community

At Parker Adventist 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, Parker Adventist 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, Parker Adventist Hospital provided over $12,713,293 in total community benefit. Community services included, but were not limited to, free lactation support and clinics to patients each month, donating $10,000 to Adventist Community Services to provide care for over 8,000 under-privileged patients, Serving 900 community members at the 9 Health fair, offering free health screenings and services, engaging 200 people at the annual Women’s Wellness Expo, and providing information and presentations on women’s health, offering an Equestrian Safety Program to donate fitted helmets and educate the community on riding safety, and holding free Community Health Seminars monthly, which reached 875 people annually.
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% of a hospital’s inpatient admissions. These ZIP codes have a combined population of 478,802.

The demographic makeup of these communities is as follows:

Race and Ethnicity: White: 81%, Black 6.4%, Asian 5.1%, Multiple Races 3.9%, Some Other Race 3%, Native American/Alaska Native 0.5%, Native Hawaiian/Pacific Islander 0.2%, Hispanic or Latino 12%

Education Level: In our community, 52.6% of the population has an Associate’s degree or higher. CO average is 44.7%

Unemployment Rate: 3.6%, CO average is 4.0%

Population with Limited English Proficiency: 5.4%, CO average is 6.7%

High School Graduation Rate: 74.5%, CO average is 77.6%

Population Living in Households with Income Below 200% of Federal Poverty level: 17.2%, CO average is 29.6%
Population Demographics in Parker Adventist Hospital's Service Area

Race

- White 81%
- Black 6.4%
- Asian 5.1%
- Native American/Alaska Native .5%
- Native Hawaiian/Pacific Islander .2%
- Other 3%
- Multiple races 3.9%

Ethnicity

- Non-Hispanic 88%
- Hispanic 12%

Associate's Degree or Higher

- Parker Service Area 52.6%
- State Average 44.7%

High School Graduation Rate

- Parker Service Area 74.5%
- State Average 77.6%

Limited English Proficiency

- Parker Service Area 5.4%
- State Average 6.7%

Unemployment Rate

- Parker Service Area 3.6%
- State Average 4.0%

Households Below 200% of Federal Poverty Level

- Parker Service Area 17.2%
- 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 and individuals who represented 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. The subcommittee met 4 times for 2 hours at each meeting from April to December 2015.

Parker Adventist Hospital’s Partnerships with Public Health

The Tri-County Health Department, which represents Douglas, Arapahoe and Adams Counties, worked closely with Parker Adventist and all of the South Denver hospitals. The main contacts for this effort were, and continue to be, Bernadette Albanese, M.D., M.P.H., Medical Epidemiologist, and Patty Boyd, RD, MPH, Strategic Partnerships Manager, at Tri-County Health Department. These representatives provided two rounds of public health data about the population in Parker Hospital’s market area. The Public Health representatives attended every meeting and provided input into the process of narrowing the selection of health issues.
Stage 1: Scanning the Data Landscape

The CHNA was conducted through a collaborative partnership between Parker Adventist Hospital, the Tri County 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. Parker Adventist Hospital’s main service area encompasses Arapahoe and Douglas Counties, which was the data used for this process.

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 selecting quantitative indicators for analysis. Community Commons, a website and data platform that houses population health indicator data, was utilized throughout the process.

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 its demographics, disparities, population, 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 1. Health Indicator Data: The health needs in the table below were analyzed during the prioritization process. See Appendix B for the full dataset.

<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>13.9%</td>
<td>12.9%</td>
<td>N/A</td>
</tr>
<tr>
<td>Breast Cancer</td>
<td>Cases per 100,000 females per year, age adjusted</td>
<td>132.3</td>
<td>125.3</td>
<td>N/A</td>
</tr>
<tr>
<td>Cervical Cancer</td>
<td>Cases per 100,000 females per year, age adjusted</td>
<td>5.1</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>37</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>113.4</td>
<td>137.4</td>
<td>N/A</td>
</tr>
<tr>
<td>Homicide</td>
<td>Rate per 100,000 population</td>
<td>2.8</td>
<td>3.7</td>
<td>5.5</td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>Chlamydia rate per 100,000 population</td>
<td>431.2</td>
<td>422.8</td>
<td>N/A</td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>HIV Rate per 100,000 population</td>
<td>164.7</td>
<td>265</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>40.4</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</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</td>
<td>24.8</td>
<td>36.5</td>
<td>N/A</td>
</tr>
<tr>
<td>Maternal, Infant, and Child Health</td>
<td>Percentage of low birth weight births</td>
<td>9.4%</td>
<td>8.8%</td>
<td>7.80%</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Percentage of adults who lack social or emotional support</td>
<td>16.5%</td>
<td>16.9%</td>
<td>N/A</td>
</tr>
<tr>
<td>Obesity/Overweight, Physical Activity and Nutrition</td>
<td>Percentage of adults 18 and older who self-report a Body Mass Index (BMI) greater than 30.0</td>
<td>19.5%</td>
<td>20.2%</td>
<td>N/A</td>
</tr>
<tr>
<td>Oral Health</td>
<td>Percentage of adults who did not receive a dental exam in the past year</td>
<td>24.0%</td>
<td>31.1%</td>
<td>N/A</td>
</tr>
<tr>
<td>Oral Health</td>
<td>Percentage of adults with poor dental health</td>
<td>7.4%</td>
<td>10.0%</td>
<td>N/A</td>
</tr>
<tr>
<td>Prostate Cancer</td>
<td>Cases per 100,000 males per year, age adjusted</td>
<td>144.5</td>
<td>147.6</td>
<td>N/A</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>Adults reporting heavy alcohol consumption</td>
<td>15.7%</td>
<td>17.6%</td>
<td>N/A</td>
</tr>
<tr>
<td>Suicide</td>
<td>Rate per 100,000 population</td>
<td>15.2</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>35.6</td>
<td>45.1</td>
<td>36</td>
</tr>
</tbody>
</table>
Stage 2: Delving into the Data to Identify Priorities

Our Parker Adventist Hospital CHNA Subcommittee received a health indicator data presentation compiled by the CHNA Steering Committee. The subcommittee identified and prioritized community health needs using the Centura Health prioritization method as detailed below. They identified the most pressing needs in the Arapahoe and Douglas County communities based on health indicators, health drivers, and health outcomes.

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.

Process to Identify Priority and Non-Priority Health Needs

The Centura Health prioritization method was adapted from the Hanlon Method for Prioritizing Health Problems. First, members of the hospital subcommittee individually rated each identified need against the size of the problem, the seriousness of the problem, and how much the need aligned with Centura Health and the community’s existing efforts. The criteria rating rubric for this step is shown below, along with the scores assigned to each need:

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%-9.9%/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%-09%/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
- Seriousness of Health Problem
- Alignment with CHNA, CHIP, community groups, hospital and system strengths
- 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?
Based on the criteria rankings assigned to each health need above, we calculated priority scores using the formula:
\[ D = C[A + (2B)] \], where:

- **D** = Priority Score
- **A** = Size of health need ranking
- **B** = Seriousness of health need ranking
- **C** = Alignment ranking

After calculating priority scores for each identified health need, we gave the need with the highest score a rank of 1, with the next highest score receiving a rank of 2, and so forth. This helped us identify the health needs in our community.

Once our community’s health needs were rated by the criteria above, we used the ‘PEARL’ test to determine the feasibility of addressing those needs. The questions we considered in the PEARL test included:

- **Propriety** - Is a program for the health problem suitable?
- **Economics** - Does it make economic sense to address the problem? Are there economic consequences if the problem is not carried out?
- **Acceptability** - Will a community accept the program? Is it wanted?
- **Resources** - Is funding available or potentially available for a program?
- **Legality** - Do current laws allow program activities to be implemented?

In addition to the PEARL test questions, we also considered Centura Health’s Mission and Values when considering health needs to prioritize and address. The final question we considered was whether our activities and strategies to address the health need align with 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.

Parker Adventist Hospital identified four needs as priority areas for which we have the ability to impact. These include:

- Mental Health/Suicide
- Healthy Eating Active Living/Obesity
- Access to Care
- Equestrian Safety

Additional data provided by the Tri-County Public Health Department was also reviewed. Please see more information in Appendix C.

**Stage 3: Working with our Community to Understand and Act**

We sought to engage our community in the qualitative data collection process. Once health needs were prioritized, the hospital subcommittee worked together to determine groups and individuals appropriate for focus groups, being sure to solicit input from underserved or minority groups within the communities we serve. We made sure to solicit input from those who know experiences of the underserved, minority, and aging populations best through personal experience or close work with them. After much discussion, the subcommittee decided to collect information from two food banks that serve homeless individuals, low income residents, and the underserved.
Next, the group identified questions to ask the focus group to gain a better understanding of mental health/suicide, healthy eating active living/obesity, and access to care. Specifically, we wanted to identify focus areas, gaps in knowledge, needs not met, or current external efforts around mental health, suicide, and healthy eating active living that could be improved by health care participation.

Castle Rock, Littleton, Parker, and Porter conducted focus groups together and shared their results. The focus groups were with a ministerial alliance group, two food banks, and one independent living facility. Each focus group lasted one hour. Highlights of the focus groups are as follows.

Ministerial Alliance: When asked about the most significant health issue in their community, the pastors identified teen suicide, followed by mental health issues in the general population, such as depression, anxiety and ADHD. The most common causes of depression and suicide were believed to be isolation, lack of foundation in Jesus Christ, and a breakdown in the family structure. The group believed that events that are designed to promote an integrated community experience would be effective in preventing and reducing mental health problems.

Food Banks: The first food bank identified “mental health” as the biggest health concern, with stress related to financial issues as the biggest contributor to depression. The inability to pay for health services due to their high cost was the biggest concern for the second focus group. When discussing obesity, participants in both focus groups agreed that the people who struggle the most with weight are the poor, elderly and minorities. There is a gap in linking obesity management with mental health concerns.

Senior Living: The residents stated that poor treatment by doctors was a significant issue. They felt that hospitals wanted to “treat and street” because they are quick to discharge, quick to medicate, hold short visits, and have rushed interactions with patients. At Parker Adventist Hospital, we understand the time restraints on healthcare providers in seeing patients. We offer support to our healthcare providers in the form of training of staff members, offering resources and offering community and Centura resources that providers can provide to their patients. When asked about mental health issues, many participants agreed that depression and anxiety about failing health are common among seniors. Regarding obesity, the focus group agreed that healthy food is expensive at grocery stores, where most of them shop for food.

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 mental health/suicide, healthy eating active living/obesity, and access to care. The first step was to present evidence-based practices focused on mental health, healthy eating active living/obesity, and access to care to our hospital subcommittees. Next, we completed an environmental scan to identify those established efforts (in Parker Adventist 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.

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, suicide, 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 that are 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 (CHAPS) Action Plan, provided by Colorado Department of Public Health and Environment. CHAPS is a standardized process used by local public health departments to meet the community health needs assessment and planning requirements. For each health priority we created specific, measurable, achievable, realistic, and time bound (SMART) goals, strategies, and metrics.

The hospital leads from the South Denver group of hospitals, which included Porter Adventist Hospital, Parker Adventist Hospital, Littleton Adventist Hospital, and Castle Rock Adventist Hospital, met as a group in this meeting and several times after this meeting. As a regional group, they decided to pursue several community health initiatives together for the following reasons: 1) all four subcommittees had prioritized mental health and obesity as their primary health issues, 2) their service areas and communities overlapped and/or were in the same counties, 3) the hospitals were interested in collaborating with the same community partners, and 4) several representatives were serving on multiple subcommittees and expressed a desire to consolidate the meetings.

As a result, a regional meeting of all four hospital subcommittees was held on December 4, 2015 for 2.5 hours with the purpose of prioritizing health initiatives and programs under the mental health and Obesity/Healthy Eating Active Living categories. In this meeting, representatives of community programs provided brief overviews of their activities and answered questions, thus providing participants with a greater understanding of their programs. The participants were then asked to rate the programs using criteria, such as the program’s ability to impact upstream (root) causes, demonstration of evidence based strategy, and demonstrated sustainability. The results of this process were shared with the group and followed by a quick rating process that identified their top choices for collaboration with community organizations. Because the rating process allowed them to rate many programs highly, the results of this endeavor demonstrated that many mental health programs were rated as equally important, and many HEAL programs were within a similar range.

After this exercise, the group was informed that South Denver hospital leaders would evaluate the results via an additional vetting process that considered funding issues, seasonal limitations, potential resource utilization, and alliance with Centura’s mission and values. The leaders discussed these issues on 12/10/2015 and agreed that their regional focus would be on mental health and suicide prevention, and obesity/healthy eating active living (HEAL). In addition to these regional initiatives, Parker Hospital will continue to support equestrian safety within the local community. Following the meeting, Logic Models and Implementation Plans of each category were developed by members of the leadership team. The Implementation Plans included SMART goals, strategies, and metrics.

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. Therefore the most effective approach to impacting health outcomes is a combination of efforts at the individual, interpersonal, organizational, community, and public policy levels.1

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

Health in Parker Adventist Hospital’s Community

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. We utilized the Centura Health Prioritization Method to determine our prioritized needs.

The health needs identified in this CHNA included:

- Obesity
- Mental health/Suicide rates
- Access to Care
- Head Injuries (Equestrian)

Prioritized Health Needs

Parker Adventist Hospital prioritized mental health/suicide, healthy eating active living/obesity, and access to care, and prevention of head injuries due to equestrian activities.

The health need Mental Health/Suicide was prioritized because Douglas and Arapahoe Counties had higher suicide rates than Denver County (the neighboring county) in 2013. Roughly 48.2% of teens in Douglas County and 45.0% of teens in Arapahoe County experienced sadness with suicidal ideation in the past 12 months, greater than the 35.9% rate in Denver County. Teens experiencing sadness were more likely to smoke cigarettes, binge drink, use marijuana, and be recently sexually active. Alarming, 16% of Arapahoe County adolescents considered suicide in the past 12 months, the same rate as the state.

Altered Mental Status is one of the top ten admitting diagnoses by volume at Parker Adventist Hospital.

Data gathered from our focus group also pointed to suicide as a high need in our community. Ministers in a focus group identified teen suicide and mental health issues (depression, anxiety) in the general population as the predominant health issues in South Denver. They believe that isolation and a breakdown in family structure contribute to depression and suicide.

The health need Healthy Eating Active Living / Obesity was prioritized because 36.9% of adults in the community...
are overweight, compared to 35.3 in the state. In the Parker community, 75.8% of adults eat less than five fruits and vegetables per day, and 14.7% of adults have no leisure time physical activity. Obesity tracks with higher rates of diabetes, high cholesterol, and heart disease.

Data gathered from our focus groups in South Denver food banks corroborated that obesity is a problem, especially among vulnerable populations, such as those with low incomes, the elderly and minorities. The group identified obstacles to healthy eating such as the expense of fresh fruits and vegetables, the high cost of recreation centers, and the lack of affordable transportation to recreation centers.

An understanding of the non-clinical factors that influence health, including environmental quality and the built environment, is important to fully grasp the needs of the communities we serve. Environmental factors, including access to healthy foods and recreation facilities, impact behavior and health outcomes.

An analysis of the environmental indicators for Arapahoe and Douglas Counties revealed that our community has both opportunities and barriers to living a healthy and active lifestyle. There are 12 recreation and fitness facilities per 100,000 residents in our community, which is higher than the state average of Colorado (11.4). Additionally, only 3.46% of the low-income population in our service area experiences low food access and there are fewer liquor stores that can contribute to unhealthy behaviors.
However, there are fewer grocery stores, SNAP- and WIC-authorized food stores in our community. Access to these resources is vital for healthy eating in our neighborhoods. Coupled with the fact that there are more fast food restaurants in our community, we see that our communities experience barriers to healthy eating.

<table>
<thead>
<tr>
<th>Environmental Indicator</th>
<th>SNAP-Authorized Food Store Access</th>
<th>WIC-Authorized Food Store Access</th>
<th>Grocery Store Access</th>
<th>Fast Food Restaurant Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Area</td>
<td>45.6</td>
<td>6.2</td>
<td>13.4</td>
<td>77.1</td>
</tr>
<tr>
<td>Colorado</td>
<td>52.27</td>
<td>8.8</td>
<td>15.7</td>
<td>76.6</td>
</tr>
</tbody>
</table>

Moving forward into our implementation plans, Parker Adventist Hospital recognizes both the opportunities and barriers to achieve a healthy and active lifestyle in our community.

Access is also prioritized as a health need in Parker Adventist Hospital’s service area because 19.5% of adults do not have a regular doctor. Additionally, 24% had no dental exam in the past year, and 7.35% have poor dental health. In terms of insurance enrollment, which we know impacts access to care, 16.8% of adults and 8.2% of children were uninsured in 2012.

Prevention of head injuries due to equestrian activities was also identified as a health issue. The Parker community has a large number of horses and equestrian-related activities. Equestrian-related injuries are among the top five injuries most commonly treated at Parker Adventist Hospital’s emergency department. Head injuries from falls cause permanent brain damage, and currently account for 60% of all deaths due to equestrian accidents. This is an issue that is unique to our community, and high on our priority list.

In summary, Parker Adventist Hospital’s vision is to expand services and care to mental health patients, increase access to health care services, reduce obesity rates, and reduce equestrian-related injuries in its community. This involves moving outside of the hospital and clinics and into the lives of all those in its community in order to educate and prevent.

Several groups are available to address mental health in the community including the Tri County Health Department, Crisis Prevention Institute, and instructors from the Arapahoe Douglas Mental Health Network.

Several groups are available to address Obesity / Healthy Eating Active Living (HEAL) in the community including Tri County Health Department, Centura Health Physician Group, Parker Hospital Bariatric Program, and Café Well.

Access to care is addressed in the community through Doctors Care, Adventist Community Services, and Centura Health Physician Group.

There are also several hospital activities and initiatives available that address mental health/suicide, healthy eating active living/obesity, and access to care.

Mental Health training programs are offered to both associates and community members in order to raise the competency levels of people who deal with mental health issues. These programs include:

- Mental Health First Aid and Youth Mental Health First Aid (Y/MHFA): In-person training that teaches how to help people developing a mental illness or in a crisis
- Crisis Prevention Institute training: Teaches the safe management of disruptive and assaultive behavior.
- Applied Suicide Intervention Skills Training (ASIST), and Assessing and Managing Suicide Risk (AMSR): Evidence based suicide screening education and training. (Focus groups participants emphasized that reducing suicide was a top concern in their communities.)
• Screening Brief Intervention and Referral to Treatment (SBIRT): Substance use screening and referral services

Obesity / Healthy Eating Active Living (HEAL) programs are designed to reduce obesity levels and promote healthy lifestyles among associates and the community. Programs at the hospital include:

• Pathways to Health and Wellness (PHW): Teaches lifestyle modifications that result in weight loss and improved biometrics.

• Weigh and Win: Kiosk program that provides an interactive experience and cash prizes for weight loss.

• CafeWell, CREATION Health: Interactive web-based program for health improvements and weight loss.

Access to care programs are designed to increase enrollment in insurance programs and connection to primary care homes. These programs enable low income residents to obtain health services, which was one of the top concerns of people in the Food Bank focus groups. Programs at the hospital include:

• Centura Community Health Advocates and Eligibility Specialists: Assist with insurance enrollment

• Centura Health Physician Group: Connects patients to primary care homes.

Access to Care

In addition to the above prioritized health needs, Centura Health and Parker Adventist 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, Parker Adventist

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**Figure 1. The Determinants of Health**

<table>
<thead>
<tr>
<th>Health Outcomes</th>
<th>Length of Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of Life</td>
<td></td>
</tr>
<tr>
<td>Social and Economic Factors (40%)</td>
<td></td>
</tr>
<tr>
<td>Health Behaviors (30%)</td>
<td></td>
</tr>
<tr>
<td>Clinical Care (20%)</td>
<td></td>
</tr>
<tr>
<td>Health Factors (Percentage of importance in determining outcomes)</td>
<td></td>
</tr>
<tr>
<td>Physical Environment (10%)</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment</td>
</tr>
<tr>
<td>Income</td>
</tr>
<tr>
<td>Family, Social Support</td>
</tr>
<tr>
<td>Community Safety</td>
</tr>
<tr>
<td>Tobacco Use</td>
</tr>
<tr>
<td>Diet and Exercise</td>
</tr>
<tr>
<td>Alcohol and Drug Use</td>
</tr>
<tr>
<td>Sexual Activity</td>
</tr>
<tr>
<td>Access to Care</td>
</tr>
<tr>
<td>Quality of Care</td>
</tr>
<tr>
<td>Air and Water Quality</td>
</tr>
<tr>
<td>Housing and Transit</td>
</tr>
</tbody>
</table>

Source: Robert Wood Johnson Foundation
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.

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) 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 CHAs to guide them through the insurance enrollment process and navigation to the appropriate source of care. Once they have received the coverage they need, our Advocates refer the patients to providers so they may begin to receive high quality and consistent medical care.

Parker Adventist Hospital's service area shows a 16.8% uninsured rate for residents between the age of 18-64 and 8.2% uninsured for children under the age of 19. There are 78.1 primary care physicians per 100,000 and 19.5% of adults report they do not have a regular doctor.

Access to Mental Health Services

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 Parker Adventist Hospital, we are currently working with the Center for Behavioral Health at Porter Adventist Hospital, Tri County Health Department,
Arapahoe Douglas Mental Health Network, and Doctors Care to provide mental health services to our patients and our communities.

Community Health Advocates and Eligibility Specialists at Parker Hospital enroll uninsured in Medicaid, Connect for Health Colorado and other insurance programs to enable patients to access mental health services. Doctors Care also enrolls its clients in insurance programs that cover mental health services.

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 counties have also chosen to apply all of their existing smoking laws to the use of electronic cigarettes.

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 across the state. There are a few farmers’ markets in Arapahoe and Douglas counties that accept SNAP benefits, however none accept WIC benefits.

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

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’s report 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, 20147.

Access to Care for Undocumented Individuals

Due to current laws and regulations, it is difficult for undocumented individuals to get health insurance8. 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 individual9. 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 helmets10. 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 others12. 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 public13. 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 counties14. 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-health15. 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\(^\text{16}\). 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\(^\text{17}\).

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. Durango received a gold rating from the League of American Bicyclists in 2015.
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

In 2012 Parker Adventist Hospital prioritized access to care and insurance enrollment, wellness and obesity, community engagement/activation, behavioral health, and equestrian safety.

Parker continued to train and support Community Health Advocates, who enrolled 14 patients in insurance plans in 2016. We continue to support Doctor’s Care to help vulnerable families received the medical attention they need.

Parker promoted the CREATION Health CafeWell program that allowed users to track online their own health goals, including weight loss and exercise levels. Health indicators are continually monitored by the Centura Health Physician Group.

Parker provided free and low cost screenings at the annual 9Health Fair and offered more than two dozen free community health seminars throughout the year.

We also partnered with Doctor’s Care to provide on-site counseling and medication management to low income families. Centura Health Physician Group increased the frequency of mental health screenings in its primary care practices, and we provided support to the Parker Task Force/Food Bank, as it serves many people with mental health issues.

We continue to provide customized, free and low cost equestrian helmets to the community. Since the program began in 2009, we have provided more than 1,800 helmets to help reduce head injuries.

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. Parker Adventist Hospital will also track progress through annual community health improvement plans and community benefit reports.

Community Health Improvement Plans

The CHNA allows Parker Adventist 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.

For comments or questions, please contact: Rachel Robinson, Director of Community and Public Relations 303-269-4729 – rachelrobinson@centura.org

No written feedback from the community was received on our last Community Health Needs Assessment.

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.

- Mayor of Town of Parker, Mike Waid
- Doctor’s Care, Barb Hanson, Development Director
- Tri-County Health Department, Patty Boyd (Strategic Partnerships Manager) / Bernadette Albanese, MD
- Parker Police – Jim Prior & Jen Rogers-Flynn
- Parker Chamber of Commerce - Dennis Houston, Executive Director
- The Crisis Center - Jennifer Walker, Executive Director
- Colorado Wellness Connection / 9Health Fair, Bonnie Thomas, President
- New Day Seventh Day Adventist Church , Pastor Lisa Engelkemier,
- South Metro Health Alliance, Traci Jones, & Val Purser
- John Christie, Licensed Professional Counselor
- Parker Pediatrics, Dr. Amy Gensler, Pediatrician
- NAMI – National Alliance on Mental Illness, Alison Sandler
- Maureen Gottino, Regional Coordinator - Colorado Crisis Services
- Doug Muir, Dir. Behavioral Health, Porter Hospital & South Denver Group
- Jennifer Hoffman, Parker Hospital, registered dietitian
- Heather Easter, Parker Hospital, bariatric counselor
- Rachel Robinson, Director of Community & Public Relations,
- Mike Hansen, Director of Mission & Ministry
- Eileen Aire, Associate Director Center for Health Administration, University of Colorado Denver
Appendix A: Data Sources

American Community Survey, 2008-12
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
Appendix B: First Round of Data

**Service Area Definition**

- Stark versus County
- The Stark Law-defined service area is defined as the lowest number of contiguous zip codes that accounts for 75% of a hospital's inpatient admissions
  - Demographic data was gathered for Stark service areas
- County level data used for health drivers, outcome, and access data
  - Keep it consistent when we prioritize. Outcome data not available at zip code level

**Centura Health Data Approach**

**Demographics:** Community & Population

**Health Drivers:** Behaviors & Environment

**Health Outcomes:** Morbidity & Mortality

**Access:** Coverage & Quality Care

Parker Adventist Hospital

Centura Health
Data Sources

- American Community Survey
- Behavioral Risk Factor Surveillance System
- National Center for Education Statistics
- National Vital Statistics System
- State Cancer Profiles
- Bureau of Labor Statistics

Parker Adventist Hospital

DEMOGRAPHICS: COMMUNITY & POPULATION

Centura’s Communities

Parker Adventist Community

Parker Adventist Stark Service Area

Service Area Population: 478,802

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Population in Age Range</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 0-4</td>
<td>34,006</td>
<td>7.2%</td>
</tr>
<tr>
<td>Age 5-17</td>
<td>98,915</td>
<td>20.7%</td>
</tr>
<tr>
<td>Age 18-24</td>
<td>35,143</td>
<td>7.3%</td>
</tr>
<tr>
<td>Age 25-34</td>
<td>63,883</td>
<td>13.3%</td>
</tr>
<tr>
<td>Age 35-44</td>
<td>77,493</td>
<td>16.2%</td>
</tr>
<tr>
<td>Age 45-54</td>
<td>76,129</td>
<td>15.9%</td>
</tr>
<tr>
<td>Age 55-65</td>
<td>54,784</td>
<td>11.4%</td>
</tr>
<tr>
<td>Age 65+</td>
<td>38,453</td>
<td>8.0%</td>
</tr>
</tbody>
</table>

Source: American Community Survey, 2010-11
Appendix B: First Round of Data

### Race and Ethnicity

#### Hispanic Population

<table>
<thead>
<tr>
<th></th>
<th>Total Population</th>
<th>Non-Hispanic</th>
<th>Hispanic or Latino</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Area</td>
<td>478,802</td>
<td>88.02%</td>
<td>11.98%</td>
</tr>
<tr>
<td>Colorado</td>
<td>5,042,853</td>
<td>79.37%</td>
<td>20.63%</td>
</tr>
</tbody>
</table>

#### Population with Limited English Proficiency

<table>
<thead>
<tr>
<th></th>
<th>Service Area</th>
<th>Colorado</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5.4%</td>
<td>6.7%</td>
</tr>
</tbody>
</table>

#### Population with a Disability

<table>
<thead>
<tr>
<th></th>
<th>Service Area</th>
<th>Colorado</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7.3%</td>
<td>9.9%</td>
</tr>
</tbody>
</table>

#### Unemployment Rate

<table>
<thead>
<tr>
<th></th>
<th>Service Area</th>
<th>Colorado</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3.6%</td>
<td>4.0%</td>
</tr>
</tbody>
</table>

### Income

#### Children Eligible for Free/Reduced Price Lunch

<table>
<thead>
<tr>
<th></th>
<th>Service Area</th>
<th>Colorado</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>24.3%</td>
<td>41.6%</td>
</tr>
</tbody>
</table>

#### Population Living in Households With Income Below 200 Percent of the Federal Poverty Level

<table>
<thead>
<tr>
<th></th>
<th>Service Area</th>
<th>Colorado</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>17.2%</td>
<td>29.6%</td>
</tr>
</tbody>
</table>

Source: American Community Survey, 2008-12
Source: National Center for Education Statistics, 2012-13
Source: American Community Survey, 2008-11
Source: National Center for Education Statistics, 2012-13
Appendix B: First Round of Data
Appendix B: First Round of Data

### General Health

#### Poor General Health
- **Service Area:** 10.31%
- **Colorado:** 12.8%

Source: Behavioral Risk Factor Surveillance System, 2006-2013

### Obesity

#### Obesity Adults
- **Service Area:** 19.5%
- **Colorado:** 20.2%

#### Overweight Adults
- **Service Area:** 36.9%
- **Colorado:** 35.3%

Source: National Center for Chronic Disease Prevention and Health Promotion, 2012

### Health Outcomes

#### Asthma
- **Service Area:** 13.9%
- **Colorado:** 12.9%


#### Diabetes
- **Service Area:** 5.5%
- **Colorado:** 6.1%

Source: National Center for Chronic Disease Prevention and Health 2012

### Health Outcomes: Beginnings

#### Teen Birth Rate (Per 1,000)
- **Service Area:** 24.8
- **Colorado:** 35.6


#### Low Birth Weight Percentage of Births
- **Service Area:** 9.4%
- **Colorado:** 8.8%


#### Healthy People 2020
- **Service Area:** 7.8%

### Heart Health

#### Percentage of Adults With Heart Disease
- **Service Area:** 2.4%
- **Colorado:** 2.7%

#### Percentage of Adults With High Blood Pressure
- **Service Area:** 23.5%
- **Colorado:** 23.1%

#### Percentage of Adults With High Cholesterol
- **Service Area:** 33.5%
- **Colorado:** 33.5%

Source: Behavioral Risk Factor Surveillance System, 2011-12
Appendix B: First Round of Data

**Cancer Incidence by Type**

<table>
<thead>
<tr>
<th></th>
<th>Service Area</th>
<th>Colorado</th>
<th>Healthy People 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>132.3</td>
<td>125.3</td>
<td>40.9</td>
</tr>
<tr>
<td>Cervical</td>
<td>5.1</td>
<td>6.2</td>
<td>7.1</td>
</tr>
<tr>
<td>Colon and Rectal</td>
<td>37.0</td>
<td>35.9</td>
<td>38.7</td>
</tr>
<tr>
<td>Lung</td>
<td>49.5</td>
<td>48.4</td>
<td>N/A</td>
</tr>
<tr>
<td>Prostate</td>
<td>144.5</td>
<td>147.6</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Source: State Cancer Profiles, 2007-2011

**Mortality**

<table>
<thead>
<tr>
<th></th>
<th>Service Area</th>
<th>Colorado</th>
<th>Healthy People 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>145.1</td>
<td>149.3</td>
<td>160.6</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>113.4</td>
<td>137.4</td>
<td>N/A</td>
</tr>
<tr>
<td>Ischemic Heart Disease</td>
<td>66.5</td>
<td>83.0</td>
<td>103.4</td>
</tr>
<tr>
<td>Stroke</td>
<td>33.8</td>
<td>36.5</td>
<td>33.8</td>
</tr>
<tr>
<td>Lung Disease</td>
<td>40.4</td>
<td>49.8</td>
<td>NA</td>
</tr>
<tr>
<td>Infant Mortality</td>
<td>6.0</td>
<td>5.5</td>
<td>6.0</td>
</tr>
<tr>
<td>Motor Vehicle</td>
<td>3.8</td>
<td>5.6</td>
<td>NA</td>
</tr>
<tr>
<td>Unintentional Injury</td>
<td>35.6</td>
<td>45.1</td>
<td>36.0</td>
</tr>
<tr>
<td>Homicide</td>
<td>2.84</td>
<td>3.7</td>
<td>5.5</td>
</tr>
<tr>
<td>Suicide</td>
<td>15.2</td>
<td>17.2</td>
<td>10.2</td>
</tr>
</tbody>
</table>


**Years of Potential Life Lost Due to Premature Death**

<table>
<thead>
<tr>
<th></th>
<th>Service Area</th>
<th>Colorado</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4,936</td>
<td>6,073</td>
</tr>
</tbody>
</table>

Source: County Health Rankings, 2008-2010

**Uninsured Adults Ages 18-64**

<table>
<thead>
<tr>
<th></th>
<th>Population</th>
<th>Population Without Medical Insurance</th>
<th>Percentage Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Area</td>
<td>316,568</td>
<td>53,323</td>
<td>16.84%</td>
</tr>
<tr>
<td>Colorado</td>
<td>3,256,899</td>
<td>635,874</td>
<td>19.5%</td>
</tr>
</tbody>
</table>

Source: Small Area Health Insurance Estimates, 2012
**ACCESS: COVERAGE**

### Uninsured Children Under Age 19

<table>
<thead>
<tr>
<th>Population</th>
<th>Population Without Medical Insurance</th>
<th>Percentage Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Area</strong></td>
<td>141,207</td>
<td>11,571</td>
</tr>
<tr>
<td><strong>Colorado</strong></td>
<td>1,276,087</td>
<td>121,166</td>
</tr>
</tbody>
</table>

Source: Small Area Health Insurance Estimates, 2012

**ACCESS: MENTAL HEALTH**

### Mental Health Hospitalizations (Per 100,000)

<table>
<thead>
<tr>
<th>County</th>
<th>Service Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arapahoe</td>
<td>2922</td>
</tr>
<tr>
<td>Douglas</td>
<td>2298</td>
</tr>
<tr>
<td>Colorado</td>
<td>2868</td>
</tr>
</tbody>
</table>

Source: Colorado Health and Hospital Association 2010-12

### Lack of Social or Emotional Support

<table>
<thead>
<tr>
<th>Service Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>16.5%</td>
</tr>
<tr>
<td>Colorado</td>
</tr>
<tr>
<td>16.9%</td>
</tr>
</tbody>
</table>


**ACCESS: QUALITY CARE**

### Mammogram

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Colorado</th>
</tr>
</thead>
<tbody>
<tr>
<td>65.8%</td>
<td>60.5%</td>
</tr>
</tbody>
</table>

Source: Dartmouth Atlas of Health Care, 2012

### Pap Test

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Colorado</th>
</tr>
</thead>
<tbody>
<tr>
<td>79.7%</td>
<td>75.5%</td>
</tr>
</tbody>
</table>

### Sigmoidoscopy or Colonoscopy

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Colorado</th>
</tr>
</thead>
<tbody>
<tr>
<td>66.2%</td>
<td>60.8%</td>
</tr>
</tbody>
</table>

**ACCESS: ORAL HEALTH**

### Adult Dental Care Utilization

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Colorado</th>
</tr>
</thead>
<tbody>
<tr>
<td>24.0%</td>
<td>31.1%</td>
</tr>
</tbody>
</table>


### Poor Dental Health

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Colorado</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.35%</td>
<td>10.0%</td>
</tr>
</tbody>
</table>


**ACCESS: QUALITY CARE**

### Adults Without a Regular Doctor

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Colorado</th>
</tr>
</thead>
<tbody>
<tr>
<td>19.5%</td>
<td>23.6%</td>
</tr>
</tbody>
</table>


### Access to Primary Care

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Number of Primary Care Physicians per 100,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>78.1</td>
<td></td>
</tr>
</tbody>
</table>

Source: Area Health Resource File, 2012

### Diabetes Management

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Colorado</th>
</tr>
</thead>
<tbody>
<tr>
<td>84.1%</td>
<td>83.4%</td>
</tr>
</tbody>
</table>

Source: Dartmouth Atlas of Health Care, 2011

### High Blood Pressure Management

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Colorado</th>
</tr>
</thead>
<tbody>
<tr>
<td>23.0</td>
<td>26.5%</td>
</tr>
</tbody>
</table>

Source: Behavioral Risk Factor Surveillance System, 2006-2010

Appendix B: First Round of Data
### Pneumonia Vaccination
Percentage of adults 65 and over who have received

**Service Area:** 78.5%
**Colorado:** 74.5%

Behavioral Risk Factor Surveillance System, 2006-2012
Source: Dartmouth Atlas of Health Care, 2012

### Preventable Hospital Events
Discharge rate per 1,000 Medicare enrollees for ambulatory-sensitive events

**Service Area:** 36.0
**Colorado:** 38.2

### Centura Health Data Approach

- **Demographics**
  - Community
  - Population

- **Health Drivers**
  - Behaviors
  - Environment

- **Health Outcomes**
  - Morbidity
  - Mortality

- **Access**
- **Coverage**
- **Quality Care**
Appendix C: Data From Local Public Health Departments

Obesity and Mental Health: Indicators Telling a Story

August 10, 2015

Weight, diet, physical activity

- Body mass index (BMI) is a widely used measure of unhealthy (over)weight, as defined by:
  - For adults, a BMI of 25 to 29 (overweight) or 30 or greater (obesity)
  - For children and adolescents, a BMI at or above the 85th to 94th BMI-for-age percentile (overweight) and above the 95th BMI-for-age percentile (obesity)

Hospital Service Area: Demographic Description Handout

Adult Overweight & Obesity is Common

Source: CDC/NCHS, Behavioral Risk Factor Surveillance System (BRFSS) 2013-2014 combined
Appendix C: Data From Local Public Health Departments
Appendix C: Data From Local Public Health Departments

### Slight Regional Variation in Obesity-Related Outcomes

<table>
<thead>
<tr>
<th>County</th>
<th>Told you have diabetes</th>
<th>Told you have hypertension</th>
<th>Told you have high cholesterol</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annapolis</td>
<td>5.2%</td>
<td>24.9%</td>
<td>32.6%</td>
</tr>
<tr>
<td>Denver</td>
<td>7.3%</td>
<td>24.7%</td>
<td>33.9%</td>
</tr>
<tr>
<td>Jefferson</td>
<td>4.5%</td>
<td>25.3%</td>
<td>34.5%</td>
</tr>
<tr>
<td><strong>COLORADO</strong></td>
<td><strong>6.3%</strong></td>
<td><strong>26.3%</strong></td>
<td><strong>34.8%</strong></td>
</tr>
</tbody>
</table>


### Lifestyle Behaviors Track With Weight

<table>
<thead>
<tr>
<th></th>
<th>Normal/ Underweight</th>
<th>Overweight</th>
<th>Obese</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consuming fruit less than once per day</td>
<td>32%</td>
<td>37%</td>
<td>39%</td>
</tr>
<tr>
<td>Consuming vegetables less than once per day</td>
<td>17%</td>
<td>19%</td>
<td>23%</td>
</tr>
<tr>
<td>At least 5 fruit/vegetable servings per week</td>
<td>59%</td>
<td>71%*</td>
<td>72%*</td>
</tr>
<tr>
<td>Drink more than one SSB per day</td>
<td>31%</td>
<td>32%</td>
<td>36%</td>
</tr>
<tr>
<td>Exercise past 30 days</td>
<td>89%</td>
<td>87%</td>
<td>77%*</td>
</tr>
<tr>
<td>Exercise &gt;2 hours per week</td>
<td>67%</td>
<td>59%*</td>
<td>54%</td>
</tr>
</tbody>
</table>

* Statistical difference versus normal weight


### Environment Can Impact Health Behavior - Adults

- Not easy to purchase healthy foods in neighborhood: 11%
- Worry about affording nutritious meals: 23%
- Do not have sidewalks or shoulders to safely walk, run, or bike: 9%


### Environment Can Impact Health Behavior - Children <14 years

- Drink more than one SSB per day: 18%
- Eat fast food more than one time per week: 66%
- Do not walk bike, or skateboard to school more than one day per week: 69%
- Households with children who could not afford food they needed in past year: 9.4%


### Obesity Risk - Take Home Points

- **Obesity is common**
- **Racial & demographic disparities**
  - Black, Hispanic, low income, less educational attainment populations are disproportionately affected
- **Lifestyle behaviors track with obesity**
  - Nutritional and physical activity choices are less than optimal in overweight and obese adults
  - Behaviors are established during childhood

### Mental Health & Substance Abuse

- Mental health is a leading cause of disability and has substantial co-morbidity with substance abuse and physical health
- Mental health impacts the entire lifespan

Sources: Healthy People 2020; National Institute of Mental Health; National Institutes of Drug Abuse.
Appendix C: Data From Local Public Health Departments
Appendix C: Data From Local Public Health Departments

Disparities Among High School Girls, Colorado

Mental Health Across the Lifespan: Children

Mental Health Care Access for Children, 4-14 years of age

Suicide-Related Hospitalizations by County

Suicide Rates by County

Gender Disparities: Suicide Vs Suicide-Related Hospitalizations*
Gender Disparities in Suicide Deaths

- Higher suicide-related hospitalizations in females, but higher suicide death rates in males
- Method of suicide
  - Males – firearms
  - Females - drugs, hanging

Mental Health Care: Costs, Insurance, Stigma

<table>
<thead>
<tr>
<th>Why did you not receive needed mental health care?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Concerned about the cost of treatment</td>
<td>75%</td>
</tr>
<tr>
<td>Did not think health insurance would cover</td>
<td>35%</td>
</tr>
<tr>
<td>Not comfortable talking with a health professional about personal problems</td>
<td>31%</td>
</tr>
<tr>
<td>Hard time getting an appointment</td>
<td>30%</td>
</tr>
<tr>
<td>Concerned about what would happen if someone found out you had a problem</td>
<td>20%</td>
</tr>
</tbody>
</table>

Source: CO Health Institute. 2015 CO Health Access Survey, Statewide

Mental Health Risk - Take Home Points

- Depression & anxiety are common
- Disparities related to socioeconomic factors
- Such as sleep disturbance, smoking, alcohol use
- Teen depression associated with suicidal ideation
- Perceived concerns about cost and insurance coverage
- Stigma is evident

Questions

Comments

Other Data Requests