Community Health Improvement Plan | 2022

Platte Valley
SCL HEALTH

Our mission is you.

TABLE of CONTENTS

Letter from the President

April 1, 2022

Dear Community Member,

At Platte Valley Medical Center, we take pride in providing the quality healthcare services our community needs while meeting them where they're at. We've been committed to serving you for more than 60 years.

One aspect of our ongoing commitment to community health improvement is our Community Health Needs Assessment (CHNA) which is conducted every three years. This assessment reveals the health issues that specifically impact our local population; helping us to create the services our community wants and needs today and in the future.

In order to understand and work to solve these complex health issues, we collaborate with community leaders, public health officials, and other community members to rank the order of health needs according to the highest level of importance in the community.

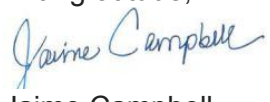
The top two priority needs identified were:

- Mental Health
- Access to Healthcare, specifically primary care providers and insurance coverage

In the following pages, you will find details about our data collection methodology, community profile, and information that we will use to implement our Community Health Improvement Plan (CHIP). The CHIP will direct our resources to address the priority needs identified and outline the actions we will take in the coming years to make the most impact.

Thank you to our community partners who wholeheartedly embraced this process. We look forward to sharing what we have learned and the steps we plan to take hereafter.

With gratitude,



Jaime Campbell
President

Introduction

The 2021 Platte Valley Medical Center Community Health Needs Assessment (CHNA) represents a systematic process that involves gathering community feedback, combined with public health data, to identify and analyze current community health issues and improvement opportunities. It is a demonstration of our care and concern for everyone who enters our doors. The mission of Platte Valley Medical Center is “to foster optimal health for all.” It also meets a requirement for regular surveillance and evaluation of public health issues impacting the hospital’s service community. This process is completed on a tri-annual basis.

Conducting the CHNA during a global pandemic presented advantages and disadvantages to the typical community engagement process, which usually includes in-person meetings in the form of focus groups and stakeholder interviews. Technology became a critical bridge in helping to overcome the limitations of “social distancing,” and, in many cases, the use of technology for virtual interviews and surveys expanded participation levels with the alleviation of drive times and transportation barriers. As a result, data were collected using a variety of sources including public health data, special research, and stakeholder forums conducted via online meetings or telephone. Finally, an additional advantage in this year’s assessment was the opportunity to expand data collection and to strengthen collaboration with other public health and healthcare organizations. Partners such as Tri-County Health Department, Weld County Health Department, Brighton Housing Authority, Colorado Health Institute, and members of the Metro Denver Partnership for Health (MDPH) agreed that working on a shared data collection model offered considerable benefits for on-going strategic development and overall health impact.

Working with its health partners and community health stakeholders (Appendix 2 and Appendix 3) in Brighton and local health departments, Platte Valley Medical Center (PVMC) has completed its 2021 CHNA and identified these priority areas for health improvement programming from 2022 through 2024:

- Mental Health
- Access to Healthcare

The complete CHNA report is available here.

Community Health Improvement Plans (CHIP)

The Community Health Improvement Plan (CHIP) is the second step in the community health engagement and improvement process. Health issues prioritized during the CHNA are further evaluated to consider available resources, community partners and evidence-based interventions that could deliver the most meaningful impact. The CHIP report summarizes specific goals, metrics, partners and desired outcomes that will be pursued during the three years of implementation. Each year, care sites have the opportunity to provide updates on progress, statistical changes and any shifts in strategic focus.

About Us

Background and Purpose

In 1960, the City of Brighton wanted to bring health care to the community. Leaders formed auxiliary teams, rallied troops, and went door to door until they raised $500,000 to open Brighton Community Hospital (BCH). BCH became the first private general medical-surgical hospital serving Adams and Southern Weld Counties and Colorado's first two-stage, hospital-nursing home medical unit licensed under one roof. In 1980, BCH became Platte Valley Medical Center.

Today, Platte Valley Medical Center (PVMC) is a secular hospital affiliated with SCL Health, Inc. PVMC affiliated with SCL Health in 2015 to strengthen its position and deliver more advanced care through the expansion of specialties and services. PVMC's work is a reflection of its care and concern for everyone who enters our doors. The mission of PVMC is "to foster optimal health for all."

The hospital serves patients in three cities:

- Brighton: Emergency and inpatient hospital, chest pain, stroke and trauma center, along with two medical office buildings for doctors' offices, a sleep lab, wound center, and outpatient imaging center.
- Commerce City (Reunion area): Pediatrics, family medicine, internal medicine, obstetrics, gynecology and high-risk pregnancy care in the medical plaza on Chambers Road and 104th Avenue.
- Fort Lupton: Walk-in clinic for urgent visits, occupational and family medical care in the medical plaza on Denver Avenue.

The passage of the Patient Protection and Affordable Care Act (ACA) requires tax-exempt hospitals to conduct Community Health Needs Assessments (CHNA) every three years, and adopt Community Health Improvement Plan (CHIP) Implementation Strategies to meet the priority health needs identified through the assessment. A CHNA identifies unmet health needs in the service area, provides information to select priorities for action and target geographical areas, and serves as the basis for community benefit programs. This assessment incorporates components of primary data collection and secondary data analysis that focus on the health and social needs of the service area.

Service Area

Platte Valley Medical Center is located at 1600 Prairie Center Parkway, Brighton, Colorado 80601. The primary service area includes six communities (including eight ZIP Codes) in Adams County and Weld County, Colorado. A majority of patient admissions at Platte Valley Medical Center originate from these cities.

Platte Valley Medical Center Service Area

City	ZIP Code	County
Brighton	80601, 80602	Adams
Brighton	80603	Weld
Commerce City	80022	Adams
Ft. Lupton	80621	Weld
Henderson	80640	Adams
Hudson	80642	Weld
Keenesburg	80643	Weld

Platte Valley Medical Center Service Area Map

Project Oversight

The CHIP process was overseen by:

Peggy Jarrett
Regional Director, Community Health Improvement
SCL Health, Platte Valley Medical Center and Good Samaritan Medical Center

E. Gaye Woods, MBA
System Director, Community Benefit
SCL Health

Data Collection Methodology

Quantitative and qualitative data collection methods, described below, were used to identify the community health needs.

Secondary Data Collection

Secondary data were collected from a variety of local, county, and state sources. For the CHNA, data are presented by ZIP code, Health Statistics Region (HSR), and county. When available, data sets are presented in the context of a comparison to Colorado state-wide data to help frame the scope of an issue as it relates to the broader community.

Secondary data for the service area were collected and documented in data tables with narrative explanation. The tables present the data indicator, the geographic area represented, the data measurement (e.g., rate, number, or percent), county and state comparisons (when available), the data source and data year. The report includes benchmark comparison data that measures PVMC data findings as compared to Healthy People 2030 objectives where available. Healthy People 2030 is a national initiative to improve the public's health by providing measurable objectives and goals that are applicable at national, state, and local levels.

Primary Data Collection and Community Surveys

PVMC conducted targeted interviews to gather information and opinions from persons who represent the broad interests of the community served by the medical center. A community survey was also used to collect information from community residents.

Colorado Health Institute (CHI), a Denver-based research and data analysis firm that works to provide health decision support and insights, developed and conducted a community survey on behalf of SCL Health. The survey was administered to more than 300 people in SCL Health's Front Range service region, including Denver, Jefferson, Adams, Weld, Broomfield and Boulder counties, from August 10 to August 23, 2021. The survey was provided in English and Spanish. CHI sent the electronic survey link to potential participants by email using Constant Contact, with limited additional outreach through personal emails and social media posts. SCL Health's internal communications team assisted with survey dissemination by sending targeted emails to local contacts. Through the use of zip code identification, survey results were segmented by each hospital's service area. Of the respondents, 49 were residents of Adams and Weld counties.

Key Informant Interviews

Seventeen (17) phone interviews were conducted for the CHNA from July 26 to September 9, 2021. Interview participants included a broad range of stakeholders (Appendix 3) concerned with health and wellbeing in Adams and Weld Counties who spoke to issues and needs in the communities served by the medical center.

The identified stakeholders were invited by email to participate in a phone interview. The stakeholder interviews were structured to obtain greater depth and richness of information on community needs identified as priorities through a discussion conducted with community representatives prior to the interviews. First, interview participants were asked to describe, from their perspectives, some of the major issues impacting the community as well as the social determinants of health contributing to poor health in the community. Interview participants were also asked to rate the impact and importance of each need prior to participating in the telephone interviews through a brief survey.

During the interviews, participants were asked to share their perspectives on the issues, challenges and barriers relative to the identified health needs (i.e.; what makes each health need a significant issue in the community? What are the challenges people face in addressing these needs?), along with identifying known resources to address these health needs, such as services, programs and/or community efforts.

The results of these community surveys are reported in the 2021 CHNA.

Resources to Address Significant Health Needs

One of the methods used to select prioritized needs was a review of the other community based organizations that are working in the need area. Identifying these additional resources helps to

inform potential collaborative strategies and efficiencies. It also recognizes the importance of leveraging existing expertise and trusted community leaders whether individual or organizational. Through the interview process, stakeholders identified community resources potentially available to address the significant health needs. A list of community resources available to address the significant health needs are presented in Appendix 1.

Public Comment

In compliance with IRS regulations for charitable hospitals, a hospital CHNA and Community Health Improvement Plan (CHIP) Implementation Strategy are to be made widely available to the public and public comment is to be solicited. The previous CHNA and CHIP Implementation Strategy were made widely available to the public on the website https://www.sclhealth.org/locations/platte-valley-medical-center/about/community-benefit/.

Public comment was solicited on the reports; however, to date no comments have been received.

Identification and Prioritization of Significant Health Needs

Significant health needs were identified from secondary data using the size of the problem (relative portion of population affected by the problem) and the seriousness of the problem (impact at individual, family, and community levels). To determine size or seriousness of the problem, the health need indicators identified in the secondary data were measured against benchmark data, specifically county rates, state rates and/or Healthy People 2030 objectives. Indicators related to the needs that performed poorly against one or more of these benchmarks met this criterion to be considered a significant need.

The analysis of secondary data yielded a preliminary list of significant needs. The initial list included:

- Access to health care
- Cancer
- COVID-19
- Dental care
- Diabetes
- Food insecurity
- Heart disease and stroke
- Housing
- Lung disease
- Mental health
- Overweight and obesity
- Substance use
- Unintentional injuries

Priority Health Needs

Community meetings and community surveys were used to gather input and prioritize the significant needs. The following criteria were used to prioritize the needs:

- The perceived severity of an issue as it affects the health and lives of those in the community
- The level of importance the hospital should place on addressing the issue.

Community Meeting to Prioritize Significant Needs

Hospital leaders, departmental representatives, and leaders from the community met on July 9, 2021 to discuss and prioritize the significant needs. A list of the meeting participants and their organizational affiliations can be found in Appendix 2. The meeting was a hybrid of in-person and virtual participation using Google Meet. The group received a summary of the secondary data. Following the presentation, the attendees met in small groups to discuss the 13 community needs. They were then asked to individually prioritize the top five issues in the Platte Valley Medical Center service area. The participants in the room were given five green dots and told to place a dot next to the five issues of greatest importance. Each dot represented one point. Participants who joined virtually wrote their top five issues in the Google Meet chat. After everyone voted, the votes were tallied up. The six issues with the most points became the top six priority needs.

1. Access to Health Care
2. Mental Health
3. Food Insecurity
4. Housing
5. Health disease and stroke
6. Diabetes

The identified significant community needs were also prioritized with input from interviews with key community stakeholders and with community members at three public events.

Prioritized Needs

A second round of prioritization consisted of Hospital leaders, departmental representatives, and leaders from the community. A list of the meeting participants and their organizational affiliations can be found in Appendix 2.The meeting occurred on September 15, 2021, to determine the priority needs to address for the next three years. The meeting was a hybrid of in-person and virtual participants using Google Meet. The group received a summary of the primary data collected from key informant phone interviews, public input from community events, and opinions collected from a community online survey. Following the presentation, attendees were given time in small groups to discuss the six issues and were asked to individually prioritize the top two issues in the Platte Valley Medical Center surrounding area.

The participants in the room were given a number one dot and a number two dot and told to identify the top two issues by placing a dot next to the two issues they felt were of greatest concern. The number one dot was worth two points and the number two dot was worth one point. People who joined virtually submitted their top two issues in the Google Meet chat. The priority needs identified were:

1. Mental Health
2. Access to Healthcare
3. Housing
4. Heart Disease/Stroke
5. Diabetes

Additional input regarding the availability of resources from the Platte Valley Medical Center Senior Leadership Team resulted in Mental Health and Access to Healthcare being chosen as the top two priorities to address for the next three years.

Acknowledging Our Community Partners

Thank you to our community partners and members. You are an important voice and ally in our efforts to improve the health of our communities.

Needs Not Prioritized

Each of the health needs identified in the CHNA process are important and PVMC along with numerous partners throughout the community are addressing these needs through various program interventions and initiatives. We have selected two need areas for priority over the next three years as a strategy to maximize resources and to accelerate impact.

Community Health Improvement Plan

There are five community health improvement core strategies that support program development. They are:

- Leverage community benefit investments toward the greatest area of impact to achieve our mission *(alignment with CHNA and vulnerable populations)*
- Utilize intervention strategies that are evidence-based and work to answer the sustainability question during program build
- Encourage innovation pilots that can address “dual” or disparate health needs
- Expand collective impact opportunities by engaging multi-sector partnerships
- Improve community engagement by highlighting community impact stories, increasing digital-based communication and attention to diversity, equity and inclusion initiatives

In addition, whenever possible we want to align measurement objectives with other community improvement efforts locally, regionally and nationally.

Priority: Mental Health

Mental health needs continue to present as an urgent and prevalent issue in many communities. Across the SCL Health system, most care sites have prioritized this issue as a community health improvement area of focus. However, issue differences driven by the specific needs of the hospital's service area population can be labeled in the priority as behavioral health, mental health or substance use disorder. To that end, PVMC uses some common definitions when talking about Mental Health.

- Behavioral Health is an umbrella term that is defined by the Substance Abuse & Mental Health Administration (a branch of the U.S. Department of Health and Human Services) as "…the promotion of mental health, resilience and wellbeing; the treatment of mental and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities." SAMHSA
- "Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community." (WHO, 2018)
- "Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home." SAMHSA

CHIP Priority: Mental Health	
Vision: We envision a community where behavioral health which affects overall well-being is supported through education and increased access to prevention and treatment services.	

Outcome Goal(s):
Decrease anxiety and poor mental health days for patients experiencing mental illness.
	Need Indicator(s):
	• 23.7% of people, ages five and older reported eight or more poor mental health days in the past month (2021) (CHNA 2021)
	• Age-adjusted suicide death rates per 100,000 (2020) (CHNA 2021)
	  ○ Adams County- 22.0
	  ○ Weld County- 17.0
	• Age-adjusted opioid overdose death rates per 100,000 (2020) (CHNA 2021)
	  ○ Adams County- 19.4
	  ○ Weld County- 10.7
	• Age-adjusted rates of emergency department

	visits mentioning intentional self-harm injuries per 100,000 (2020) (CHNA 2021) ○ Adams County- 128.5 ○ Weld County- 139.6 ○ Colorado-129.5 • Percentage of the adult population reporting more than 14 days of poor mental health per month (CHNA 2021) ○ Adams County- 11.8% ○ Weld County- 12.6% ○ Colorado- 10.9%
Objective: • Increase access to mental health services. • Increase the awareness of health care providers and the community of the prevalence of mental health illness and the importance of treatment.	**Community Partners:** • SCL Health Medical Group, Brighton Family Medicine and Integrated Internal Medicine • Community Reach Center • Eagle View Adult Center • Weld County Area Agency on Aging • Pennock Center for Counseling • Colorado Department of Public Health and Environment (CDPHE) Office of Suicide Prevention • Healthcare Quality Improvement Partnership • Rocky Mountain Crisis Partners • Colorado Department of Human Services's Office of Behavioral Health

Tactic(s)	Community Partner(s)	Metric	Status
Integrated Behavioral Health Program This is an evidence-based program whereby a behavioral health provider is embedded in an interprofessional model of care within the primary care setting to integrate behavioral health and primary care seamlessly.	SCL Medical Group, Brighton Family Medicine and Integrated Internal Medicine	1. 75% of patients, aged 18 and older at the participating clinics will have completed the Patient Health Questionnaire (PHQ) or the Generalized Anxiety Disorder Assessment (GAD7) at the end of twelve months of the program. 2. By the end of twelve months of implementation, increase the Press	Target: A Mental Health provider will be operational in the clinics by Q3, 2022. The clinics will implement a team-based model of care for integrated behavioral health by Q3, 2022. By Q3, 2023, the clinics will have baseline screening data with

		Ganey ambulatory clinic patient experience top box score (percentage of patients replying good or very good) by 3% for the question: *"Please rate: How well the staff worked together to care for you"* (survey sent only to people 18 or older).	which to develop quality improvement targets.
Mental Health First Aid training (MHFA) This one-day course teaches the signs and symptoms of a mental health crisis, what to do in an emergency, and where to get help.	Community Reach Center	Host 3 MHFA trainings per year.	Ongoing
Aging Mastery Program (AMP) training This is a 10-course program to help older adults age well, including through Healthy Relationships.	• Eagle View Adult Center • Weld County Area Agency on Aging • Pennock Center for Counseling	Host 2 AMP courses per year.	Ongoing
Zero Suicide Collaboration Zero Suicide is an evidence-based framework for safety and quality improvement in heath care, rooted in the belief that suicide deaths among people receiving care in health systems are preventable.	• CDPHE Colorado Office of Suicide Prevention • Healthcare Quality Improvement Partnership • Rocky Mountain Crisis Partners	1. Complete and submit a formal commitment from the hospital leadership to implement the program. 2. Complete and submit an organization self study. 3. Complete and submit a workforce study. 4. Submit a plan for implementing Zero Suicide framework, including training plan. 5. Submit the number	Completed Q4 2022 Q4 2022 Q4 2022 Q4 2022

		and percentage of staff that have received training. 6. 100% of individuals who screen positive for suicide risk are provided with an assessment for safety.	Q4 2022
Follow-Up Project Follow up services are telephonic caring contacts offered to clients discharging from an emergency department after experiencing a mental health crisis or overdose event. These contacts typically occur weekly for 30 days, a high risk time period post-discharge. This program is a collaboration among the office of Suicide Prevention, Rocky Mountain Crisis partners, the Office of Behavioral Health and other health systems in the state.	• CDPHE Colorado Office of Suicide Prevention • Rocky Mountain Crisis Partners • CDHS' Office of Behavioral Health	Track # of eligible patients, # of patients referred, # who accepted and declined the program.	Expected go-live date in Q2 2022

Priority: Access to Healthcare

Access to healthcare is a central category of SDoH and references a broad set of barriers that limits or prevents regular medical care, whether preventive or acute. Access examples include the availability of providers (including specialty care), cost of pharmaceuticals, proximity to a healthcare facility or a lack of insurance coverage. Often these barriers lead to unmet health needs, delays in regular primary care visits, and sometimes, death.

CHIP Priority: Access to Healthcare

Vision: We envision a community where people are able to have access to quality, affordable and culturally competent care, regardless of their situation.

Outcome Goal(s):

Improve overall health outcomes.

Need Indicator(s):

- Health Insurance Coverage, Civilian, Non-Institutionalization Population (2019) (CHNA 2021)
  - PVMC Service Area- 90.6%
  - Health Statistical Region (HSR) 14 Adams County- 90.9%
  - HSR 18 Weld County- 95.9%
  - Colorado- 93.5%
- Individuals who did not get doctor care that was needed due to cost in the last 12 months (2019) (CHNA 2021)
  - HSR 14 Adams County- 16.9%
  - HSR 18 Weld County- 12.1%
  - Colorado- 12.8%
- 60% of Community Interview responses to the question "*Who are some populations in your area who are not regularly accessing health care and social services?*" noted that Hispanic/Latino communities, including undocumented immigrants or migrant populations, were underserved (CHNA 2021).

Objective:

- Decrease barriers to accessing care for the Hispanic/Latino community.
- Increase Hispanic/Latino community members with a medical home.

Community Partners:

- Benefits in Action
- Community Connections
- Area Churches
- Almost Home
- Brighton Housing Authority

Tactic(s)	Community Partner(s)	Metric	Status
Provide one-on-one and group opportunities to speak with a representative to sign up for insurance or get connected with a primary care provider (PCP) to the Hipsanic/Latino community	• Benefits in Action • Community Connections • Area Churches • Almost Home • Brighton Housing Authority	Reach 75 individuals to either sign up for insurance or to get connected with a PCP by the end of 2022.	In process. Representative to be in place by Q3, 2022.
Provide health literacy education to the Hispanic/Latino community	• Benefits in Action • Area Churches • Almost Home • Brighton Housing Authority	Host two community seminars in 2022.	Currently under discussion. Benefits in Action representative to be in place by Q3, 2022.

Areas of Continued Work Improvement

Cardiovascular Health was chosen as a priority for the 2018 PVMC CHNA and even though it was not chosen as a top priority in this cycle, the hospital continues to support the work on this chronic health issue. In July of 2020, PVMC began an initiative to deliver medically tailored meals to eligible patients discharged to their primary home with a diagnosis of congestive heart failure in partnership with Project Angel Heart. Reduction of fluid retention, supported by a healthy diet, is shown to have a large impact on cardiac health. These patients were eligible to receive one meal a day for 30 days post discharge that limits salt intake and helps patients reduce fluid retention. This initiative has been funded through PVMC's Community Health Investment Program (CHIP) grant. Since the start of the program, 28 patients have chosen to participate in this program. The average readmission rate for patients who have received meals is now 10%, down from 20% in 2018 - a 50% reduction overall. Comments from program participants include:

"These meals have been such a blessing and positive addition to my mom's daily routine. As her caregiver, this has taken a great deal of stress off of me. The portions are perfect for her."

"It's great to have so many vegetables in Project Angel Heart's meals and with less salt. I have my weight under control and less salt helps with my blood pressure. Thank you."

"A recent doctor visit showed vast improvement in all aspects, including diabetes and high blood pressure. I am very grateful for Project Angel Heart's assistance in my diet."

Appendices

Appendix 1. Community Resources

Platte Valley Medical Center solicited community input through key stakeholder interviews to identify resources potentially available to address the significant health needs. These identified resources are listed in the table below. This is not a comprehensive list of all available resources. For additional resources refer to 2-1-1 Colorado at *https://211colorado.communityos.org/cms/node/142*.

Significant Needs	Community Resources
Access to Care	Adams County Human Services, Adams County Health Alliance, Adams County Health Department, Call-n-Ride, Clinica Family Services, Colorado Access, Cutlivando Colorado, Denver Regional Mobility and Access Council (DRMAC), Eagle View Adult Center, Health First Colorado Medicaid Enrollment Program, Kids First Health Care School-Based Center, North Colorado Health Alliance, Regional Care Collaborative for Medicaid Population, Regional Transportation District (RTD) Public Transportation, Salud Family Health Center, Senior Hub, Sunrise Community Health, Tri County Health Department, Tri County Human Services, Veyo Medicaid Transportation, Via Mobility, Weld County Health Department, Weld County Human Services
Diabetes	Adams County Human Services, Angel Heart Meals, Barbara Davis Center for Diabetes University of Colorado, Brighton Shares the Harvest, Colorado Access, Cultivate Boulder, Noom, North Colorado Health Alliance, Salud Family Health Clinic, Senior Hub, Sunrise Community Health, Tri County Human Services, Weight Watchers, Weld County Health Department, Weld County Human Services, Women Infant and Children Food and Nutrition Service (WIC)
Food Insecurity	Brighton Shares the Harvest, Boulder County Farmers Market, Center for People with Disabilities, Community Food Share, Emergency Family Assistance Association, Food Connect Colorado, Fruita Community Center, Helping Hands of Harvest, Joy's Kitchen, Meals on Wheels, Northglenn Christian Food Bank, Senior Hub, Senior Support Services, St Elizabeth's Pantry, Tin Shed Food Pantry, Waterstone Food Pantry, We Don't Waste
Heart Disease and Stroke	Adams County Health Department, American Heart Association, Colorado Access, Golden Eagle Senior Center, Rocky Mountain Stroke Center, Salud Family Health Center FQHC, Sunrise Community Health FQHC, Senior Hub, Tri County Health Department, Thriving Weld Community Partnership, Weld Aging Well, Weld County Health Department

Housing	Almost Home, Brighton Housing Authority, Catholic Charities, Boulder Shelter for the Homeless, Denver Rescue Mission, Family Homestead, Family Housing Network, Family Promise, Greeley Family House, Growing Home, Guadalupe Community Center, Hope @ Miracle House, House of Neighborly Service, Let Your Light Shine, Mile High Behavioral Healthcare Emergency Shelter, New Genesis, Salvation Army, Sacred Heart House of Denver, Unison Housing Partners, Volunteers of America Female Senior Shelter
Mental Health	Adams County Human Services, Adult and Juvenile Mental Health Courts, Aurora Mental Health Center, BAART Programs, Brighton Youth Commission, Center for Family Outreach, Colorado Crisis Services, Community Reach Center, Crisis Assessment Center, Family Integrated Treatment (FIT) Court, Heart-Centered Counseling, North Colorado Health Alliance, North Range Behavioral Health, Pennock Counseling Center, Richard Lambert Foundation Family Grief and Healing Center, Salud Family Health Center FQHC, Senior Hub, Sunrise Community Health FQHC, Sox Place, Thriving Weld Community Partnership, Tri County Human Services, United Way of Weld County, Weld County Human Services

Appendix 2. CHNA Prioritization Meeting Participants

Community Health Needs Assessment Prioritization Meeting July 9, 2021

Attendee	Title	Organization
Alicia Hinds	Quality and Safety Administrative Coordinator	PVMC
Ashley Dunn	Executive Director	Almost Home
Brian Wilson	Assistant Club Director	Boys and Girls Club
Caitlyn Major	Communications Manager	PVMC
Carolyn Jannsen	Executive Director of PVMC Foundation	PVMC
Danielle Humphrey	Director of Critical Care	PVMC
Debra Bristol	Chief of Staff	Brighton Housing Authority
Eric Aakko	Division Director, Health Education, Communication and Planning	Weld County Health Department
Evan Landvik	Director of Care Coordination and Behavioral Health	PVMC
Hannah Murphy	Clinical Dietitian Manager	PVMC
John Hicks	President, Platte Valley Medical Center	PVMC
Patrice Farrell-DeLine	Regional Vice President of Mission Integration	SCL Health
Peggy Jarrett	Regional Director of Community Health Improvement	PVMC
Stephanie Aldrich	Volunteer Services Supervisor	PVMC
Sue Corbett	Manager of Eagle View Adult Center	Eagle View Adult Center
Troy Stoehr	Chief Financial Officer	PVMC
Wendy Colon	Director, Emergency Department	PVMC

Community Health Needs Assessment Prioritization Meeting September 15, 2021

Attendee	Title	Organization
Alicia Hinds	Quality and Safety Administrative Coordinator	PVMC
Ashley Dunn	Executive Director	Almost Home
Brian Wilson	Assistant Club Director	Boys and Girls Club
Caitlyn Major	Communications Manager	PVMC
Carolyn Jannsen	Executive Director of PVMC Foundation	PVMC
Debra Bristol	Chief of Staff	Brighton Housing Authority
Gaye Woods	Director System Community Benefits	SCL Health
Hannah Murphy	Clinical Dietitian Manager	PVMC
Jennifer Morse	Vice President of Development	Salud Family Health Center
Jody Pierce	Executive Director	Pennock Center for Counseling
Patrice Farrell-DeLine	Regional Vice President of Mission Integration	SCL Health
Peggy Jarrett	Regional Director of Community Health Improvement	PVMC
Samantha McCrory	Diversity, Equity and Inclusion Coordinator	SCL Health
Stephanie Aldrich	Volunteer Services Supervisor	PVMC
Sue Corbett	Manager of Eagle View Adult Center	Eagle View Adult Center
Susan Chavez	Executive Director	Richard Lambert Foundation
Wendy Colon	Director, Emergency Department	PVMC

Appendix 3. CHNA Community Interviewees

Community input was obtained from interviews with public health professionals, representatives from organizations that represent medically underserved, low-income, or minority populations, and community residents.

Name	Title	Organization
Jonelle Addabbo, MCN, RDN	Government Programs Supervisor	Food Bank of the Rockies
Lisa Bitzer	Director of Operations	Via Mobility Services
Lisa Brody, MS, LPC	Program Manager	Community Reach Center
Haley Houtchens, BSN, RN, CPN, AE-C	Children's Hospital Nurse Consultant	Brighton School District 27J
Stephanie Knight	Executive Director	The Senior Hub
Patricia Lujan, MA	Treatment Center Director	BAART
Molly Markert	Contract Manager & Community Liaison	Colorado Access
Joy Memmen	Stroke/Chest Pain Coordinator	Platte Valley Medical Center
Jennifer Morse	Vice President of Development	Salud Family Health Centers
Jody Pierce	Executive Director	Pennock Center for Counseling
Emma Pinter	Commissioner	Adams County
Rhonda Plambeck	Student Health & Wellness Coordinator	Brighton School District 27J
Callie Preheim, MSPH	Population Health Epidemiologist	Tri-County Health Department
Desiree Quintanilla	Intervention Services Coordinator	Brighton School District 27J
Janet Rausch, RD	Outpatient Dietician, Wellness and Education	Platte Valley Medical Center
Paula Samide, RN, MSN, CCM, CCHC	District School Nurse	Weld RE-8 School District
Luzmaria Shearer	Member, PVMC Foundation Board and Patient Partnership Council (PPC)	Platte Valley Medical Center