At a Glance: Community Health Needs Assessment
St. Anthony North Health Campus

Area Served

Adams and Broomfield Counties

Priorities

- Behavioral Health
- Healthy Eating Active Living (HEAL)/Obesity
- Access to Care

Partners

Tri-County Health Department, Broomfield Health Department, Weld County Health Department, Community Reach Mental Health Services, Arapahoe House Addiction Treatment Centers, Centura Health Behavioral Health Network, City of Westminster/Recreation Services, Westminster School District 50, Local Pastors/North Denver Deanery and members of the SANHC Community Board
Community Health Needs Assessment
St. Anthony North Health Campus

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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 St. Anthony North Health Campus 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:
St. Anthony North Health Campus 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: Behavioral Health**

Behavioral health was chosen as a health need due to data in the St. Anthony North Health Campus service area. In the service area there were 3,184 mental health hospitalizations per 100,000 individuals, compared to the average of 2,868 in the state. Additionally, 18.5% of individuals in the community reported having a lack of social or emotional support, higher than 16.9% in the state. Additionally, alcohol-related Emergency Department admissions were leading causes of admission at both hospitals.

To address behavioral health, we are partnering with the community to leverage the strengths of the hospital and community partners to fill gaps and meet the needs within the community. We will develop and strengthen community relations and partnerships, increase organizational capacity and strengthen foundational care team skills to promote behavioral health.

The strategies we will use to do this include the following:

1) Implement continuing education for associates to increase knowledge and use of clinical tools, methods and communication strategies to promote behavioral health.

2) Increase associate and community awareness to improve referrals to behavioral health resources within our system and in the community.

**Prioritized Need: Healthy Eating and Active Living (HEAL)**

HEAL was the second health need that was selected based on health indicator data describing St. Anthony North Health Campus’ service area. In our community, 24.7% or adults are obese, and 38.1% are overweight. These percentages are much higher than the state averages of 20.2% and 35.3% respectively. The higher obesity and overweight adults in our service area are of concern due to the associated illnesses such as asthma, diabetes, cardiovascular disease, high blood pressure and high cholesterol. Of concern, too, is that obesity rates are higher among those with less education, lower incomes and minority populations.

To address HEAL, we are partnering with the community to leverage the strengths of the hospital and community partners to fill gaps and meet the needs within the community. We will develop and strengthen community relations and partnerships, increase organizational capacity and strengthen foundational care team skills to promote healthy eating and active living.

The strategies we will use to do this include the following:

1) Increase community participation and engagement in evidence-based prevention and disease-specific classes. Partner with community resources and develop a method to ensure sustainability of classes over time.

2) Implement continuing education for associates to increase knowledge and use of clinical tools, methods and communication strategies to encourage healthy eating active living.

3) Build foundational and sustainable programs that allow associate and community engagement to improve the health of our community.
Implementation Planning Process:

The first step to developing our implementation plans was to present evidence-based practices focused on addressing behavioral health and healthy eating and active living to our hospital subcommittees. Next, we completed an environmental scan to determine which established efforts in St. Anthony North Health Campus 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. Once our community’s health needs were identified and prioritized, we began the process to develop an implementation plan to address behavioral health and healthy eating/active living. The first step was to present evidence-based practices focused on behavioral health and healthy eating/active living to our hospital subcommittees. Next, we completed an environmental scan to identify those established efforts (in St. Anthony North Health Campus 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.

Implementation Plan Review and Approval:

The final implementation plans were presented to and approved by the St. Anthony North Health Campus Board on April 19, 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, St. Anthony North Health Campus 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 St. Anthony North Health Campus’ 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 St. Anthony North Health Campus 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 St. Anthony North Health Campus, 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 St. Anthony North Health Campus 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 St. Anthony North Health Campus and the Broomfield, Tri County and Weld County Public Health Departments. 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, St. Anthony North Health Campus 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 explain the drivers of emergency room and inpatient visits. The knowledge we gained from the CHNA process helped our hospitals more effectively lay out their strategic plan for addressing the health needs in their communities. Over the course of the year, this CHNA process facilitated collaboration within our family of hospitals, helping us build a stronger system in which our hospitals benefit from powerful learning networks and relationships, rather than function as separate entities.
Since its foundation in 1971, St. Anthony North Health Campus has provided people throughout Westminster, Erie, Brighton, Broomfield, Northglenn and Thornton and the surrounding communities compassionate, personalized, whole-person care. At its inception St. Anthony North Hospital opened as a full service 196-bed hospital serving the north metro community. In 2015, St. Anthony North Health Campus was opened at a new location in Westminster, offering an award-winning, 92 bed hospital specializing in women’s services, breast imaging, cardiovascular services and general surgery. The Hospital maintains The 84th Avenue campus remains open for outpatient services, including primary care, Emergency and a 24 hour mental health crisis center.

St. Anthony North Health Campus is sponsored by Catholic Health Initiatives and is part of Centura Health, Colorado’s largest hospital and health care network delivering advanced care to more than half a million people each year.

**Distinctive Services**

St. Anthony North Health Campus offers leading medical experts, cutting-edge technology, and a broad array of specialties and services. Our distinctive services include:

- One-on-one Birth by Design consultations
- Comprehensive mammography and breast diagnostic services
- Nationally Recognized Cardiovascular Care
- Fully accredited American College of Surgeons Commission Cancer Care program

Our expertise in these areas has earned us a number of awards and honors throughout the years. St. Anthony North Health Campus is proud to have received the following awards:

- The Joint Commission’s Gold Seal of Approval® for certification as a Primary Stroke Center
- Healthgrades Honors for Critical Care Excellence Award™ (2015-2016), Five-Star Recipient for Treatment of Heart Failure and Treatment of Bowel Obstruction in 2016
Commitment to Our Community

At St. Anthony North Health Campus, 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, we are 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, St. Anthony North Health Campus provided over $25,967,181 in total community benefit. Community services ranged from chaplain training to providing over 4,200 patients with supportive therapies. In fiscal year 2015, our community benefit activities included serving over 700 people with needed health screenings at the 9Health Fair, supporting patients through Alcoholics Anonymous Groups, and providing 662 Spanish-speaking women with lay birth coaches through our Doula program.
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 218,151.

The demographic makeup of these communities is as follows:

Race and Ethnicity: White=85.8%; Black=1.4%; Asian=5.3%; Native American/Alaskan Native=0.5%; Native Hawaiian/Pacific Islander=<0.1%; some other race=3.2%; Multiple races=3.7%

16.9% of our community identifies as Hispanic or Latino

Education Level: Population with Associates Level Degree or Higher=46.4%, CO average is 44.7%

Unemployment Rate: 6.7%, CO average is 4.0%

Population with Limited English Proficiency: 5.2%, CO average is 6.7%

High School Graduation Rate: 72.7%, CO average is 77.6%

Population Living in Households with Income Below 200% of Federal Poverty level: 18.3%, CO average is 29.6%
Population Demographics in St. Anthony North Health Campus’ Service Area

Race

- Non-Hispanic: 83.1%
- Hispanic: 16.9%

Ethnicity

- White: 85.8%
- Black: 1.4%
- Asian: 5.3%
- Native American/Alaska Native: 0.5%
- Native Hawaiian/Pacific Islander: 0.01%
- Other: 3.2%
- Multiple races: 3.7%

Associate’s Degree or Higher

- St. Anthony North Health Campus Service Area: 46.4%
- State Average: 44.7%

High School Graduation Rate

- St. Anthony North Health Campus Service Area: 72.7%
- State Average: 77.6%

Limited English Proficiency

- St. Anthony North Health Campus Service Area: 5.2%

Unemployment Rate

- St. Anthony North Health Campus Service Area: 6.7%
- State Average: 4.0%

Households Below 200% of Federal Poverty Level

- St. Anthony North Health Campus Service Area: 18.3%
- 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 representatives from our hospital and the 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 five times during the 2015 CHNA process. Through mobilizing community partnerships, the subcommittee brought together over 21 individuals, representing 11 agencies, dedicating approximately 21+ collective hours.

St. Anthony North Health Campus’ Partnerships with Public Health

St. Anthony North Health Campus worked closely with Tri-County Health Department which represents Adams County, a large part of our service area. Tri County representatives provided valuable public health data about population in our market area. St. Anthony North Health Campus also worked closely with Broomfield Health Department and its representatives. They presented data about population and obesity in Broomfield, in addition to Broomfield Public Health Improvement Plan. Our third partnership with Public Health included Weld County Health Department, which provided data about Erie. The Public Health representatives attended all meetings and provided valuable input into the process of selection of health concerns.
Stage 1: Scanning the Data Landscape

The CHNA was conducted through a collaborative partnership between St. Anthony North Health Campus, Tri-County Health Department, Broomfield Health Department, a portion of Weld 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. St. Anthony North Health Campus’ main service area encompasses Adams and Broomfield 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 demographics, disparities, populations, and distinct health needs. These areas address the social determinants of health, quality of life, and healthy behaviors, all things that we know impact community health. To be sure we were measuring all determinants of health, we conducted a full legal and environmental scan of issues and policies impacting health in our community.
**Table 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>14%</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>114.2</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>7.4</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>43.2</td>
<td>36.9</td>
<td>38.7</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Percentage of adults aged 20 and older who have ever been told by a doctor that they have diabetes</td>
<td>7.3%</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>140.6</td>
<td>137.4</td>
<td>N/A</td>
</tr>
<tr>
<td>Homicide</td>
<td>Rate per 100,000 population</td>
<td>4.1</td>
<td>3.7</td>
<td>5.5</td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>Chlamydia rate per 100,000 population</td>
<td>449.3</td>
<td>422.8</td>
<td>N/A</td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>HIV Rate per 100,000 population</td>
<td>165.5</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>58.7</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>6.5</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>48.4</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>8.7%</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>18.5%</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>24.7%</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>34.1%</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>10.4%</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>135.4</td>
<td>147.6</td>
<td>N/A</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>Adults reporting heavy alcohol consumption</td>
<td>16.3%</td>
<td>17.6%</td>
<td>N/A</td>
</tr>
<tr>
<td>Suicide</td>
<td>Rate per 100,000 population</td>
<td>15.9</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>42.9</td>
<td>45.1</td>
<td>36</td>
</tr>
</tbody>
</table>
Stage 2: Delving into the Data to Identify Priorities

Our St. Anthony North Health Campus 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 Adams, Broomfield, and Erie 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>

Based on the criteria rankings assigned to each health need above, we calculated priority scores using the formula: \( D = C[A + (2B)] \), where:

\[
D = \text{Priority Score} \\
A = \text{Size of health need ranking} \\
B = \text{Seriousness of health need ranking} \\
C = \text{Alignment ranking}
\]
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.

St. Anthony North Health Campus identified two needs as priority areas for which we have the ability to impact. These include:

- Behavioral Health
- Healthy Eating/Active Living (HEAL)

The St. Anthony North Health Campus Subcommittee received additional data presented by Tri-County Health Department (See Appendix C). The data presented was specifically about adult and childhood rates of obesity, demographics of obesity in Adams County, lifestyle behaviors and consequences of obesity, environmental impact on obesity, behavioral health, depression, and anxiety, disparities among different populations regarding mental health outcomes and mental health across the lifespan. Tri-County also, presented their HEAL strategies. Another data presentation was given by Broomfield Health Department, presenting their Public Health Improvement Plan, which focused on obesity and a Healthier Broomfield.

**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. After much discussion the subcommittee decided to collect information from four very diverse and varying demographic groups. They included clergy, elementary school Hispanic mothers, teenagers, and seniors.

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

Two representatives from our subcommittee conducted all 4 of the focus groups; the first was with 17 Pastors from the North Denver Deanery in a parish hall. The next focus group was completed with 25 Hispanic mothers in a local school. Our last two focus groups were attended by 27 Teens at a Boys & Girls Club and 14 seniors
Stage 4: Developing the Implementation Plan

Once our community’s health needs were identified and prioritized, we began the process to develop an implementation plan to address behavioral health and healthy eating/active living. The first step was to present evidence-based practices focused on behavioral health and healthy eating/active living to our hospital subcommittees. Next, we completed an environmental scan to identify those established efforts (in St. Anthony North Health Campus 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 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 subcommittee from St. Anthony North Health Campus then met to brainstorm and perform a gap analysis for the focus areas of behavioral health and healthy eating and active living.

Social-Ecological Model

The social-ecological model recognizes the complex interplay between individual, relationship, community, and societal factors. Individuals are responsible for making and maintaining lifestyle choices, such as healthy eating and active living. However, the ability to make these choices is determined largely by the social environment we live in (i.e., community norms, laws, policies). Barriers to healthy eating and active living are shared by the community, and removal of the barriers makes behaviors attainable and sustainable. The overlapping rings in the model illustrate how factors at one level influence factors at another level (see Figure 2). Therefore the most effective approach to impacting health outcomes is a combination of efforts at the individual, interpersonal,
organizational, community, and public policy levels.

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

**Healthy Eating:**

*Individual:* Eat nine servings of fruits/vegetables daily

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

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

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

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

**Active Living:**

*Individual:* Exercise for 150 minutes/week

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

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

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

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

**Behavioral Health:**

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

*Interpersonal:* Positive connections with peers and family

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

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

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

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

1 [http://www.cdc.gov/violenceprevention/overview/social-ecologicalmodel.html](http://www.cdc.gov/violenceprevention/overview/social-ecologicalmodel.html)
Figure 2. The Socio-Ecological Model

- **Public Policy**
- **Community**
  - Cultural values, norms
- **Organizational**
  - Environment, ethos
- **Interpersonal**
  - Social network
- **Individual**
  - Knowledge, attitude, skills
Health in St. Anthony North Health Campus’ 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 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. 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, in order of priority:

- Behavioral Health
- Healthy Eating/ Active Living

Prioritized Health Needs

St. Anthony North Health Campus prioritized behavioral health and healthy eating/active living.

Behavioral Health

Behavioral health was chosen as a health need due to data in the St. Anthony North Health Campus service area. In the service area there were 3,184 mental health hospitalizations per 100,000 individuals, compared to the average of 2,868 in the state. Additionally, 18.5% of individuals in the community reported having a lack of social or emotional support, higher than 16.9% in the state.

Alcohol abuse “unspecific” was the third most frequent admitting diagnosis for the Emergency Department at the 84th Ave Neighborhood Health Center. Alcohol abuse “unspecific” was the seventh most frequent admitting diagnosis for the...
Emergency Department at the St. Anthony North Health Campus. The ninth most frequent admitting hospital diagnosis to the Health Campus from both Emergency Departments has been alcohol abuse with a behavioral health component.

Several resources that are available to promote behavioral health include the following:

- Mental Health First Aid trains providers and community members with the tools to support individuals in a mental health crisis.
- Screening, Brief intervention, Referral to Treatment (SBIRT) addresses risk factor for suicide, substance abuse and depression.
- Applied Suicide Intervention Skills Training (ASIST) and Assessing and Managing Suicide Risk (AMSR) target suicide reduction.

**Health Eating and Active Living (HEAL)**

Healthy eating and active living (HEAL) was the second health need that was selected based on health indicator data describing St. Anthony North Health Campus’ service area. In our community, 24.7% or adults are obese, and 38.1% are overweight. These percentages are much higher than the state averages of 20.2% and 35.3% respectively.

The higher obesity and overweight adults in our service area are of concern for the health campus because of the associated illnesses such as asthma, diabetes, cardiovascular disease, adults with high blood pressure and adults with high cholesterol which have rates that are higher than Colorado’s. Of concern too, is that obesity rates are higher among those with less education, lower incomes and minority populations.

<table>
<thead>
<tr>
<th>Environmental Indicator</th>
<th>Recreation and Fitness Facility Access per 100,000</th>
<th>Poor General Health</th>
<th>Obesity Adults</th>
<th>Overweight Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Area</td>
<td>5.6</td>
<td>15%</td>
<td>24.7%</td>
<td>38.1%</td>
</tr>
<tr>
<td>Colorado</td>
<td>10.8</td>
<td>12.8%</td>
<td>20.2%</td>
<td>35.3%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Asthma</th>
<th>Diabetes</th>
<th>Adults with High Blood Pressure</th>
<th>Adults with High Cholesterol</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Area</td>
<td>14%</td>
<td>7.3%</td>
<td>25.3%</td>
<td>34.6%</td>
</tr>
<tr>
<td>Colorado</td>
<td>12.9%</td>
<td>6.1%</td>
<td>23.1%</td>
<td>33.5%</td>
</tr>
</tbody>
</table>
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 Adams and Broomfield Counties revealed that our community has both opportunities and barriers to living a healthy and active lifestyle. The lower income population (5.2%) has lower food access compared to 6.39% at the state level. There are fewer opportunities to access liquor stores and fast food chains, which can contribute to unhealthy behaviors. These opportunities are coupled with the fact that Adams and Broomfield Counties experience high outdoor air quality.

<table>
<thead>
<tr>
<th>Environmental Indicator</th>
<th>Fast Food Restaurant Access</th>
<th>Liquor Store Access</th>
<th>Low Income Population with Low Food Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Area</td>
<td>72.2</td>
<td>22.5</td>
<td>5.2</td>
</tr>
<tr>
<td>Colorado</td>
<td>76.6</td>
<td>25</td>
<td>6.4</td>
</tr>
</tbody>
</table>

However, grocery store access in our service area is slightly lower than that of the state of Colorado, with 13.7 grocery stores per 100,000 population, and there are fewer SNAP-authorized food stores. Recreation and fitness facility access is of concern in our community, as there are half as many fitness facilities in our area than the average for Colorado.

Several resources that are available to address the obesity issue include the following:

- Centura Health Physician Group (CHPG) primary care and specialty practices that monitor BMI
- Pathway to Health and Wellness provides a comprehensive approach to weight loss
- The Healthy Hospital Compact has influenced the health campus’ cafeteria in providing healthier selections
- Cafe Well offers web based approaches to BMI, weight loss, high blood pressure, and high cholesterol

Access to Care

In addition to the above prioritized health needs, Centura Health and St. Anthony North Health Campus 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 behavioral health and healthy eating/active living needs identified in the CHNA process. As a nonprofit and faith-based hospital, St. Anthony North Health Campus 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’s) who works 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, and at local events to engage them with CHA’s to guide them through the insurance enrollment process and navigation to the appropriate source of care. Once they have received the coverage they need, our Advocates refer the patients to providers so they may begin to receive high quality and consistent medical care.

St. Anthony North Health Campus has a full-time Community Health Advocate (CHA) certified to enroll patients and their families into public and commercial insurance options. The CHA and hospital Eligibility Specialists reach all uninsured patients entering our system and support them until enrolled in coverage. Additionally, our CHA assesses the connection to a medical home and, if missing, connects patients to a primary care provider and helps to schedule their first appointment at their medical home. These referrals increase the likelihood that people meet their behavioral health, HEAL and injury prevention needs in the primary care setting.

At St. Anthony North Health Campus, Assess to Health care is another important issue though not included in the formal prioritization process it will continue to be addressed. Data points show in tables below:

### Uninsured Adults Ages 18-64

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Population</th>
<th>Population without Medical Insurance</th>
<th>Percentage Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Area</td>
<td>259,512</td>
<td>61,784</td>
<td>23.8%</td>
</tr>
<tr>
<td>Colorado</td>
<td>3,256,899</td>
<td>635,874</td>
<td>19.5%</td>
</tr>
</tbody>
</table>

*Source: Robert Wood Johnson Foundation*
Access to Behavioral Health Services

Inadequate access to behavioral health services is also a concern in the communities we serve. Centura Health has recognized this gap and is currently working with behavioral health partners and providers to better integrate behavioral health services into our hospitals, clinics, and neighborhood health centers. At St. Anthony North Health Campus, we are currently working with Community Reach to provide behavioral health services to our patients and our communities. Below are some of the initiatives St. Anthony North Health Campus has been working on to address behavioral health:

• Maintained partnership with state Alcoholics Anonymous and Al-Anon support groups.

• Expanded partnerships with Community Reach and Arapahoe House for behavioral health and substance abuse community needs.

• Co-located behavioral health services to improve access to behavioral health and substance abuse resources for our communities. (24 hour Crisis Unit opened December 1, 2014 at the 84h Ave. Neighborhood Health Center)

• Increased the partnership with ED Crisis Team for patient, family and community education.

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Adults without a regular MD</th>
<th>Access to Primary Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Area</td>
<td>25%</td>
<td>52.9%</td>
</tr>
<tr>
<td>Colorado</td>
<td>23.6%</td>
<td>79.2%</td>
</tr>
</tbody>
</table>
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.¹ 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. Brighton, Commerce City, and Arvada extended smoking bans to parks, and trails. Arvada also extended its smoking bans to transit waiting areas. Broomfield possesses a few extensions to Colorado’s state laws regarding tobacco use. For example, the no-smoking perimeter around buildings is extended to 20 feet.

**SNAP and WIC Accepted at Farmer’s Markets**²

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 Adams and Broomfield 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.³ 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 only insufficient to support families anywhere inside the state, and is only sufficient to support one-person households in Otero, Bent, and Custer Counties.⁴ 76% of workers in the most common occupations do not earn wages sufficient to support their families.⁵

**Homelessness**⁶

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

**Marijuana Legalization – Effect on Tourists**

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

Access to Care for Undocumented Individuals

Due to current laws and regulations, it is difficult for undocumented individuals to get health 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 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. 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. 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. 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. Despite the Affordable Care Act’s mandate that commercial insurers create “parity” between mental health care services and physical care services, insurers are still able to reimburse hospitals at a higher rate for physical healthcare than mental healthcare. Low funding and low reimbursement rates are leaving providers unable to invest in improving their behavioral health services.

Lack of Integration between Primary Care and Behavioral Healthcare

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

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

Bike friendliness is an important function to encourage active lifestyles. Also, bike friendliness means creating roads that are cognizant of bicyclists, which leads to the reduction of unnecessary bike and car accidents. Colorado is currently named by The League of American bicyclists as a top 10 state for bike friendliness. Policies and laws can be enacted to increase bike friendliness and bike safety. In 2015, Westminster received a bronze rating from the League of American Bicyclists. Arvada received a Silver rating. Both cities have laws and ordinances in protection of cyclists.

1 http://www.gaspforair.org/gasp/ordinance/ordinance_index.php
2 https://www.ams.usda.gov/local-food-directories/farmersmarkets
11 http://www.denverpost.com/ci_12498806
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
14 https://www.colorado.gov/pacific/sites/default/files/PCO_HPSA-mental-health-map.pdf
15 http://extras.denverpost.com/mentalillness/
Conclusion

Evaluation

Progress since our last CHNA

In our previous CHNA, we prioritized behavioral health, as related to alcohol and substance abuse. Many persons with alcohol and substance abuse also struggle with underlying mental health issues. The most common disorders associated include schizophrenia, bipolar disorder, obsessive-compulsive disorder, post-traumatic stress disorder, panic disorder, and antisocial personality disorder. Therefore, alcohol and substance abuse are not stand-alone problems. Additionally, we prioritized health care access, heart disease and chronic obstructive pulmonary disease. In response to these needs, we partnered with organizations in the community that could help us provide increased access and services needed.

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. St. Anthony North Health Campus will also track progress through annual community health improvement plans and community benefit reports.

Community Health Improvement Plans

The CHNA allows St. Anthony North Health Campus 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:

Monica Buhlig, Group Director of Community Health, Mountains and North Denver Operating Group, Centura Health,
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.

Bernadette Albanese, M.D., MPH, Tri-County Health Department
Leota Banecks, Crisis Assessment Specialist, St. Anthony North Health Campus
Patty Boyd, RD, MPH, Strategic Partnership Manager, Tri-County Health Department
Barbara Bronson, Manager Nurse Family Partnership, St. Anthony Hospital Nurse Home Visitor Program
Scott Burfitt, Director Ambulatory Operations, St. Anthony North Health Campus
Candy Cordova, HBA/Financial Counselor, St. Anthony North Health Campus
Justin Cutler, Recreation Service Manager, City of Westminster
Kathleen Drozda, Faith Community Nurse Coordinator, Lead for CHNA, St. Anthony North Health Campus
Marie Grucelski, Public Health Educator, Broomfield Health Department
Sister Patricia Hayden, S.C., VP Mission Integration, St. Anthony North Health Campus
Diane Kennedy, Manager Case Management, St. Anthony North Health Campus
Father Ken Koehler, Community Board Member & Local Pastor
Cindy Kronauge, MPH, PhD, Health Data Analyst, Weld County Health Department
Sarah Lind, Data Project Analyst, St. Anthony North Health Campus
Molly Long, CHA, 84th Neighborhood Health Center
Doug Muir, Director Behavioral Health Service Line, Porter Adventist Hospital
Kate Osmundson, Communication Officer, Arapahoe House
Bryan Trujillo, Manager Community Health Advocates, Centura Corp.
Abigail Tucker, PsyD, LP Director, Community Reach Center
Irene Tynes, Manager Outpatient Education, St. Anthony North Health Campus
Jason Vahling, Director of Public Health, Broomfield Health Department
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

St. Anthony North Health Campus

Centura Health Data Approach
DEMOGRAPHICS: COMMUNITY & POPULATION
HEALTH DRIVERS: BEHAVIORS & ENVIRONMENT
HEALTH OUTCOMES: MORBIDITY & MORTALITY
ACCESS: COVERAGE & QUALITY CARE

Centura Health Data Approach

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Health Drivers</th>
<th>Health Outcomes</th>
<th>Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community</td>
<td>Behaviors</td>
<td>Morbidity</td>
<td>Coverage</td>
</tr>
<tr>
<td>Population</td>
<td>Environment</td>
<td>Mortality</td>
<td>Quality Care</td>
</tr>
</tbody>
</table>

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
**St. Anthony North Health Campus**

**DEMographics: Community & Population**

**Centura’s Communities**

**Service Area Population:** 218,151

<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>16,206</td>
<td>7.4%</td>
</tr>
<tr>
<td>Age 5-17</td>
<td>82,240</td>
<td>38.4%</td>
</tr>
<tr>
<td>Age 18-24</td>
<td>17,716</td>
<td>8.1%</td>
</tr>
<tr>
<td>Age 25-34</td>
<td>32,266</td>
<td>14.7%</td>
</tr>
<tr>
<td>Age 35-44</td>
<td>35,644</td>
<td>16.4%</td>
</tr>
<tr>
<td>Age 45-54</td>
<td>37,510</td>
<td>16.9%</td>
</tr>
<tr>
<td>Age 55-64</td>
<td>21,075</td>
<td>9.8%</td>
</tr>
<tr>
<td>Age 65+</td>
<td>15,519</td>
<td>7.1%</td>
</tr>
</tbody>
</table>

Source: American Community Survey, 2008-12

**Race and Ethnicity**

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Service Area</th>
<th>Colorado</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>55.11%</td>
<td>64.13%</td>
</tr>
<tr>
<td>Black</td>
<td>1.62%</td>
<td>0.90%</td>
</tr>
<tr>
<td>Asian</td>
<td>1.14%</td>
<td>2.71%</td>
</tr>
<tr>
<td>Native American/Alaska Native</td>
<td>0.53%</td>
<td>0.92%</td>
</tr>
</tbody>
</table>

**Hispanic Population**

<table>
<thead>
<tr>
<th>Total Population</th>
<th>Non-Hispanic</th>
<th>Hispanic or Latino</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Area</td>
<td>218,151</td>
<td>83.12%</td>
</tr>
<tr>
<td>Colorado</td>
<td>5,042,853</td>
<td>79.37%</td>
</tr>
</tbody>
</table>
Appendix B: First Round of Data
Appendix B: First Round of Data
Appendix B: First Round of Data
Appendix C: Data From Local Public Health Departments

Obesity and Mental Health: Indicators Telling a Story

Bernadette Allanuese, MD, MPH
Tri-County Health Department
July 28, 2015

Hospital Service Area: Demographic Description Handout

Weight, diet, physical activity

Adult Overweight & Obesity is Common

- Denver Health Analysis:
  - 23% of children overweight at age 2 yrs remained overweight at age 5 yrs
  - 35% of children overweight at age 2 yrs were obese at age 5 yrs
  - 69% of children obese at 2-5 yrs age remained obese at ages 6-11 yrs

Source: Denver Health, CO BMIR Surveillance System, 2011

Child Obesity Carries Into Adulthood

Alternate Measurement of Obesity

<table>
<thead>
<tr>
<th>CO BMIR Registry</th>
<th>% Adults Obese</th>
<th>% Children Obese</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adams County</td>
<td>36.3%</td>
<td>29.5%</td>
</tr>
<tr>
<td>Broomfield County</td>
<td>27.6%</td>
<td>14.2%</td>
</tr>
<tr>
<td>Denver County</td>
<td>30.7%</td>
<td>17.7%</td>
</tr>
</tbody>
</table>

Source: Denver Health, CO BMIR Surveillance System, 2011
Appendix C: Data From Local Public Health Departments

Obesity Tracks With Demographic Characteristics

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Percentage obese</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td></td>
</tr>
<tr>
<td>Less than high school</td>
<td></td>
</tr>
<tr>
<td>High school graduate</td>
<td></td>
</tr>
<tr>
<td>Some college or more</td>
<td></td>
</tr>
<tr>
<td>&lt;$5,000</td>
<td></td>
</tr>
<tr>
<td>$5,000-$9,999</td>
<td></td>
</tr>
<tr>
<td>$10,000-$30,000</td>
<td></td>
</tr>
<tr>
<td>&gt;$30,000</td>
<td></td>
</tr>
</tbody>
</table>

Consequences of Obesity

- Diabetes
- Hypertension
- High cholesterol

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>Adams</td>
<td>7.7%</td>
<td>22.4%</td>
<td>33.6%</td>
</tr>
<tr>
<td>Brownfield</td>
<td>3.8%</td>
<td>28.5%</td>
<td>35.1%</td>
</tr>
<tr>
<td>Denver</td>
<td>7.3%</td>
<td>24.7%</td>
<td>25.6%</td>
</tr>
<tr>
<td>COLORADO</td>
<td>6.8%</td>
<td>20.3%</td>
<td>34.5%</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>35%</td>
<td>31%</td>
<td>33%</td>
</tr>
<tr>
<td>Consuming vegetables less than once per day</td>
<td>37%</td>
<td>16%</td>
<td>33%</td>
</tr>
<tr>
<td>Walking 30 minutes or more time in past week</td>
<td>35%</td>
<td>19%</td>
<td>33%</td>
</tr>
<tr>
<td>Drink less than one SDB per day</td>
<td>31%</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td>Exercise past 30 days</td>
<td>90%</td>
<td>81%</td>
<td>87%</td>
</tr>
<tr>
<td>Exercise &gt;70 hours per week</td>
<td>17%</td>
<td>19%</td>
<td>17%</td>
</tr>
</tbody>
</table>

* Statistics difference vs. normal/underweight

Source: CBHE, Behavioral Risk Factor Surveillance System (BRFSS), 2015
Environment Can Impact Health Behavior - Adults

- Not easy to purchase healthy foods in neighborhood: 21%
- 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 SSE 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 their needed in past year: 2.1%

Obesity Risk - Take Home Points

- Obesity is common
  - Obesity tracked with diabetes, heart disease
  - Childhood obesity progresses into adulthood

- Racial & demographic disparities
  - Risk, history, low income, less education, 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

How Common is Depression & Anxiety in Adults?

<table>
<thead>
<tr>
<th>State</th>
<th>12 mos past mental health days in past month</th>
<th>Current depression</th>
<th>Ever had anxiety/ disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adams</td>
<td>14.1%</td>
<td>11.1%</td>
<td>17.2%</td>
</tr>
<tr>
<td>Brownfield</td>
<td>9.2%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Denver</td>
<td>14.1%</td>
<td>9.9%</td>
<td>16.6%</td>
</tr>
<tr>
<td>COLORADO</td>
<td>12.4%</td>
<td>6.8%</td>
<td>15.1%</td>
</tr>
</tbody>
</table>

Consequences of Depression in Adults

- Currently depressed
  - Trouble sleeping
  - Keep drinking
  - Working

- Not currently depressed
  - Trouble sleeping
  - Keep drinking
  - Working

Appendix C: Data From Local Public Health Departments

Consequences of Anxiety in Adults

- Anxiety disorder
- No anxiety disorder

- Trouble sleeping
- Poor concentration
- Smoking

Sadness Among High School Students

"During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?"

- Consistently across Denver Metro area, teens experiencing sadness are more likely to:
  - Smoke cigarettes
  - Binge drink
  - Use marijuana
  - Be recently sexually active

Teen Sadness Associated with Suicidal Ideation

Regional Variations in Adolescent Depression

<table>
<thead>
<tr>
<th>County</th>
<th>Feeling sad or hopeless</th>
<th>Considered suicide in past 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adams</td>
<td>28%</td>
<td>17%</td>
</tr>
<tr>
<td>Boulder/Boonefield</td>
<td>22%</td>
<td>14%</td>
</tr>
<tr>
<td>Denver</td>
<td>27%</td>
<td>13%</td>
</tr>
<tr>
<td>COLOrado</td>
<td>21%</td>
<td>14%</td>
</tr>
</tbody>
</table>

Disparities Among High School Girls, Colorado

- Male
- Female

Mental Health Across the Lifespan: Children

- Difficulty with emotions, behavior, or getting along with others
- Depression
- Anxiety problems
- Attention deficit disorders
- Any depression, anxiety, conduct or other behavior disorder

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

<table>
<thead>
<tr>
<th>Description</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child in need of mental health care or counseling in past 12 months</td>
<td>12%</td>
</tr>
<tr>
<td>Not able to received necessary mental health care</td>
<td>12%</td>
</tr>
<tr>
<td>On medication for depression</td>
<td>25%</td>
</tr>
<tr>
<td>On medication for anxiety problems</td>
<td>28%</td>
</tr>
<tr>
<td>On medication for attention deficit disorder</td>
<td>74%</td>
</tr>
</tbody>
</table>

*Note: Data from the National Center for Health Statistics.

### Suicide Rates by County

<table>
<thead>
<tr>
<th>County</th>
<th>2011 Age-Adjusted Rate per 100,000</th>
<th>2012 Age-Adjusted Rate per 100,000</th>
<th>2013 Age-Adjusted Rate per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adams</td>
<td>24.1</td>
<td>24.1</td>
<td>24.1</td>
</tr>
<tr>
<td>Broward</td>
<td>19.3</td>
<td>19.3</td>
<td>19.3</td>
</tr>
<tr>
<td>Dade</td>
<td>20.5</td>
<td>20.5</td>
<td>20.5</td>
</tr>
</tbody>
</table>

*Source: CDC WONDER, National Center for Health Statistics.

### Suicide-Related Hospitalizations by County

<table>
<thead>
<tr>
<th>County</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adams</td>
<td>187</td>
<td>231</td>
</tr>
<tr>
<td>Broward</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>Dade</td>
<td>115</td>
<td>186</td>
</tr>
</tbody>
</table>

*Source: CDC WONDER, National Center for Health Statistics.

### Gender Disparities: Suicide Vs Suicide-Related Hospitalizations

- Higher suicide-related hospitalizations in females, but higher suicide death rates in males.

*Source: CDC WONDER, National Center for Health Statistics.*
Appendix C: Data From Local Public Health Departments

Age-adjusted Suicide Rates by Year, Adams County, 2006-2013

Males vs. Females

Poor Mental Health More Common

- Use of public insurance or no insurance
- Persons with poor oral health
- Persons with poor general health
- Persons in 25-49 yrs

Mental Health Care: Costs, Insurance, Stigma

Who didn’t receive needed mental health care?

- Concerned about the cost of treatment: 76%
- Did not think health insurance would cover: 55%
- Not comfortable talking with a health professional about personal problems: 31%
- Hard time getting an appointment: 38%
- Concerned about what would happen if someone found out you had a problem: 26%

Mental Health Risk - Take Home Points

- Depression & anxiety are common
- Depression impacts health behaviors
- Barriers to accessing mental health care

The Health Gradient

- Individually oriented prevention action
- Health hazards

Questions

Comments

Other data requests
Appendix C: Data From Local Public Health Departments

BROOMFIELD'S PUBLIC HEALTH IMPROVEMENT PLAN

Jason Vahling, APH
Public Health Director

WHY A PUBLIC HEALTH IMPROVEMENT PLAN?
- 2008 Public Health Reauthorization Act
- Ensure access to core public health services
- Develop local priorities
- Meet quality standards
- Prepare for accreditation

PUBLIC HEALTH MODEL

THE PHIP

What Is the Public Health Improvement Plan (PHIP)?
How Did We Get Here?
Broomfield's Community Approach To Address Obesity.
Questions?
Appendix C: Data From Local Public Health Departments

**Overweight or Obese Prevalence Among Children and Adolescents, 2010-2012**

- 14% of Bloomfield children (aged 2-14) are overweight or obese.
- 7.3% of Colorado high school students are obese.
- 10.7% of Colorado high school students are overweight.

**Economic Cost**

- $190 Billion in healthcare costs/year.
- 21% of annual medical spending is on obesity-related illness.
- $4.3 Billion in annual losses to businesses.

**Obesity Increases the Risk of Over 20 Conditions, Including:**

- Sleep Apnea
- Heart Disease
- Stroke
- Type 2 Diabetes
- Musculoskeletal and Other Diseases

**Risk Factors**

- Calorie-rich and high fat diets
- Physical inactivity
- Cigarette smoking
- Alcohol and high-calorie drink consumption
- Cultural factors
- Living at lower income levels
- Lack of sleep
- Certain medications
- Stress
Appendix C: Data From Local Public Health Departments

**PHIP**

**What is the Public Health Improvement Plan (PHIP)?**

**How Did We Get Here?**

**Community Approach To Address Obesity Questions?**

**PHIP**

**Factors That Affect Health**

**PHIP**

**Community Approach**

**SECTOR APPROACH**
- Childcare
- Schools
- Worksites
- Older Adult Sites
- Health care
- Community
- Media and public awareness

**PHIP**

**Increase Community Outreach and Public Awareness Related to Obesity Prevention**
- Form a PHIP Advisory Team
- Media and marketing
  - Articles in the Broomfield Enterprise and B in the Loop
  - Advertising
- Establish a social media presence

**PHIP**

**Improve Nutrition and Physical Activity Among the Broomfield Residents**
- Expand the Healthy Hearts Program
- Train child care facilities
- Promote Let’s Move
- Offer classes at the Library
- Enhance the WIC program
- Implement classes in the community

Appendix C: Data From Local Public Health Departments
Appendix C: Data From Local Public Health Departments

ENHANCE THE CITY AND COUNTY OF BROOMFIELD'S EMPLOYEE WELLNESS PROGRAM

- Promote wellness in the employee newsletter
- Display signage
- Provide wellness classes
- Increase physical activity in the workplace

ENHANCE HEALTH AND HUMAN SERVICES CLIENTS' KNOWLEDGE AND AWARENESS OF WELLNESS

- Provide physical activity and nutrition education during clinic visits
- Distribute wellness packets through public health clinics

What is the Public Health Improvement Plan (PHIP)?
How Did We Get Here?
Broomfield’s Community Approach To Address Obesity.
Questions?

QUESTIONS?

TOGETHER WE CAN MAKE A HEALTHIER BROOMFIELD

Contact Information:
Jason Yalding, MPH
jyalding@broomfield.org
www.broomfieldhealth.org
Local Public Health Agencies (LPHAs) in Denver Metro Area:
Evidence Based Practices Being Utilized to
Promote Healthy Eating and Active Living (HEAL) and Reduce Obesity

<table>
<thead>
<tr>
<th>Local Public Health Agencies (LPHAs) in Denver Metro Area</th>
<th>Evidence Based Practices Being Utilized to</th>
<th>Promote Healthy Eating and Active Living (HEAL) and Reduce Obesity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address social and educational disparities to promote health equity.</td>
<td>Leverage early childhood education programs for low-income racial/ethnic minority students to reduce educational gaps, improve health, and promote healthy eating.</td>
<td>Children</td>
</tr>
<tr>
<td>Encourage participation in community coalitions and partnerships to address obesity.</td>
<td>Build coalitions to support a collaborative network through agencies with shared interest for promoting HEAL and establishing preventive strategies.</td>
<td>All ages</td>
</tr>
<tr>
<td>Improve physician and nurse education by implementing continuing medical education designed to increase knowledge of clinical tools and methods, and improve communication strategies for prevention in at-risk patients.</td>
<td>Increase the number of Colorado physicians with diabetes and obesity guidelines included in a disease prevention program.</td>
<td>Adults</td>
</tr>
<tr>
<td></td>
<td>Encourage healthcare professionals to adopt Colorado Adult and Childhood Obesity Guidelines.</td>
<td>All ages</td>
</tr>
<tr>
<td></td>
<td>Implement motivational interviewing training for physicians so that they can prompt patients and parents to weigh the pros, cons, and affordability of HEAL.</td>
<td>All ages</td>
</tr>
<tr>
<td>Increase access to physical activity, prioritizing disproportionately affected communities.</td>
<td>Improve access to active transportation among young children and their families.</td>
<td>Children</td>
</tr>
<tr>
<td></td>
<td>Increase access among young children and their families to locations to be physically active.</td>
<td>Children</td>
</tr>
<tr>
<td></td>
<td>Encourage organizations and systems impacting young children and their families to promote physical activity.</td>
<td>Children</td>
</tr>
<tr>
<td></td>
<td>Conduct community-wide campaigns that involve many community sectors, are highly visible, broad-based, and are part of multi-component strategies to increase physical activity, and stand-alone media campaigns.</td>
<td>All ages</td>
</tr>
<tr>
<td></td>
<td>Collaborate with local governments to include infrastructure support for bikes and sidewalks in their comprehensive plans.</td>
<td>All ages</td>
</tr>
<tr>
<td></td>
<td>Support programming and/or infrastructure for Safe Routes to School.</td>
<td>Children &amp; Adolescents</td>
</tr>
<tr>
<td></td>
<td>Improve access to outdoor recreational facilities and enhance infrastructure supporting bicycling and walking.</td>
<td>All ages</td>
</tr>
<tr>
<td></td>
<td>Promote increased duration of breastfeeding, prioritizing disproportionately affected communities.</td>
<td>Support Colorado hospitals to become certified as a baby-friendly.</td>
</tr>
<tr>
<td></td>
<td>Increase access to professional support for breastfeeding.</td>
<td>Infants</td>
</tr>
<tr>
<td></td>
<td>Increase access to peer support for breastfeeding.</td>
<td>Infants</td>
</tr>
<tr>
<td></td>
<td>Increase access to professional education around breastfeeding.</td>
<td>Infants</td>
</tr>
<tr>
<td></td>
<td>Support breastfeeding in early care and education settings.</td>
<td>Infants</td>
</tr>
<tr>
<td></td>
<td>Implement continuity of lactation care initiatives that link maternity facilities and community providers to support breastfeeding families.</td>
<td>Infants</td>
</tr>
<tr>
<td></td>
<td>Support policies that promote breastfeeding through effective and consistent messaging.</td>
<td>Infants</td>
</tr>
<tr>
<td></td>
<td>Increase support for breastfeeding in child care programs through policy and environmental change.</td>
<td>Infants</td>
</tr>
<tr>
<td></td>
<td>Implement breastfeeding initiatives by providing access and support for mothers and improve regulation on lactation laws.</td>
<td>Infants</td>
</tr>
<tr>
<td></td>
<td>Increase support for breastfeeding in workplaces through policy and environmental change.</td>
<td>Infants</td>
</tr>
</tbody>
</table>
### Local Public Health Agencies (LPHAs) in Denver Metro Area:
Evidence Based Practices Being Utilized to Promote Healthy Eating and Active Living (HEAL) and Reduce Obesity

| Strategy Implementation Setting | Primary Target Age Group | Current Strategy | Other
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promote fruit and vegetable consumption, prioritizing disproportionately affected communities.</td>
<td>Children</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Implement 5 a Day (Way to Enhance Children's Activity and Nutrition) curriculum in community education to increase positive nutrition knowledge and healthy eating habits.</td>
<td>All ages</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Increase hospital institutional procurement of local farm produce, Colorado Proud products, and/or farm-to-table programs.</td>
<td>All ages</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Implement policies and environmental approaches to make healthy choices easier, for example, by changing cafeteria options or vending machine content.</td>
<td>All ages</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Increase access to produce for SNAP and WIC recipients through incentive programs, such as SNAP Double Bucks and USDA healthy incentives.</td>
<td>Children</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Increase access to fruits and vegetables through pricing, placement, and outreach planning strategies.</td>
<td>All ages</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Encourage organizations and systems that serve children and families to promote fruit and vegetable consumption.</td>
<td>Children &amp; Adolescents</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Improve geographic availability of supermarkets in underserved areas and offer healthier food and beverage choices that are affordable.</td>
<td>All ages</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Promote replacing sugary drink consumption with healthy beverages, prioritizing disproportionately affected communities.</td>
<td>Children</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Increase availability of safe, free drinking water and healthier beverages such as water, low-fat milk (which could be substituted for sugar-free adenosin) and.</td>
<td>All ages</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Support positive community norms for healthy beverage consumption through effective and consistent messaging, limited advertisement of unhealthy foods and beverages and discourage consumption of sugar-sweetened beverages.</td>
<td>All ages</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Promote healthy beverage consumption through policy and environmental changes in schools and schools.</td>
<td>All ages</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Identify new and existing partner communication channels to disseminate chronic disease education messages and chronic disease-related to sugar-sweetened beverage consumption.</td>
<td>All ages</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Reduce food insecurity and hunger.</td>
<td>All ages</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Incorporate food insecurity screening as part of doctor visits and increased screening to community resources.</td>
<td>All ages</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Establish a Food Policy Council to look at options to increase availability and affordability of local fresh food (such as farmers' markets, community gardens, and stores).</td>
<td>All ages</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Workplaces and employers offer and promote access to healthy foods and beverages and opportunities for physical activity.</td>
<td>Adults</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Implement worksite behavioral and social strategies to offer group counseling to increase physical activity and improve diet, and behavioral strategies to support and maintain change.</td>
<td>Adults</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Implement worksite behavioral and social strategies that promote rewards and reinforcement for positive health behavior, such as using incentives for completing employee challenges in point systems to support and sustain behavior change.</td>
<td>Adults</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Implement worksite behavioral and social strategies to build support system between coworkers and employees' families to increase likelihood of sustaining behavior change within and outside the work environment.</td>
<td>Adults</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Implement worksite strategies that provide lectures and written materials to employees to increase knowledge about a healthy diet and physical activity and highest voluntary behavior change conducive to health.</td>
<td>Adults</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Promote HEAL in healthcare organization institutional policies and in clinical practices (e.g., cafeteria vending machines, coffee carts and other opportunists).</td>
<td>All ages</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Increase access to healthy foods and beverages in worksites and government settings.</td>
<td>All ages</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Implement vending, pricing, and marketing strategies to increase sales of healthier food/beverage options and decrease sales of unhealthy items.</td>
<td>All ages</td>
<td>✔</td>
<td>✔</td>
</tr>
</tbody>
</table>


Appendix C: Data From Local Public Health Departments
Appendix C: Data From Local Public Health Departments

Factors to Affect Health Behaviors:
Health Impact Pyramid & Social Determinants of Health

Tri-County Health Department
Jefferson County Public Health
Denver Public Health
Boulder County Public Health
Broomfield Public Health and Environment

The Health Impact Pyramid

Increasing individual effort needed
Concentration
Critical thinking
Long-lasting behavioral interventions
Systems change to minimize unhealthy behaviors
Biocultural and biophysical factors

Social-Ecological Model

Structural, Policy, and Organizational
Community
Institutional and Organizations
Intergenerational
Individual

Health Impact Pyramid for Fall Prevention

Increasing individual effort needed
Communities
Social environments
Education environments for older adults
Systemic change
Implement population level programs
Implement individual level programs
Implement individual level programs
Implement individual level programs

Reinforcing the Impact of Change

80% of child safety seats not installed properly

Failure to install safety seats properly
Care & safety seat design
Care & safety seat design
Care & safety seat design
Care & safety seat design
Care & safety seat design

Behavior
Social Norms
Systems
Policy

The Health Gradient

Individuals change percentage in clinic

Health impacts

Health benefits

Health improvements

Improving health
Appendix C: Data From Local Public Health Departments

Erie:

People

<table>
<thead>
<tr>
<th>Race and Hispanic Origin</th>
<th>Total</th>
<th>Caucasian</th>
</tr>
</thead>
<tbody>
<tr>
<td>White, non-Hispanic</td>
<td>94.2%</td>
<td>94.0%</td>
</tr>
<tr>
<td>Black or African American</td>
<td>5.7%</td>
<td>5.7%</td>
</tr>
<tr>
<td>American Indian and Alaska</td>
<td>0.1%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Asian or Pacific Islander</td>
<td>0.4%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Native Hawaiian or Other Polynesian</td>
<td>0.1%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Other Race, present, 2010</td>
<td>2.0%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Hispanic, present, 2010</td>
<td>83.4%</td>
<td>83.7%</td>
</tr>
<tr>
<td>White, non-Hispanic</td>
<td>94.2%</td>
<td>94.0%</td>
</tr>
<tr>
<td>Black or African American</td>
<td>5.7%</td>
<td>5.7%</td>
</tr>
<tr>
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</tr>
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<td>Hispanic, present, 2010</td>
<td>83.4%</td>
<td>83.7%</td>
</tr>
</tbody>
</table>

Disability

<table>
<thead>
<tr>
<th>Disability Status</th>
<th>Total</th>
<th>Caucasian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>95.0%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Under 17 years old with disability</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>18-64 years old with disability</td>
<td>3.0%</td>
<td>3.0%</td>
</tr>
<tr>
<td>65+ years old with disability</td>
<td>12.0%</td>
<td>12.0%</td>
</tr>
</tbody>
</table>

People Cont.
Appendix C: Data From Local Public Health Departments

**Education**

<table>
<thead>
<tr>
<th>Education</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 9th grade</td>
<td>2.0%</td>
<td>1.6%</td>
</tr>
<tr>
<td>9th to 12th grade</td>
<td>1.0%</td>
<td>0.8%</td>
</tr>
<tr>
<td>High School Graduate</td>
<td>15.6%</td>
<td>22.1%</td>
</tr>
<tr>
<td>Some College or degree</td>
<td>27.9%</td>
<td>30.6%</td>
</tr>
<tr>
<td>Associate degree</td>
<td>8.5%</td>
<td>8.2%</td>
</tr>
<tr>
<td>Bachelor's degree</td>
<td>16.3%</td>
<td>15.8%</td>
</tr>
<tr>
<td>Master's or Professional degree</td>
<td>31.2%</td>
<td>33.4%</td>
</tr>
<tr>
<td>High school graduate or higher percent of persons aged 25+, 2011</td>
<td>57.4%</td>
<td>45.7%</td>
</tr>
<tr>
<td>Bachelor's degree or higher, percent of persons aged 25+, 2009-2011</td>
<td>66.3%</td>
<td>71.0%</td>
</tr>
</tbody>
</table>

**Unemployment**

<table>
<thead>
<tr>
<th>Occupation Type</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>All unemployment</td>
<td>4.3%</td>
<td>4.6%</td>
</tr>
</tbody>
</table>
Appendix D: Data From Community Focus Group

4 Focus Groups
- Varying demographics
  - Clergy (9/15/15)
  - Elementary School Mothers (9/22/15)
  - Teenagers (9/23/15)
  - Seniors (10/8/15)

Held in community locations, food and/or gift cards given to all participants.

Clergy (North Denver Deanery Pastors)
Our Lady Mother Catholic Church – Commerce City, CO

**Current Resources**
- Counselors at Immaculate Heart of Mary Church
- Community Reach
- Jaffco Mental Health

**Current Gaps**
- Language (Spanish)
- Financial
- Availability (time)
- Lost in the system
- Immediate care/acute care & crisis care

**Partnerships**
- Clergy
- Schools
- Police
- Family

**Road Blocks**
- Lack of awareness
- Lack of trust
- Stigma
- Culture
- Lack of education
- Too long of process, lost in system
- Knowledge of hotline/phone numbers

Clergy (North Denver Deanery Pastors)
Our Lady Mother Catholic Church – Commerce City, CO

**Greatest Need:**
- TEENS
  - Addiction, substance abuse, self-harm, pornography
- Parents
  - Afraid of knowing, awareness, broken families, parents with low self-esteem & MH issues

**ACTION PLAN:**
- Carse/education - patients & families
  - Signs/symptoms of MH
  - Identification
  - Clergy & staff education
  - Legal responsibilities
- Stop the fear of reporting
- Trust
- Awareness of services
- Informational literature/pamphlets on MH
  - Bilingual
- Available at various locations

Clergy (North Denver Deanery Pastors)
Our Lady Mother Catholic Church – Commerce City, CO
Clergy (North Denver Deanery Pastors)
Our Lady Mother Catholic Church — Commerce City, CO

**Healthcare:**
- Training — assessment, what to say, who to refer to, what to do, next steps
- Provide translated resources, written materials
- APP for devices — information, resources, self-assessment, de-escalation, tips, live person to talk/massage with, hotline info
- KEEP IT SIMPLE
- More education
- Offer alternative therapies to medication
- More translation services (Spanish speaking chaplains, Spanish speaking instructors)

**Other Comments:**
- Some clergy felt animosity in ER setting (they are the outsider, unwelcomed)

---

Women (Hispanic mothers of elementary kids)
Mesa Elementary School, District 50 — Westminster, CO

**Current Resources**
- Clinica Campisina
- Community Reach
- Schools
- Internet
- Hospital

**Current Gaps**
- Language (Spanish)
- Financial
- Education
- More interpreters in HC

**Partnerships**
- Schools
- Communicate through the schools, P/T conferences

**Road Blocks**
- Language (Spanish)
- Financial

---

Women (Hispanic mothers of elementary kids)
Mesa Elementary School, District 50 — Westminster, CO

**ACTION PLAN:**
- Class/education — held at the schools
  - Teen classes — bullying, depression, stress, violence, drug/substance abuse
  - Parent classes — how to deal with teens, victims of violence, drug/alcohol abuse, women’s MH
- Sliding scale for MH costs
- More specialists
- More clinics for undocumented
- Informational literature/pamphlets on MH
  - Bilingual
  - Available in schools

**Greatest Need:**
- TEENS
- Parents
- Financial
Appendix D: Data From Community Focus Group

Women (Hispanic mothers of elementary kids)
Metz Elementary School, District 50 – Westminster, CO

Healthcare:
- Provide Resources—all kinds, written materials (bilingual)
- More education
- Offer alternative therapies to medication
- More translation services (Spanish speaking chaplains, Spanish speaking instructors)
- Support groups for mothers and teenagers

Other Comments:
- Lots of discussion on stress, depression
- Women’s abuse, sexual abuse

Teenagers (ages 12-16)
Boys & Girls Club (Highpoint) – Brighton, CO

Current Resources
- Friends
- Some parents
- School counselors (mostly academic though)

Current Gaps
- Someone to trust
- Someone with no judgment
- Few true therapists in schools
- No peer-to-peer groups

Partnerships
- NOT hospitals
- Friends (partnerships to them)
- Some family
- Some church leaders

Road Blocks
- Not enough training to support their friends
- Lack of trust
- Judgmental

Teenagers (ages 12-16)
Boys & Girls Club (Highpoint) – Brighton, CO

Greatest Need:
- Someone to go to—TRUSTWORTHY, non-judgmental, not get in trouble
- Money
Appendix D: Data From Community Focus Group

Teenagers (ages 12-16)
Boys & Girls Club (Shoemaker) – Brighton, CO

Healthcare:
- Support the schools
- Provide educational/informational materials
- Support Boys & Girls club staff with training on MH (and other leaders)

Other Comments:
- Safe places to go for support groups and classes
  - Libraries, coffee shops, hotels, churches, and some schools

Seniors (“Stepping On” Class)
64th Ave, Neighborhood Health Center – Westminster, CO

Current Resources: Friends (other seniors)
Some family members
Some PCPs

Current Gaps:
- Don’t know of programs
- LESS Awareness
- System: broken/too hard to navigate
- H/C workers talk at them not with them
- Insurance doesn’t cover it

Partnerships:
- Senior centers (MAC)
- 84th Ave NHC, Crisis center
- Churches
- Support Groups

Road Blocks:
- Themselves (naïve, unaware)
- Transportation
- Money
- Prescription drugs vs OTC drugs
- Ambulation (lack of)

Greatest Need:
- Loneliness
- Lack of friends/social interaction

ACTION PLAN:
- Social interactions and educational initiatives (community and hospital events)
- Information available at other locations (senior centers, library, libraries, etc.)
- Education classes:
  - Stress, depression, anxiety, MH/health first aid
  - Medication safety, medication awareness
  - PSS (Phone screen and psychotherapists)
    - More “stepping on” classes (in both sites)
  - Calling with reminders
  - Panic attacks
- Alternative therapies (Dancing, physical activities, music/art therapy, pet therapy)
- Classes offered for free/low cost for seniors, because insurance doesn’t cover
  Classes/prevention and senior low on tight budgets (excluding) to come for free
Appendix D: Data From Community Focus Group

Seniors ("Stepping On" Class)
34th Ave. Neighborhood Health Center – Westminster, CO

Healthcare:
- Stress/Depression
- Medication safety and awareness
- Fraud & Personal safety (fear of it)
- "Stepping On" classes (or classes like it)

Other Comments:
- "Society is going down"
  - Increased divorce rates, single parents, too much to handle by themselves—leads to people not thinking clearly
- Happy and surprised to be a part of a focus group where their opinions were asked and valued (not being told things)
- All extremely thankful!

Resources Summary
(from Focus Groups)

Clergy
- Counselors at Immaculate Heart of Mary Church
- Commonly read
- Affiliates Mental Health

Mothers
- Clinita Community Health
- School
- Internet
- Hospital

Teenagers
- Friends
- Some parents
- School counselors (mostly academic thought)

Seniors
- Friends (other seniors)
- Some family members
- Some PCPs

Gaps Summary
(from Focus Groups)

Clergy
- Language (Spanish)
- Financial
- Emotional
- More interpreters in HC

Mothers
- Language (Spanish)

Teenagers
- Someone to trust
- Someone with no judgment
- Fewer therapists in schools
- No peer-to-peer group

Seniors
- Don’t know of programs
- LESS Awareness
- System broken too hard to navigate
- HC works talk at them not with them
- Insurance doesn’t cover it

Partnerships Summary
(from Focus Groups)

Clergy
- Schools
- Police
- Family

Mothers
- Schools
- Community through the schools, PTA conferences

Teenagers
- Not hospitals
- Friends (partnerships to them)
- Some family
- Some church leaders

Seniors
- Senior centers (MAC)
- 34th Ave NMC, Crisis Center
- Church
- Support Groups

Road Blocks Summary
(from Focus Groups)

Clergy
- Lack of awareness
- Lack of trust
- Insult
- Culture
- Lack of education
- Too big of process, lost in system
- Knowledge of hotline/phone numbers

Mothers
- Language (Spanish)
- Financial

Teenagers
- Not enough training to support their friends
- Lack of trust
- Judgmental

Seniors
- Themselves (make, unable)
- Transportation
- Money
- Prescription drugs vs OTC drugs
- Ambulation (Mill)
### Greatest Need Summary
(from Focus Groups)

- **Clients**
  - TEENS
  - Mothers
  - Parents
- **Mothers**
  - TEENS
  - Parents
- **Teenagers**
  - Some people to go to
  - Trustworthiness
  - Non-judgmental
  - Not get in trouble
  - Money
- **Seniors**
  - Loneliness
  - Lack of meaningful interaction

### Action Plan Summary
(from Focus Groups)

- **Classes/Education**
  - Mental Health First Aid (MHFA)
  - Coping
  - Signs/symptoms/Recovery
  - "Stepping On" (for seniors)
  - Stress, depression, anxiety
  - TEENS (specific
  - Workplace stress
  - Relationships
  - Medication safety
- **Awareness**
  - Bilingual Services
  - Alternative Therapies
  - Support Groups
    - Peer-to-peer
    - Subject based
  - APP for phone/devices
    - "Safe-to-Tell"

### Healthcare Summary

- **Education**
- Support for schools
- Provide training for staff (B&G club, schools, etc.)
- Offer alternative therapies
  - Alternative to medication
- Provide Resources
- More bilingual services
- Create an APP
- Provide written information

### Questions...