2016
Community Health Needs Assessment
Penrose-St. Francis Health Services
Partners

Peak Vista Community Health Center, El Paso County Health Department (EPCHD), Pikes Peak Hospice and Palliative Care, Silver Key, Community Partnership for Child Development (CPCD), Colorado Springs Health Partners (CSHP), Holy Apostles Catholic Church, Woodmen Valley Chapel A.C.T.S., Community Health Partners, Live Well Colorado, Kaiser Permanente, Catholic Charities, Osteopathic Foundation
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 Penrose-St. Francis Health Services (PSF) 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 Centers for Disease Control (CDC), the National Vital Statistics System, and the American Community Survey, among others. Specific health indicator data was 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:
PSF 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: Obesity**

Childhood Obesity

EPCHD data shows a trend of increasing obesity rates for all ages, but especially among our youth. The decision was made to narrow the focus of this health priority in two ways. First, was to focus on children and youth to include a targeted approach to families whenever possible. It was also determined that we needed to narrow the priority further to focus on specific disparately affected communities. The 80910 and 80916 zip codes have been identified as areas with 50% of the population at or below 200% FPL. El Paso County’s low income population with low food access is 9.25% compared with Colorado’s 6.4%. Recreation and fitness facility access of 9 per 100,000 population is also lower than the Colorado average of 10.8. Both of these factors assisted in determining strategy.

Three evidence-based strategies were then promoted for development into an implementation plan from the HEAL process:

- Increase access to physical activity, prioritizing disparately affected communities.
- Reduce food insecurity and hunger, prioritizing 80910 and 80916 zip codes.
- Promote breastfeeding, prioritizing identified zip codes of need specific to St. Francis Medical Center.

**Prioritized Need: Intentional Injury**

Youth Suicide

Intentional Injury is described as deliberate infliction of harm or death to self or to another person. Suicides by youth in El Paso County accounted for 13% of all youth suicides in Colorado resulting in El Paso County having the highest suicide rate for youth in the state. (Colorado Child Fatality Prevention System Annual Report 2008-2012).

As a hospital system, PSF responds to the community needs, but is also cognizant of providing the best service for our hospitalized patients. The CHNA steering committee acknowledged that suicide is a health issue to be addressed as a hospital system. Narrowing the focus to youth brings leadership to our trusted collaborative partnerships for addressing youth suicide as a priority health issue. It was also noted that the strategies would have a collateral effect for all age groups.

Strategies were developed to address both hospital and community concerns utilizing evidence based practices.

- Determine utilization of evidence-based mental health screening tools in the PSF system and community to promote systematic screening approach based on data collected.
- Promote PSF and community training and education including adult and youth Mental Health First Aid (MHFA), and Adverse Childhood Experiences (ACE).
- Promote and encourage a community campaign to reduce the stigma of behavioral health conditions that include youth suicide.
- Identify and develop systematic referral methodology for “safe social discharge” of all youth positively screened as high risk for suicide.
Prioritized Need: Access to Care

In addition to the above prioritized health needs, Centura Health and Penrose-St. Francis Health Services 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.

Implementation Planning Process:

The first step to developing our implementation plans was to present evidence-based practices focused on addressing childhood obesity, youth suicide, and access to care to our hospital subcommittees. Next, we completed an environmental scan to determine which established efforts in Penrose-St. Francis Health Services 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 childhood obesity, youth suicide, and access to care. The first step was to present evidence-based practices focused on addressing obesity and intentional injury to our hospital subcommittee. Next, we completed an environmental scan to identify those established efforts (within PSF 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. Based upon the data and evidenced-based practices, the PSF community steering committee narrowed the focus of the prioritized issues. The narrowed focus and strategies were proposed by the steering committee:

• Obesity: Focus on children in disparate populations
• Intentional Injury: Focus on youth suicide

At this point, the community steering committee matched potential organizations with potential partners aligned around identified strategies. The group determined their ability to lead in the areas of training, screening and education for the suicide prevention initiative. The plan would be to start with hospital associates and then offering to the community targeting the zip codes of 80910 and 80916 in SE Colorado Springs. This area is already targeted with a national grant due to the high poverty and low access to health and community services.

Implementation Plan Review and Approval:

The final implementation plans were presented to and approved by the Penrose-St. Francis Board on Wednesday, March 2, 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, Penrose-St. Francis Health Services 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 Penrose St. Francis’ 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 Penrose-St. Francis (PSF) Health Services 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. Penrose Hospital and St. Francis Medical Center are two hospitals, but together they are Penrose-St. Francis Health Services. The two hospitals are filing this CHNA report jointly. This approach continues to strengthen partnerships between PSF, our local public health department, community leaders, faith-based leaders, and stakeholders. Our goal is to build our organizational capacity in population health best practices and to better position PSF 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. We seek to promote and create social, physical, and and spiritual 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 Penrose-St. Francis and the El Paso County Health Department (EPCHD). 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, providing training for care teams and community providers, PSF is continuing to strengthen opportunities for good health and addressing the social 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 to 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.
After 60 railroad workers were injured in a train derailment near Leadville in the late 1880s, B.P. Anderson, MD, and four sisters of St. Francis of Perpetual Adoration began a door-to-door fundraising campaign to build a hospital in Colorado Springs. Since its inception, Penrose-St. Francis Health Services has been infused with vision and dedicated to clinical excellence, whole-person care and serving the unique needs of its communities.

Today, Penrose-St. Francis Health Services is a full-service, 522-bed acute care facility in Colorado Springs which includes Penrose Hospital and St. Francis Medical Center. Penrose-St. Francis has been named one of “America’s 50 Best Hospitals” for nine years in a row (2008 - 2016) by Healthgrades, plus we are southern Colorado’s only Magnet Recognized hospital. We are part of Centura Health, Colorado and western Kansas’ largest hospital and health care network delivering advanced care to more than half a million people each year, across 17 hospitals, two senior living communities, health neighborhoods, physician practices and clinics, home care and hospice services, and Flight For Life® Colorado.

We continue to combine social platforms and expand our services within the community. In 2015, we partnered with the YMCA of the Pikes Peak Region to open the Tri-Lakes Health Pavilion in Monument. Later that same year, we opened the Broadmoor Neighborhood Health Center. Both are providing a variety of tailored services for their respective communities. We intend to build several more Neighborhood Health Centers across the Pikes Peak region to conveniently bring health and wellness services directly to consumers in their neighborhoods.

**Distinctive Services**

While Penrose-St. Francis Health Services (PSF) offers a full complement of emergency, medical and surgical services, several programs and clinical specialties truly distinguish the system:

- The Penrose Cancer Center brings leading-edge, compassionate cancer care to the people of southern Colorado.

- Penrose-St. Francis’ acclaimed heart program consistently achieves outcomes that exceed national benchmarks.

- St. Francis Medical Center specializes in maternal-child health with a state-of-the-art birthing center, a Level IIIA neonatal intensive care unit and northern Colorado Springs’ only dedicated pediatric unit.

- Five-Star for Hip Fracture Treatment 2016

- Pulmonary Care Excellence Award 2015 and 2016

- American College of Surgeons trauma survey: no deficiencies

- National Accreditation Program for Breast Centers

- Stroke Gold Plus- Target: Stroke Elite Plus
Commitment to Our Community

At PSF 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 building vibrant and healthy neighborhoods PSF 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, PSF contributed $54,655,861 in total community benefit dollars which impacted more than 274,000 people. Some of the notable community services included:

- Six Neighborhood Nurse Centers provided 4,000 professional nursing visits to the poor and underserved in collaboration with community crisis centers.

- We donated 1,376 free immunizations to those in need in partnership with community organizations.

- The John Zay Guest House provided no cost overnight accommodations to 3,000 out of town patients and families.

- Working with school districts, PSF reached out to the youth in our community to educate them on nutrition, exercise, and safety.
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 527,449.

The demographic makeup of these communities is as follows:

Race and Ethnicity: Native American/Alaskan Native .77%; Asian 5.54%; Black 6.34%; Hispanic or Latino 15.07%; White 81.11%; Native Hawaiian/Pacific Islander .32%; Some other race 4.99%; Multiple Races 5.18%.

Education Level: The percentage of the population in the Pikes Peak region with an Associate degree or higher is 45.5%. This is comparable to the Colorado state average of 44.7%.

Unemployment Rate: The 5.1% unemployment rate in our area is higher than the state average of 4.0%.

Population with Limited English Proficiency: El Paso County has a lower level of residents with a limited English proficiency than the state average. Our service area is at 4.2% and the state average of 6.7%

High School Graduation Rate: 78.4% of adolescents are graduating from high school which is a slightly higher rate than the Colorado state average of 77.6%.

Population Living in Households with Income Below 200% of Federal Poverty level: 29% of our overall population is living at or below this poverty level, which is consistent with the state average of 29.5%. One of the zip-codes in our area has a poverty level of 50% and is targeted with community initiatives included in the PSF CHIP.
Population Demographics in Penrose-St. Francis Health Services's Area

Race

- White 81.11%
- Black 6.34%
- Asian 5.54%
- Native American/Alaska Native .77%
- Native Hawaiian/Pacific Islander .32%
- Other 4.99%
- Multiple races 5.18%

Ethnicity

- Non-Hispanic 84.93%
- Hispanic 15.07%

Associate's Degree or Higher

- PSF Service Area: 45.5%
- State Average: 44.7%

High School Graduation Rate

- PSF Service Area: 78.4%
- State Average: 77.6%

Limited English Proficiency

- PSF Service Area: 4.2%
- State Average: 6.7%

Unemployment Rate

- PSF Service Area: 5.1%
- State Average: 4.0%

Households Below 200% of Federal Poverty Level

- PSF Service Area: 29%
- 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. Members met four times for two hours over the course of this assessment.

Penrose-St. Francis Health Services’ Partnerships with Public Health

The partnership with El Paso County Health Department progressed from cooperation to collaboration during our year-long assessment process. Two EPCHD staff participated in the community steering committee providing public health expertise. An EPCHD epidemiologist provided the qualitative El Paso County health data analysis prior to prioritizing the health issues. In a subsequent meeting they provided data specifics for the identified priorities and “Factors Affecting Health Behaviors” on the social determinants of health. These presentations supplemented the previous data and were a prelude for the qualitative data collection.

Leadership changes at EPCHD improved our ability to move forward in aligning our three-year process with their five-year accreditation. This results in a vision that will reduce duplication of services as well as provide a collective and complimentary health implementation plan.
Stage 1: Scanning the Data Landscape

The CHNA was conducted through a collaborative partnership between Penrose-St. Francis Health Services, El Paso 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. The main service area for PSF encompasses El Paso County.

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 measured all determinants of health, we conducted a full legal and environmental scan to identify 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>12.2%</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>124</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>6.7</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>38</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>6.6%</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>137.1</td>
<td>137.4</td>
<td>N/A</td>
</tr>
<tr>
<td>Homicide</td>
<td>Rate per 100,000 population</td>
<td>4.8</td>
<td>3.7</td>
<td>5.5</td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>Chlamydia rate per 100,000 population</td>
<td>437.5</td>
<td>422.8</td>
<td>N/A</td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>HIV Rate per 100,000 population</td>
<td>146.9</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>50.3</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>7.5</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>34.2</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>9.6%</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>16.1%</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>21.2%</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>28.9%</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>9.6%</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>168.7</td>
<td>147.6</td>
<td>N/A</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>Adults reporting heavy alcohol consumption</td>
<td>13.5%</td>
<td>17.6%</td>
<td>N/A</td>
</tr>
<tr>
<td>Suicide</td>
<td>Rate per 100,000 population</td>
<td>18.4</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</td>
<td>45.1</td>
<td>36</td>
</tr>
</tbody>
</table>
Stage 2: Delving into the Data to Identify Priorities

Our PSF CHNA subcommittee received a health indicator data presentation compiled by the Centura 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 Pikes Peak area 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>
<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%-.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>

Table 2. Centura Health CHNA Prioritization Method: Sample Criteria Rating

Guiding Considerations

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?
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, as well as our Catholic Health Care Directives, 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.

The PSF community steering committee identified two needs as priority areas where we have the ability to make an impact:

These include:

1. Obesity
2. Intentional Injury

**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 the experiences of the underserved, minority, and aging populations best through personal experience or close work with them.

Next, the group identified questions to ask the focus group to gain a better understanding of obesity and intentional injury. Specifically, we wanted to identify focus areas, gaps in knowledge, needs not met, or current external efforts around [these needs] that could be improved by health care participation.
Community input has been a priority throughout this process, starting with the selection of a community based steering committee. Continuing this community focus, PSF engaged in a data collection process. Once health needs were prioritized, the steering committee identified groups and individuals appropriate for focus groups, soliciting participation from underserved or minority agencies and groups within the neighborhoods we serve. Four focus groups and two key informant interviews were conducted at our two hospitals and one congregation.

Next, the hospital identified a focus group leader and pertinent questions that would be asked to gain a better understanding of obesity and intentional injury. Specifically, we wanted to identify focus areas, gaps in knowledge, needs not met, or current external efforts around the two prioritized areas that could be improved by a collaborative approach with health care participation.

Thirty community members attended one of the four focus groups. The members included representatives from school districts, safety-net and community crisis sites, police, fire and military organizations as well as suicide and domestic violence prevention groups. Ten community members were not agency affiliated but represented targeted populations and faith groups. Each focus group meeting was ninety minutes long with the facilitator using the identified questions.

The discussions were open and honest with several priorities rising to the top within all groups. The community continues to look to PSF to lead and advocate for whole person care. One participant shared; “If they don’t find hope, they don’t use resources and they give up. The issues of obesity and intentional injury both need an approach that sees the person, not just the problem by itself.” Outreach programs need to be in the community at the grass roots level and interventions need to be doable and not “down the road somewhere.”

Another theme that wove through all the focus groups was how interventions in each area had collateral effect on other health issues. Depression screening, for instance, could have a related impact on the co-morbidities of obesity, heart disease, diabetes, as well as suicide prevention. Addressing active living could have an impact on depression and suicide as it offers people a better self-image.

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 obesity and intentional injury. The first step was to present evidence-based practices focused on addressing obesity and intentional injury to our hospital subcommittee. Next, we completed an environmental scan to identify those established efforts (within PSF 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, 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 resources and programs in their communities that are available, impactful, and gaining traction locally, regionally, and statewide that address mental health and/or healthy eating and active living. They also spoke to current gaps in programming that health care systems or hospitals can help 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 narrowed focus areas and the input from the Centura Health community health group process highlighted that hospital trust and leadership in the community was believed to be an area in which the hospital could make a difference in the community. Therefore, providing leadership, in collaboration with current organizations, for screenings, trainings and education in identified health issues through evidenced-based practices could provide the greatest impact.

At this point, the community steering committee matched potential organizations with potential partners aligned around identified strategies. The group determined their ability to lead in the areas of training, screening and education for the suicide prevention initiative. The plan would be to start with hospital associates and then offering to the community targeting the zip codes of 80910 and 80916 in SE Colorado Springs. This area is already targeted with a national grant due to the high poverty and low access to health and community services.

The SE area of the city will also be the target for the obesity reduction initiative using HEAL strategies, with the goal to increase and support evidence-based strategies for active living and primary prevention in disparate communities.

At the end of this meeting, the group was informed that the PSF’s internal committee and Centura representatives would evaluate the results via additional vetting process that considers funding issues, seasonal limitations and potential resource utilization in accordance with Centura’s mission and values.

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.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.


**Figure 2.**

The Socio-Ecological Model
Health in Penrose-St. Francis Health Services Community

Identified Health Needs

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 detailed 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. 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
- Intentional Injury

Prioritized Health Needs

Penrose–St. Francis Health Services prioritized the top two of the ten health indicators identified for El Paso County. Both of these identified needs, obesity and Intentional Injury, are packed with potential opportunities for collaborative impact to the community. The steering committee was then tasked with narrowing these two very big health issues to maximize partnering opportunities. The social-ecological model was presented by EPCHD and provided a foundational understanding of the factors that lead to changed behavior. No one organization can have the desired impact working on its own.

The subcommittee used data provided by EPCHD, focus groups, and their own extensive knowledge of community programs that would align with the priorities to narrow the focus for developing an effective implementation plan. This process included review of evidence based programs including the IOM reports on obesity and the Community Guide.

Percentage of adults who are overweight

<table>
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<th>Penrose-St. Francis Service Area</th>
<th>Colorado</th>
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</thead>
<tbody>
<tr>
<td>36%</td>
<td>36.9%</td>
<td>35.3%</td>
</tr>
</tbody>
</table>

24
**OBESITY: Childhood Obesity**

EPCHD data shows a trend of increasing obesity rates for all ages, but especially among our youth. The decision was made to narrow the focus of this health priority in two ways. First, was to focus on children and youth to include a targeted approach to families whenever possible. It was also determined that we needed to narrow the priority further to focus on specific disparately affected communities. The 80910 and 80916 zip codes have been identified as areas with 50% of the population at or below 200% federal poverty line. El Paso County's low income population with low food access is 9.25% compared with Colorado's 6.4%. Recreation and fitness facility access of 9 per 100,000 population is also lower than the Colorado average of 10.8. Both of these factors assisted in determining strategy. In our community, 21.2% of adults are obese, compared to 20.2% in the state. Additionally, 36.9% of adults are overweight, compared to 35.3% of adults in Colorado.

**INTENTIONAL INJURY: Youth Suicide**

Intentional Injury is described as deliberate infliction of harm or death to self or to another person. According to the CDC, suicide is the third leading cause of death in ages 10-14 and second leading cause of death in ages 15-24. Suicide has surpassed motor vehicle crashes as the leading cause of injury mortality. (Am J Public Health. 2012;102: e84-e92.doi 10.2105/AJPH.2012.300960)

Suicides by youth in El Paso County accounted for 13% of all youth suicides in Colorado resulting in El Paso County having the highest suicide rate for youth in the state. (Colorado Child Fatality Prevention System Annual Report 2008-2012). The suicide rate in our community is 18.4 per 100,000, higher than the state average of 17.2 per 100,000.

Strategies were developed to address both hospital and community concerns utilizing evidence based practices.

- Determine utilization of evidence-based mental health screening tools in the PSF system and community to promote systematic screening approach based on data collected.

- Promote PSF and community training and education including adult and youth MHFA (Mental Health First Aid), and ACE (Adverse Childhood Experiences).

- Promote and encourage a community campaign to reduce the stigma of behavioral health conditions that include youth suicide.

- Identify and develop systematic referral methodology for “safe social discharge” of all youth positively screened as high risk for suicide.
There are many resources available to address or promote the identified health needs in our community. The Pikes Peak region has a national reputation in collaborative work for improving the health of our community and PSF has been a lead partner in these endeavors. The Community Health Partnership (CHP) brings together top-level health care administrators to vision, develop and oversee collaborative work for the medically underserved. CHP programs include CATCH (Coordinated Access to Community Health); the safety-net system, Regional Care Collaborative Organization (RCCO) who provides regional Medicaid oversite. PSF is also a key partner with the Colorado Springs Fire Department (CSFD) CARES program, EPCHD Healthy Community Collaborative, the Interfaith Health Program and the more recent Build Health Challenge (ACCESS) grant. PSF leads partnership programs through the Neighborhood Nurse Centers, Catholic Heath Initiative’s (CHI) Violence Prevention program and the Healthy Church Initiative. Building on these and other trusted relationships offers complete confidence in the collaborative work that can be accomplished in the priority areas that this CHNA will address. Our working relationship with the El Paso County Health Department in the areas of Women and Children (WIC), Child Fatality Review Team (CFRT), Peaceful Households and Teen Suicide grant will bring a combined strength for both prioritized efforts. One member of a focus group was quick to point out the link between both of these initiatives. “If we are to address the strategies for obesity looking at a whole person, we will also be addressing the issues of intentional injury. At the core of both there is an understanding and listening to the person about what brought them to this point in their life.”

Access to Care

In addition to the above prioritized health needs, Centura Health and Penrose-St. Francis Health Services 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.

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, PSF 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) to work with uninsured individuals or those without a primary care doctor to enroll them into coverage and link them with providers. Our goals are to increase the number of patients in our communities who have a designated primary care medical home and to decrease the numbers who are uninsured. We identify uninsured patients in our Emergency Departments, our community-based partner organizations, our Neighborhood Nurse Centers and at local events to engage them with CHAs to guide them through the insurance enrollment process and navigation to the appropriate source of care. Once they have received the coverage they need, our advocates refer the patients to providers so they may begin to receive high-quality and consistent medical care.
Penrose–St. Francis has also supported Faith Community Nurses in six Neighborhood Nurse Centers. The centers are located at crisis intervention sites that also include two safety-net clinics and the SET Family Medicine Clinic that assist uninsured/underinsured with access to appropriate health care.

There are two Community Health Advocates in the Colorado Springs area, one based out of Penrose and one based out of St. Francis. They both focus on community outreach while working to get coverage for self-pay patients that are admitted into the hospital EDs. During Open Enrollment (November through February), South State was able to enroll 692 community members into either Medicaid or a commercial plan and assisted an additional 165 with questions on obtaining the proper care. Through partnering with the Neighborhood Nurse Centers, they have been able to form important relationships with the community to better work with our population, provide them with the quality care that they need, and keep patients from utilizing the ED when they can get medical help elsewhere.

In our community, 18.1% of adults were uninsured and 8.8% of children were uninsured. Our uninsured rates for adults were similar to Colorado rates (18.6%), and child rates were slightly better than Colorado (9%). Enrollment in insurance is a step toward care, also recognizing the importance of a medical home. We have 56.8 primary care physicians per 100,000 population (vs. 79.2 in Colorado), and 21.2% of adults do not have a regular doctor (vs. 23.6 in Colorado).

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 working with mental health partners and providers to better integrate mental health services into our hospitals, clinics, and neighborhood health centers.

At PSF we have introduced behavioral health services into our Centura Health Physicians Group (CHPG) neighborhood primary care practices along with inpatient and outpatient services provided for our patients. The Psychiatric Emergency Triage Team (PETT) is available 24/7 at both hospitals. Our Employee Assistance Program (EAP) program is available for all associates and also reaches into businesses and schools.
PSF is also working on relationships with the Crisis Stabilization Unit (CSU) lead by AspenPointe, the Crisis Response Team (CRT), which is part of the CSFD CARES Program, as well as several community collaborative groups. All are working to provide increased mental health services to our patients and our communities especially targeting those with the least ability to access traditional models of service.

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 several Farmers’ markets in El Paso County that accept SNAP payments; however there are none that accept WIC.

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. Of the ten largest occupations held by residents in El Paso County, only three have a median hourly wage that would place a one-parent family with a preschooler over the Self-Sufficiency standard.

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’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, 2014.

Access to Care for Undocumented Individuals

Due to current laws and regulations, it is difficult for undocumented individuals to get health insurance. 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. 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. Currently, it is legal for anyone over the age of 18 to use a phone while driving.

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.13 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.14 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.15 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.16 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.17 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.18

Also, Colorado has the seventh highest suicide rate in the nation.19 In the month before their deaths, a majority of people who have committed suicide were found to have visited a primary care physician.20 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. Colorado Springs received a silver ranking from the League of American Bicyclists in 2015 and possesses many laws and ordinances dedicated to bicyclist safety and convenience.

1 http://www.gasforair.org/gasp/ordinance/ordinance_index.php
2 https://www.ams.usda.gov/local-food-directories/farmersmarkets
12 http://www.denverpost.com/ci_12498806
13 C.R.S. 27-65-105
14 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
15 https://www.colorado.gov/pacific/sites/default/files/PCO_HPSA-mental-health-map.pdf
16 http://extras.denverpost.com/mentalillness/
Conclusion

Evaluation

Progress since our last CHNA

In our previous CHNA the priorities identified were wellness and obesity, access to care, behavioral health and strengthening networks to increase health partnership. While there were many successes in striving toward these goals, we also learned from the process. In our evaluation of the last CHNA PSF is moving forward in the following areas to increase our outcomes.

• More sophisticated data collection and analysis.
• Engaging with community agencies to improve regular and effective communication.
• Assessment of what didn’t work the way we anticipated in utilizing current community efforts along with an intentional goal to convene a group specific to the results of this assessment.
• Develop a more targeted and integrative approach with community partners and our internal group.

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. PSF will also track progress through annual community health improvement plans and community benefit reports.

Community Health Improvement Plans

The CHNA allows PSF 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

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. While the tracking of a specific activity will not show up in a category within the Community Benefits Report for FY16, the report does show that our serving the poor and underserved in our community exceeds the tax benefit identified. With that in mind, the benefits we provide to the community have and always will be a vital aspect of our non-profit and faith-based hospital status. As we continue into the CHNA implementation strategies, we will expand our utilization of these reports to track progress through our CHNA priorities.
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: lawrenceseidl@centura.org or cynthiawacker@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.

- Kandy Buckland, Peak Vista Community Health, Chief Nursing and Operations Officer
- Kelley Vivian, El Paso County Health Department, Development and Strategic Initiatives Officer
- Kate Watkins, El Paso County Health Department, Epidemiologist
- Mia Ramirez, Kaiser Permanente, Sr. Community Health Specialist
- Lynne Jones, Colorado Springs Health Partners, Director of Marketing
- Noreen Landis-Tyson, Community Partnership for Child Development, Executive Director
- Fr. Paul Wicker, Holy Apostles Catholic Church, Senior Pastor
- Dick Siever, Woodmen Valley Chapel; ACTS program, Executive Director
- Pat Ellis, Silver Key, Executive Director
- Martha Barton, Pikes Peak Hospice and Palliative Care, Executive Director
- Andy Barton, Catholic Charities, Executive Director
- Doris Ralston, Colorado Osteopathic Foundation, Executive Director
- Carol Bruce-Fritz, Community Health Partners, Executive Director
- Mina Liebert, Live Well Colorado, Executive Director
- Larry Seidl, Penrose -St. Francis Health Services, South State V.P. of Mission Integration
- Cynthia Wacker, Penrose -St. Francis Health Services, Community Outreach Coordinator
- Cynthia Latney, Penrose -St. Francis Health Services, Chief Nursing Officer
- Charlene Coffin, Penrose- St. Francis, Clinical Manager, Psychiatric Emergency Triage Team
- Leslie Schwender, Penrose -St. Francis, Community Benefits Coordinator
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

Centura Health Data Approach

**DEMOGRAPHICS:** COMMUNITY & POPULATION  
**HEALTH DRIVERS:** BEHAVIORS & ENVIRONMENT  
**HEALTH OUTCOMES:** MORBIDITY & MORTALITY  
**ACCESS:** COVERAGE & QUALITY CARE

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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
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

Penrose-St. Francis Health System

DEMOGRAPHICS: COMMUNITY & POPULATION

Centura’s Communities

Penrose-St. Francis Community

Population, Density (Persons per Sq/Mile) by Tract, ACES 2008-13

Penrose-St. Francis Stark Service Area

Service Area Population: 527,449

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<th>Population in Age Range</th>
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<td>Age 5-17</td>
<td>99,935</td>
<td>19.0%</td>
</tr>
<tr>
<td>Age 18-24</td>
<td>49,498</td>
<td>9.4%</td>
</tr>
<tr>
<td>Age 25-34</td>
<td>74,810</td>
<td>14.2%</td>
</tr>
<tr>
<td>Age 35-44</td>
<td>70,218</td>
<td>13.3%</td>
</tr>
<tr>
<td>Age 45-54</td>
<td>80,139</td>
<td>15.2%</td>
</tr>
<tr>
<td>Age 55-64</td>
<td>58,937</td>
<td>11.2%</td>
</tr>
<tr>
<td>Age 65+</td>
<td>56,374</td>
<td>10.7%</td>
</tr>
</tbody>
</table>

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

### Race and Ethnicity

#### Service Area

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>White</th>
<th>Black</th>
<th>Asian</th>
<th>Native American/Alaska Native</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Area</strong></td>
<td>81.11%</td>
<td>6.34%</td>
<td>2.54%</td>
<td>0.77%</td>
</tr>
<tr>
<td><strong>Colorado</strong></td>
<td>84.15%</td>
<td>3.99%</td>
<td>2.71%</td>
<td>0.97%</td>
</tr>
</tbody>
</table>

#### 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><strong>Service Area</strong></td>
<td>527,449</td>
<td>84.93%</td>
<td>15.07%</td>
</tr>
<tr>
<td><strong>Colorado</strong></td>
<td>5,042,853</td>
<td>79.37%</td>
<td>20.63%</td>
</tr>
</tbody>
</table>

### Population

#### Population with Limited English Proficiency

- **Service Area**: 4.2%
- **Colorado**: 6.7%

Source: American Community Survey, 2008-12

#### Population With a Disability

- **Service Area**: 11.0%
- **Colorado**: 9.9%

Source: American Community Survey, 2008-12

#### Unemployment Rate

- **Service Area**: 5.1%
- **Colorado**: 4.0%


### Income

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

- **Service Area**: 36.1%
- **Colorado**: 41.6%

Source: National Center for Education Statistics, 2011-13

- **Service Area**: 29.0%
- **Colorado**: 29.6%

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

**POPULATION WITH ASSOCIATES LEVEL DEGREE OR HIGHER**

- **Service Area**: 45.5%
- **Colorado**: 44.7%

**HIGH SCHOOL GRADUATION RATES**

- **Service Area**: 78.4%
- **Colorado**: 77.6%

Sources:
- American Community Survey, 2008-12
- National Center for Education Statistics, 2008-09
- Healthy People 2020

---

**HEALTH BEHAVIORS**

- **Weekend workers**: 13.5%
- **Adults eating less than 5 fruits and vegetables daily**: 74.4%
- **Current smokers**: 17.4%
- **Adults with no leisure-time physical activity**: 16.2%

- **Service Area**: 13.5%
- **Colorado**: 17.6%

Sources:
- Behavioral Risk Factor Surveillance System, 2005-09
- National Center for Chronic Disease Prevention and Health Promotion

---

**ENVIRONMENT**

- **Liquor Store Access Per 100,000 Population**: 18.96
- **Low Income Population with Low Food Access**: 9.25%
- **Recreation and Fitness Facility Access Per 100,000 Population**: 9

- **Service Area**: 18.96
- **Colorado**: 24.6

Sources:
- U.S. Bureau of Economic Analysis, 2010

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**Air Quality/Ozone**

- **Service Area**: 0.0%
- **Colorado**: 0.1%

Sources:
- National Environmental Public Health Tracking Network, 2008
- Federal Bureau of Investigation Uniform Crime Reports, 2010-12

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**Violent Crime**

- **Service Area**: 412.7
- **Colorado**: 321.0

Sources:
- National Environmental Public Health Tracking Network, 2008
- Federal Bureau of Investigation Uniform Crime Reports, 2010-12

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**HEALTH OUTCOMES: MORBIDITY & MORTALITY**

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Appendix B: First Round of Data
Appendix B: First Round of Data

### Uninsured Children Under Age 19

<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>150,173</td>
<td>15,548</td>
<td>8.8%</td>
</tr>
<tr>
<td>Colorado</td>
<td>1,276,087</td>
<td>121,166</td>
<td>9.3%</td>
</tr>
</tbody>
</table>


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

- **El Paso**
  - Service Area: 2621
  - Colorado: 2868

- **Service Area**
  - Percentage: 16.1%
  - Colorado: 16.9%


### Quality Care: Mammogram

- **Service Area**
  - Percentage: 54.9%
  - Colorado: 60.5%

- **Service Area**
  - Percentage: 74.6%
  - Colorado: 75.5%

- **Service Area**
  - Percentage: 67.7%
  - Colorado: 60.8%


### Oral Health: Adult Dental Care Utilization

- **Service Area**
  - Percentage: 28.9%
  - Colorado: 31.1%

- **Service Area**
  - Percentage: 9.6%
  - Colorado: 10.0%


### Quality Care: Access to Primary Care

- **Service Area**
  - Percentage: 56.8
  - Colorado: 79.2

- **Service Area**
  - Percentage: 78.7
  - Colorado: 83.4

- **Service Area**
  - Percentage: 26.0
  - Colorado: 26.5

**ACCESS: QUALITY CARE**

**Pneumonia Vaccination**
Percentage of adults 65 and over who have received

Service Area 72.7%
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 37.0
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