Community Health Needs Assessment | 2021

Platte Valley
SCL HEALTH

Our mission is you.

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Letter from the President

December 1, 2021

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

In the following pages, you will find much detail about our data collection methodology, community profile, and information that we will use to implement our Community Health Improvement Plan. The Community Health Improvement Plan 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,

John Hicks
President/CEO

Executive Summary

The 2021 Platte Valley Medical Center Community Health Needs Assessment (CHNA) represents a systematic process that involves gathering extensive 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 the 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 in Brighton and the Tri-County Health Department, 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

Since the Last CHNA (2018):

In 2018, the last time PVMC conducted a CHNA, participants identified Mental Health/Substance Use and Cardiovascular Disease (Heart Disease and Stroke) as the top two priorities for Community Health Improvement Planning. These priorities from 2018 remain important to participants in the 2021 CHNA, but access to health care will be added as a priority. PVMC's prior community health improvement implementation period, from 2018 to 2021, included multi-level interventions aimed at impacting the following priority areas. Highlights include:

Mental Health/Substance Use

Colorado Alternatives to Opioids (ALTO) Project: PVMC participated in the Colorado ALTO project to decrease new opioid prescriptions to discharged patients and increase the use of e-prescribing of controlled substances for discharged patients.

NARCAN kit distribution: A program was initiated in 2021 to distribute NARCAN kits at discharge to any patient admitted with a diagnosis of heroin or opioid overdose or who is determined to be at-risk of an overdose in the future.

Mental Health First Aid: In collaboration with Community Reach Center, PVMC sponsored Mental Health First Aid training for staff and the community.

Question, Persuade and Refer (QPR) training: In collaboration with Pennock Center for Counseling and Mental Health Partners, PVMC sponsored QPR trainings on suicide prevention.

Grants for local mental health counseling services: PVMC's Community Health Investment Program supports local counseling centers through its grant process. Pennock Center for Counseling and the Richard Lambert Foundation have both received funding to help provide therapy services to low-income clients.

Cardiovascular Disease (Heart Disease and Stroke)

Heart attack and stroke education: The PVMC Chest Pain and Stroke Coordinator provides education on the signs and symptoms of heart attacks and strokes to the public and staff. Information on how COVID-19 can increase the incidence of strokes was introduced in 2020.

Cooking Matters: PVMC sponsored a six-week cooking class for the community called "Cooking Matters" to promote heart-healthy eating.

Stroke Support Groups: Monthly support groups are provided by the PVMC Physical Therapy staff. The Rocky Mountain Stroke Center provides collaboration with some of the groups.

Information about other CHNA related activities can be found in Appendix 6.

Methodology

Secondary data were collected from a variety of local, county, and state sources. When available, data are presented in the context of Adams County, Weld County, and Colorado to help frame the scope of an issue as it relates to the broader community. The report includes benchmark comparison data that compares Platte Valley Medical Center data findings to Healthy People 2030 objectives.

PVMC conducted targeted interviews to gather information and opinions from 17 persons who represent the broad interests of the community served by the medical center. Community input was gathered at three local events. An online community survey was also used to collect information from 49 community residents of Weld and Adams counties.

Identification 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). The analysis of secondary data yielded a preliminary list of significant health needs, which then informed primary data collection. The primary data collection process helped to validate secondary data findings, identify additional community issues, solicit information on disparities among subpopulations, and ascertain community assets to address needs.

The following significant community needs were determined:

- Access to Health care
- Cancer
- COVID-19
- Dental care
- Diabetes
- Overweight and Obesity
- Unintentional Injuries
- Food Insecurity
- Heart Disease and Stroke
- Housing
- Lung Disease
- Mental Health
- Substance Use

Priority Health Needs

Community stakeholders, hospital leaders and departmental representatives were asked to rank the health needs according to the highest level of importance in the community at a meeting on July 9, 2021. Their input resulted in the following prioritization of the significant health needs:

- Access to health care
- Mental health
- Food insecurity
- Housing
- Heart disease and stroke
- Diabetes

More than 350 area residents were engaged at three community events to provide a voice to the community needs process. Mental health, housing and access to health care emerged as the top

three prioritized needs from these community events. Stakeholder interviewees also prioritized the needs. Mental health and housing had the highest scores for severe impact on the community, needs that have worsened over time, and insufficient resources available to address the need. When asked to prioritize the health needs according to the highest level of importance in the community, access to health care and mental health were ranked as the top two priority needs in the service area. Finally, survey respondents were asked to identify the most pressing health concerns from a list of options. Adams County survey respondents identified behavioral health as the biggest health issue in the community. Weld County respondents identified substance use as the most pressing health concern.

Final Priority Needs

A second round of prioritization consisted of Hospital Leaders, departmental representatives, and leaders from the community. The meeting occurred on September 15, 2021, to discuss the primary data and to further rank the needs based on the data that had been gathered from the community and key informants. The results of this process was:

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.

Next Steps

With its top community health priorities identified in the CHNA (Mental Health, Access to Healthcare), PVMC will begin developing a Community Health Improvement Plan (CHIP). The CHIP will be complete in 2022 and represents the next steps in the community assessment process. This includes continuing work with community stakeholders to develop implementation strategies to address the identified need areas. The plan will present a deep dive of prioritized health areas looking at specific populations, disparities and barriers to improved outcomes. It will also highlight other organizations that are currently addressing similar issues within the community.

Introduction

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 System. 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 itsr care and concern for everyone who enters our doors. The mission of Platte Valley Medical Center 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, and 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 Implementation Strategies to meet the priority health needs identified through the assessment. A Community Health Needs Assessment 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.

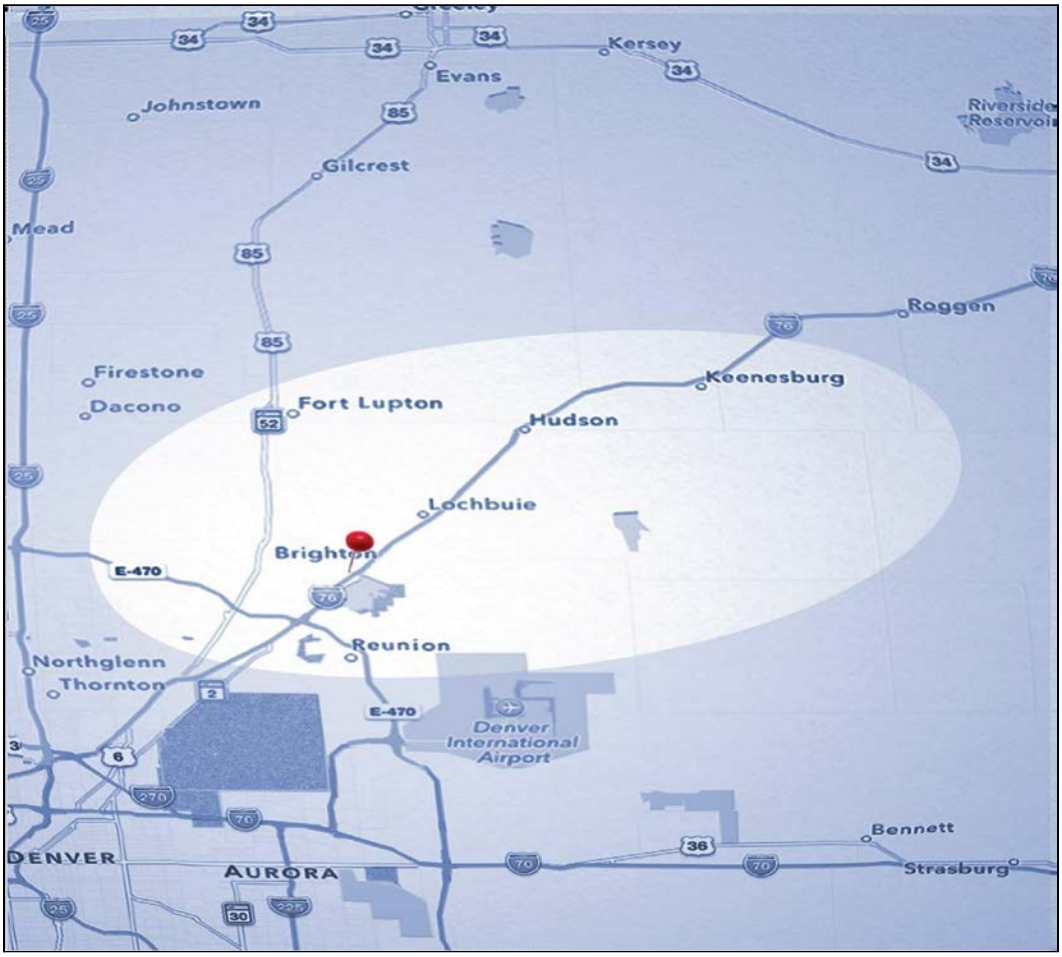
Service Area

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.

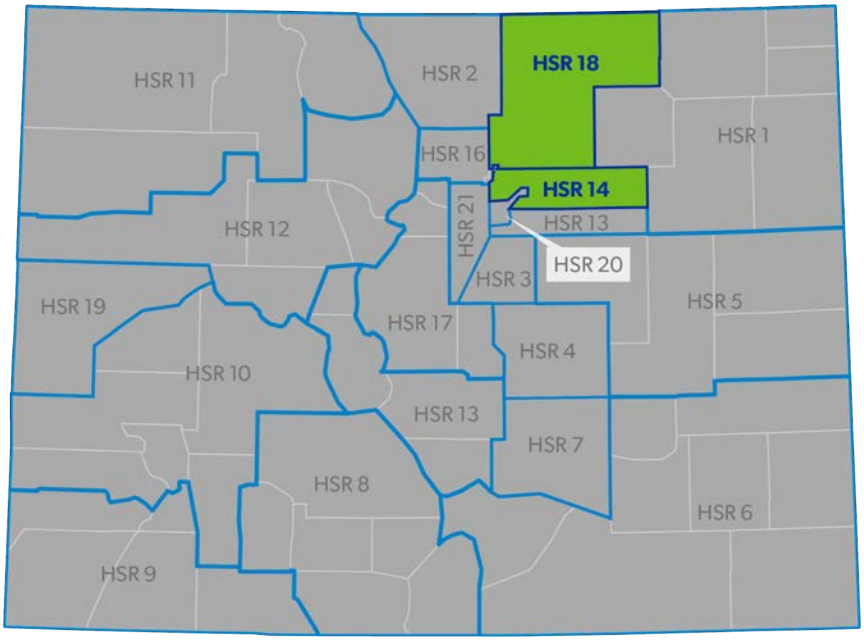
Platte Valley Medical Center Service Area

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



The Health Statistic Regions (HSR) for Platte Valley Medical Center is HSR 14 for Adams County, and HSR 18 for Weld County.



Project Oversight

The CHNA 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

Consultants

The Colorado Health Institute (CHI) was founded in 2002 to fill a need for nonpartisan, independent data and evidenced-based analysis to support decision-makers. CHI Director Allie Morgan, MPA; Policy Analyst Chrissy Esposito, MPH; and Policy Analyst Lindsey Whittington, MPH collected the secondary data and completed the community survey for the CHNA. www.coloradohealthinstitute.org

Biel Consulting, Inc. completed the CHNA report. Biel Consulting, Inc. is an independent consulting firm that works with hospitals, clinics and community-based nonprofit organizations. Led by Dr. Melissa Biel, Biel Consulting, Inc. has more than 20 years of experience conducting hospital CHNAs and is an expert in the field of community benefit for nonprofit hospitals. Melissa Biel was assisted by Caden Cerveris, MPA. www.bielconsulting.org

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, 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..

The results of these community surveys are reported in Appendix 1.

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 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. A list of the stakeholder interview respondents, their titles and organizations can be found in Appendix 2. Interview results are detailed in Appendix 3.

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 4.

Public Comment

In compliance with IRS regulations 501(r) for charitable hospitals, a hospital CHNA and Implementation Strategy are to be made widely available to the public and public comment is to be solicited. The previous CHNA and 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 medical center 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 5. 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.

Prioritized Needs

1. Access to health care – 15
2. Mental health – 15
3. Food insecurity – 13
4. Housing – 9
5. Heart disease and stroke – 9
6. Diabetes – 8

Community Input

Platte Valley Medical Center engaged community members at three events to further discuss and prioritize the needs. The first community event was held on July 22, 2021, at the City of Brighton Picnic and engaged 102 people. The second event was August 5, 2021, at the Adams County Senior Resource Fair and engaged 59 people. The third community event was held on September 11, 2021, at the Ft. Lupton Trappers Day and engaged 195 people.

A poster with the top identified issues was used to solicit additional community input. Community members were asked to think about the biggest problems in the community. They were then given two votes: One vote (worth two points) to identify a problem they felt was the biggest issue, and one vote for the second biggest issue (worth one point). The votes were tallied and yielded the following results:

Community Members Prioritization of Community Needs

	Mental Health	Access to Care	Housing	Diabetes	Heart Disease	Food Insecurity
#1 Points	292	112	146	84	64	32
#2 Points	86	100	52	38	31	30
Ranking Totals	**378**	**212**	**198**	**122**	**95**	**62**

Key Informant Interviews

The identified significant community needs were also prioritized with input from interviews with key community stakeholders. The following criteria were used to prioritize the needs:

- The perceived severity of a health or community issue as it affects the health and lives of those in the community.
- Improving or worsening an issue in the community.
- Availability of resources to address the need.
- The level of importance the hospital should place on addressing the issue.

Each of the stakeholder interviewees was sent a link to an electronic survey (Survey Monkey) in advance of the interview. The stakeholders were asked to rank each identified health need. The percentage of responses were noted as those that identified the need as having severe or very severe impact on the community, had worsened over time, and had a shortage or absence of resources available in the community. Not all survey respondents answered every question, therefore, the response percentages were calculated based on respondents only and not on the entire sample size. Mental health and housing had the highest scores for severe impact on the community, and needs that have worsened over time. Mental health and access to health care had the highest scores for insufficient resources available to address the need.

Significant Needs	Severe and Very Severe Impact on the Community	Worsened Over Time	Insufficient or Absent Resources
Access to health care	75.0%	50.0%	81.3%
Diabetes	31.3%	31.3%	50.0%
Food insecurity	75.0%	68.8%	68.8%
Heart disease and stroke	26.7%	20.0%	33.3%

Housing	81.3%	75.0%	75.0%
Mental health	93.8%	87.5%	93.8%

The interviewees were also asked to prioritize the health needs according to the highest level of importance in the community. The total score for each significant health need (possible score of 4) was divided by the total number of responses for which data were provided, resulting in an overall score for each significant need. Access to health care, mental health and diabetes were ranked as the top three priority needs in the service area. Calculations resulted in the following prioritization of the significant needs:

Significant Needs	Priority Ranking (Total Possible Score of 4)
Access to health care	4.00
Mental health	3.88
Diabetes	3.62
Food insecurity	3.56
Housing	3.47
Heart disease and stroke	3.46

Community Survey

Survey respondents were asked to identify the most pressing health concerns from a list of options. Adams County survey respondents identified behavioral health as the biggest health issue in the community. Weld County respondents identified substance use as the most pressing health concern.

	Most Cited Issue	2nd Most Cited Issue	3rd Most Cited Issue
Adams County	Behavioral health	Chronic illnesses	COVID-19-19
Weld County	Substance use	Access to health care	Violence/crime

Meeting to Finalize Priorities

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 5.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 health care
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.

Review of Progress from previous CHNA

In 2018, PVMC conducted its last most recent CHNA. Significant health needs were identified from issues supported by primary and secondary data sources gathered for the CHNA. The medical center's Implementation Strategy associated with the 2018 CHNA addressed:

- Mental Health/Substance Use
- Heart Disease/Stroke

Impact was planned through a commitment of community benefit programs and resources. The impact of the actions that PVMC used to address these significant health needs can be found in Appendix 6. Below are examples, addressing each priority area, illustrating impact during the 2018-2021 CHNA period.

Mental Health/Substance Use

Colorado Alternatives to Opioids (ALTO) Project: PVMC participated in the Colorado ALTO project to decrease new opioid prescriptions to discharged patients and increase the percentage of e-prescribing of controlled substances for discharged patients.

NARCAN kit distribution: A program was initiated in 2021 to distribute NARCAN kits at discharge to any patient admitted with a diagnosis of heroin or opioid overdose or those determined to be at-risk of a future overdose.

Mental Health First Aid: In collaboration with Community Reach Center, PVMC sponsored the Mental Health First Aid training for staff and community residents.

Question, Persuade and Refer (QPR) training: In collaboration with Pennock Center for Counseling and Mental Health Partners, PVMC sponsored QPR trainings on suicide prevention.

Grants for local Mental Health counseling services: PVMC's Community Health Investment Program supports local counseling centers through its grant process. Pennock Center for Counseling and the Richard Lambert Foundation have both received funding to increase availability of therapy sessions to low-income clients.

Cardiovascular Disease (Heart Disease and Stroke)

Heart Attack and Stroke Education: The PVMC Chest Pain and Stroke Coordinator provides on-going education on the signs and symptoms of heart attacks and strokes to the public and staff. Information on how COVID-19 can increase the incidence of strokes was also introduced in 2020.

Cooking Matters: PVMC sponsors a six-week cooking class called "Cooking Matters" to promote heart healthy eating.

Stroke Support Groups: Monthly support groups are provided by the PVMC Physical Therapy staff. The Rocky Mountain Stroke Center collaborates to provide support with some of the groups.

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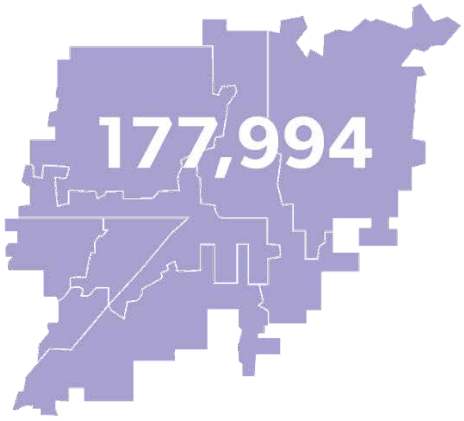
Community Profile

Population

On average, from 2015 to 2019, the population of the PVMC service area was 177,994. Adams County had a population of 504,108, and Weld County's population was 305,345. Colorado's total population was 5,610,349.

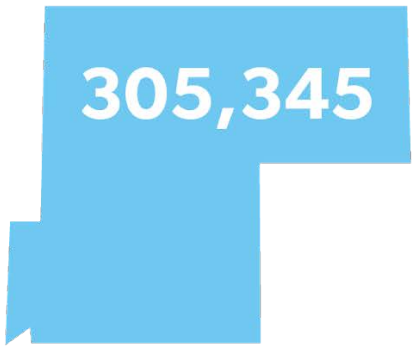
TOTAL POPULATION

PVMC SERVICE AREA



ADAMS COUNTY

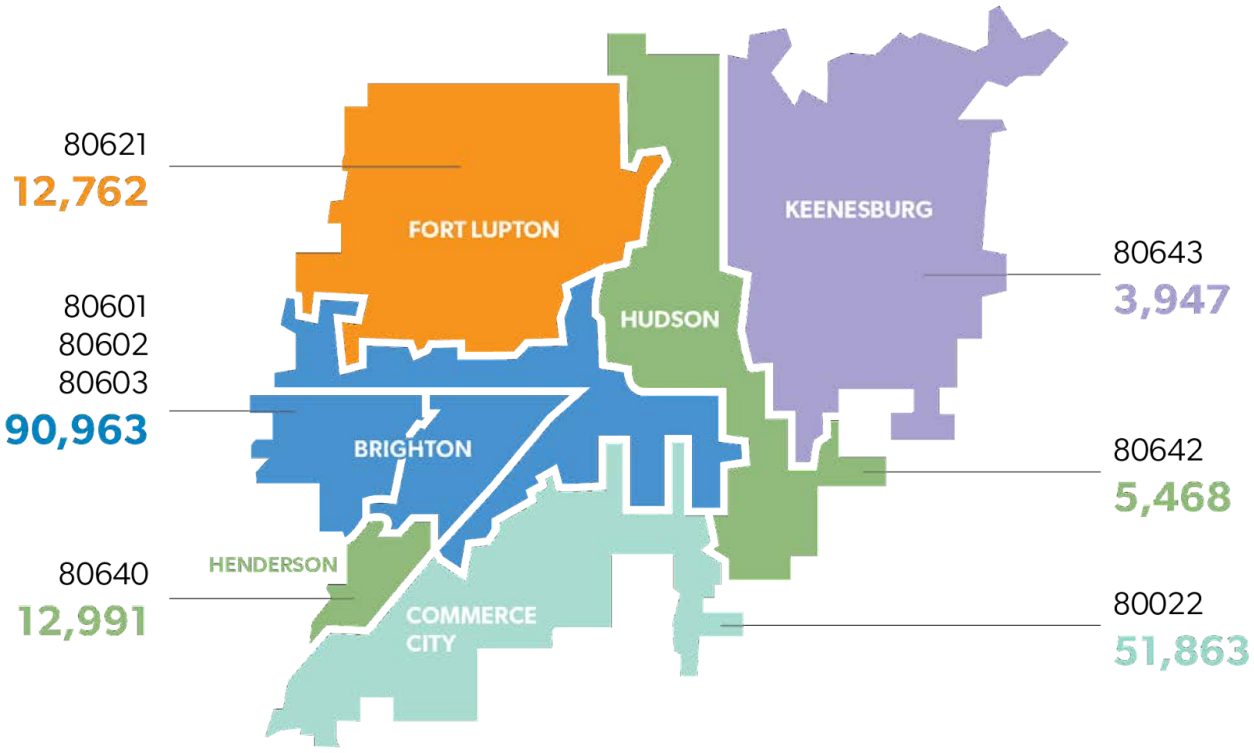
WELD COUNTY



COLORADO

Source: Colorado Health Access Survey, SCL Health CHNA Database 2019 | https://www.coloradohealthinstitute.org/research/CHAS

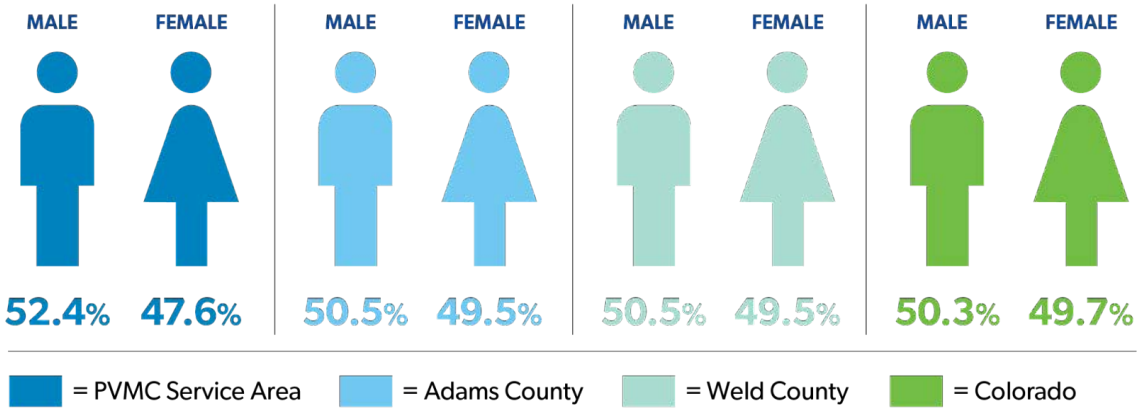
POPULATION, BY ZIP CODE



Source: American Community Survey, SCL Health CHNA Database 2015-2019. https://data.census.gov/cedsci

In the service area, 52.4% of the population was male and 47.6% was female. In Colorado, 50.3% of the population was male and 49.7% was female.

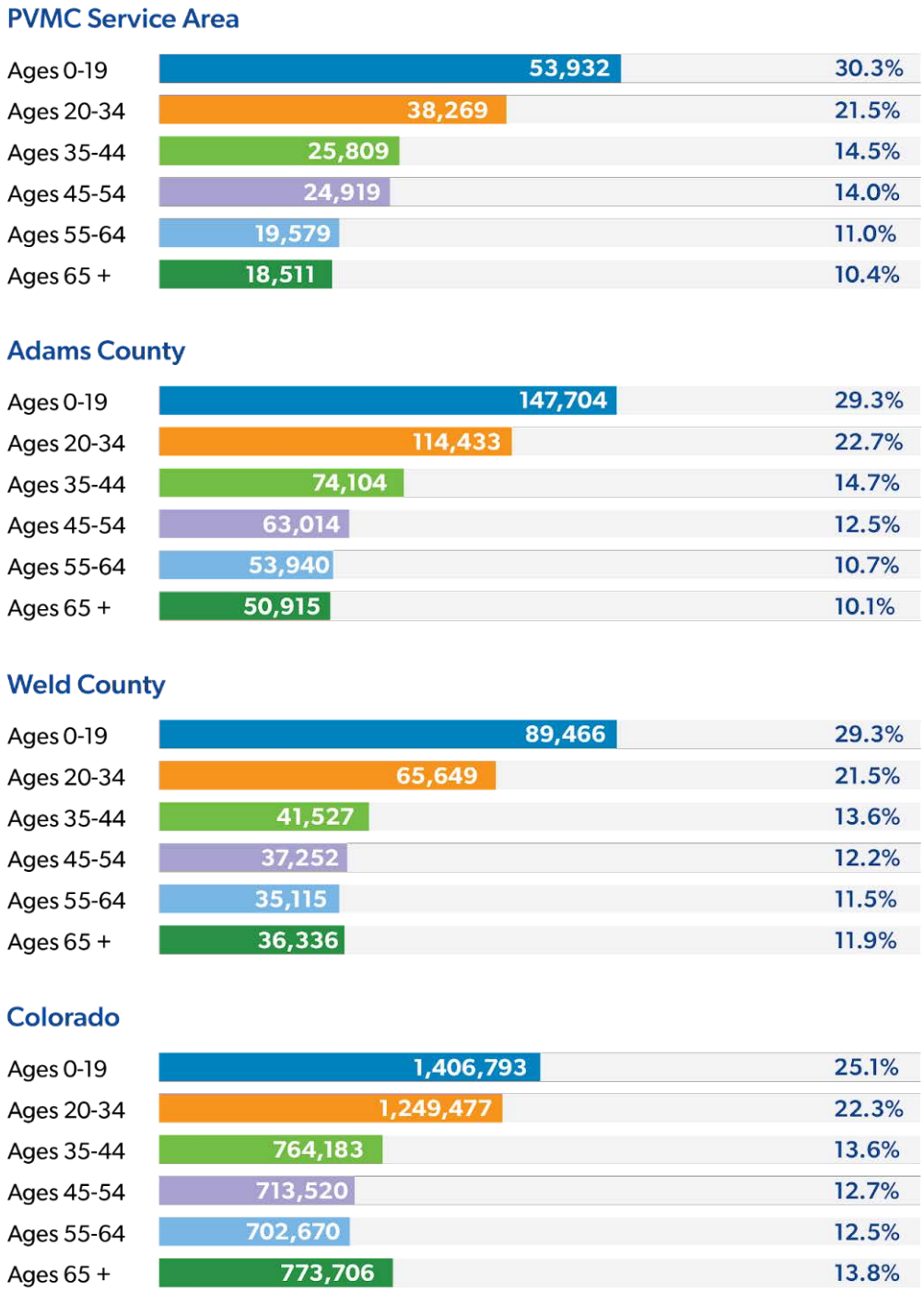
POPULATION BY GENDER



Source: American Community Survey, SCL Health CHNA Database 2015-2019. https://data.census.gov/cedsci/

Youth, ages 0 – 19, make up 30.3% of the population in the service area. About 60% of the population was 20 to 64 years old and 10.4% were 65 years and older. The service area had a higher percentage of youth, ages 0-19 and adults, ages 35-44 and 45-54, than found in Colorado.

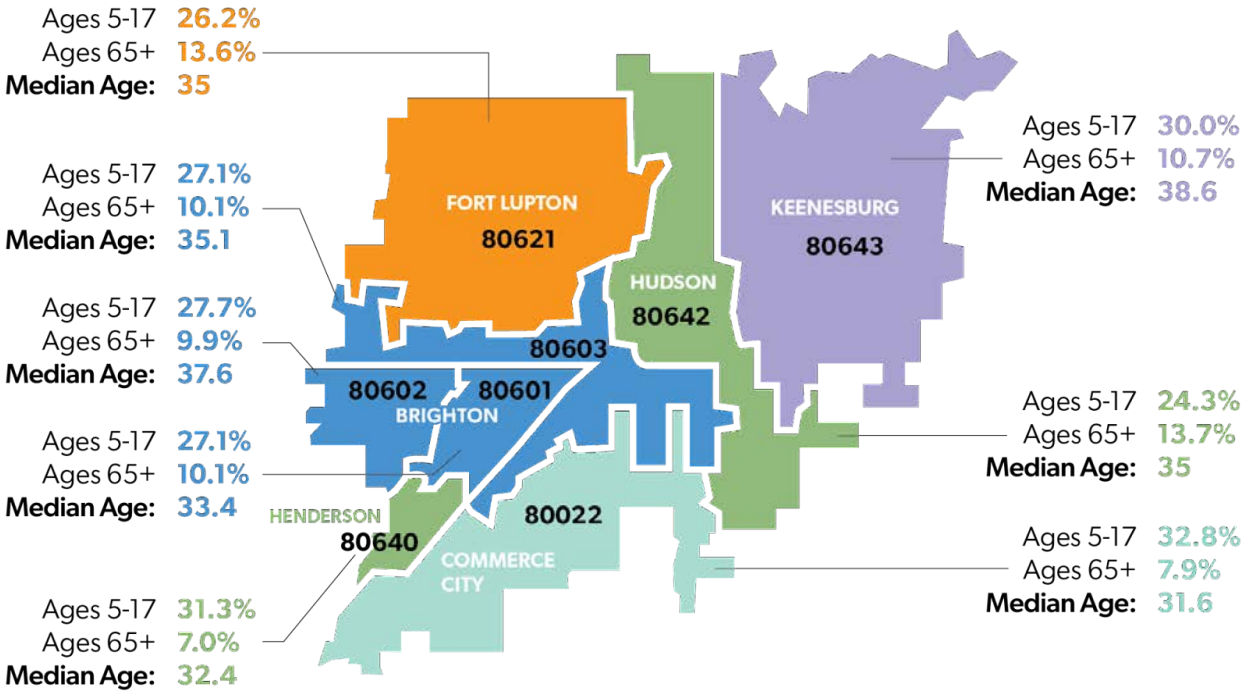
POPULATION, BY AGE



Source: American Community Survey, SCL Health CHNA Database 2015-2019. https://data.census.gov/cedsci

Commerce City had the largest percentage of youth, ages 5-17 (32.8%) and Henderson had the smallest percentage of seniors (7.0%) in the service area. Hudson had the smallest percentage of youth (24.3%). Hudson had the highest percentage of seniors (13.7%) in the service area.

POPULATION, BY YOUTH, SENIORS AND MEDIAN AGE



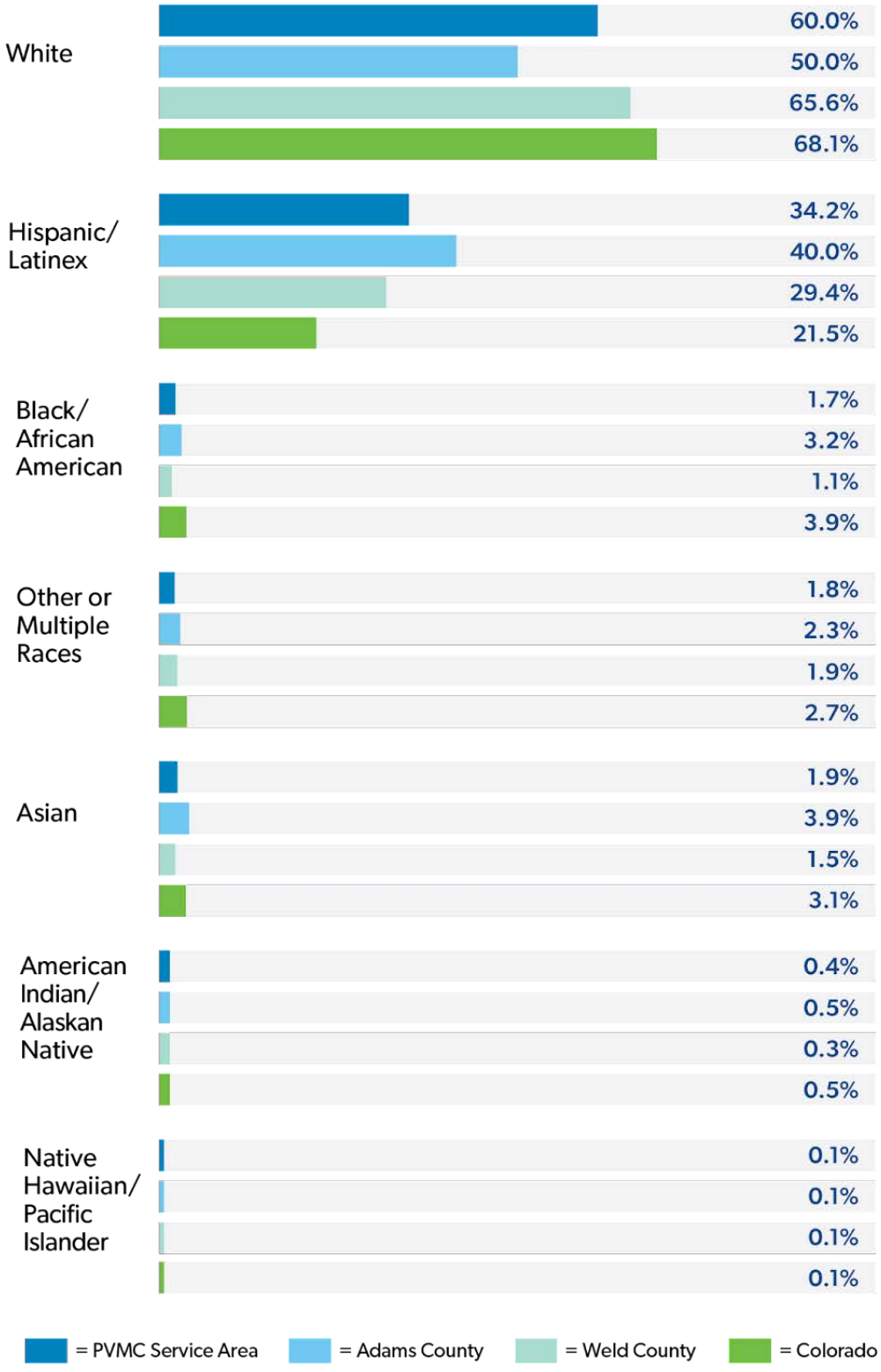
Adams County		Weld County		Colorado	
Ages 5-17	27.0%	Ages 5-17	26.3%	Ages 5-17	22.5%
Ages 65+	10.1%	Ages 65+	11.9%	Ages 65+	13.8%
Median Age:	33.8	Median Age:	34.4	Median Age:	36.7

Source: American Community Survey, SCL Health CHNA Database 2015-2019. https://data.census.gov/cedsci

Race and Ethnicity

In the service area, 60.0% of the population is White, 34.2% are Hispanic/Latinx, 1.9% are Asian, and 1.7% are Black/African American. The service area had a higher percentage of Hispanic/Latinx residents (34.2%) than Colorado (21.5%).

RACE/ETHNICITY



Source: American Community Survey, SCL Health CHNA Database 2015-2019. https://data.census.gov/cedsci

Over half of the population in Commerce City (53.4%) is Hispanic or Latinx. Brighton 80602 has the highest percentage of Asians (6.9%) in the service area. Commerce City also has the highest percentage of African Americans (4.7%).

Race/Ethnicity, by Place

	ZIP Code	White	Hispanic Latinx	Asian	Black/African American
Brighton	80601	56.3%	36.0%	3.0%	1.6%
Brighton	80602	72.1%	16.9%	6.9%	1.2%
Brighton	80603	61.3%	35.4%	0.7%	1.5%
Commerce City	80022	37.5%	53.4%	1.6%	4.7%
Ft. Lupton	80621	51.3%	45.9%	0.0%	0.6%
Henderson	80640	50.6%	43.9%	2.6%	1.3%
Hudson	80642	70.6%	25.7%	0.0%	2.3%
Keenesburg	80643	80.3%	16.5%	0.0%	0.3%
Colorado		**68.1%**	**21.5%**	**3.1%**	**3.9%**

Source: American Community Survey, SCL Health CHNA Database 2015-2019. https://data.census.gov/cedsci/

Language

Over three-quarters of the service area population, ages 5 years and older, speak only English in the home (76.9%). About 23% speak a language other than English at home, and 20.5% of the population speaks Spanish at home. These rates are higher than found in Colorado.

Language Spoken at Home, Population 5 Years and Older

	PVMC Service Area	Adams County	Weld County	Colorado
Speaks language other than English at home	23.1%	29.0%	19.3%	16.9%
Speaks Spanish at home	20.5%	23.6%	17.0%	11.7%

Source: American Community Survey, SCL Health CHNA Database 2015-2019. https://data.census.gov/cedsci/

Social Determinants of Health

Social determinants of health (SDoH) are defined by Healthy People 2030 as “conditions in the environments in which people live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.”[1] SDoHs typically include five broad focus areas: economic stability, education, social and community context, health and health care, and neighborhood and built environment.

Increasingly, SDoH areas are being prioritized within CHNAs as health systems acknowledge the drivers of poor health outcomes and the many influences that are outside of the clinical setting. For example, a patient’s zip code is a better predictor of health than genetics. As a result, hospitals are joining local public health departments in addressing these root causes to improve patient care and overall health outcomes. Addressing the upstream sources of a patient’s condition is key to improving overall population health, and over the past two cycles of conducting the CHNA, PVMC has prioritized SDoH areas in food access, access to care, and education.

[1] https://www.cdc.gov/socialdeterminants/faqs/index.htm

KEY TAKEAWAYS:

SOCIAL DETERMINANTS OF HEALTH (SDOH)

SDOH

Social determinants of health (SDOH) have a major impact on people's health, well-being, and quality of life. Examples of SDOH include:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

— Healthy People 2030 (image and content)

Social Determinants of Health

Vaccine Event Spot Survey

In March 2021, we surveyed 1,389 of the 5,000 attendees at an SCL Health community vaccination event to gain an understanding of urgent needs. Our findings showed that Social Isolation was a pressing concern for those surveyed. Respondents also reported a need for accessible health services, housing & transportation, and availability of providers.

Most Impactful Health Influencers

Food and Housing — *Colorado Health Foundation Food Insecurity Executive Report*

Food Security has the following social benefits:

- Positively impacts long-term self-sufficiency (employment options/$$)
- Reduces poverty
- Increased high school graduation by 18%
- Poor nutrition is a leading contributor to diseases that disproportionately affect minorities and low-income populations

People Who Experienced Social or Financial Challenges Reported Worse Health

Percentage reporting fair or poor general health, 2021

Housing unstable: **45.1%**	Housing stable: **10.1%**
Food insecure: **40.2%**	Food secure: **9.7%**
Lacked child care:* **12.3%**	Had child care:* **6.5%**
Uninsured: **22.8%**	Insured: **11.9%**
Unemployed: **23.3%**	Employed: **10.8%**

"There have been three main requests: food security, economic stability, and mental/behavioral health resources."

- Eric Moore, Director of Advocacy, The Center for African American Health, Colorado Health Access Survey pg.16

Transportation

"How does transportation affect health and opportunity? Better transportation options mean better access to opportunity. When transit options are built with accessibility and affordability in mind, the benefits ripple far and wide through increased jobs, stimulating the economy, and connecting communities to schools, business and services."

– CDPHE Health Equity Guide (image and content)

Social Effects of Reliable Transportation

- Access to Better Jobs
- Access to Schools for Kids
- Access to a Larger Variety of Foods
- Access to Services (i.e. Doctor, Childcare, Etc.)

SCL Health Highlighted Partners

Almost Home Inc.

a precious child — Empowering Kids to Succeed

Housing Authority City of Brighton

To learn more consider these additional data supports:

Colorado Health Access Survey 2021
www.coloradohealthinstitute.org/research/colorado-health-access-survey-2021

CDPHE Health Equity Guide 2018
drive.google.com/file/d/11yomHCix8Q3yHQBDf3Ecm3MPWQVXxqzy/view

Colorado Health Foundation Food Insecurity Executive Report
coloradohealth.org/sites/default/files/documents/2017-06/Food_Insecurity_FINAL.pdf

Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion
health.gov/healthypeople/objectives-and-data/social-determinants-health

American Community Survey
www.census.gov/programs-surveys/acs

Poverty

Poverty thresholds are used for calculating official poverty population statistics and are updated each year by the Census Bureau. For 2019, the federal poverty threshold for one person was $12,490, and for a family of four, $25,750. In the service area, 8.7% of the population was living at or below 100% of the Federal Poverty Level (FPL), and 24.6% were considered low-income (living at or below 200% FPL). These poverty rates were lower than the county rates of poverty. Colorado had higher rates of people living below 100% (10.3%) and 200% (25.4%) of the poverty level compared to the service area (8.7% and 24.6%, respectively).

Ratio of Income to Poverty Level, Total Population

	Below 100% Poverty	Below 200% Poverty
PVMC Service Area	8.7%	24.6%
Adams County	10.8%	29.0%
Weld County	10.0%	26.5%
Colorado	10.3%	25.4%

Source: American Community Survey, SCL Health CHNA Database 2015-2019. https://data.census.gov/cedsci/

Unemployment

Within the service area, Commerce City (4.9%) and Ft. Lupton (4.7%) had the highest unemployment rates and Keenesburg had the lowest unemployment rate (1.7%). Colorado had an unemployment rate of 4.3%, higher than the service area (3.7%).

Unemployment Rate of Civilian Labor Force

	ZIP Code	Total Population	Unemployment Rate
Brighton	80601	40,766	4.0%
Brighton	80602	36,262	2.6%
Brighton	80603	13,935	3.9%
Commerce City	80022	51,863	4.9%
Ft. Lupton	80621	12,762	4.7%
Henderson	80640	12,991	4.5%

Hudson	80642	5,468	3.3%
Keenesburg	80643	3,947	1.7%
Adams County		**504,108**	**4.0%**
Weld County		**305,345**	**4.1%**
Colorado		**5,610,349**	**4.3%**

Source: American Community Survey, SCL Health CHNA Database 2015-2019. https://data.census.gov/cedsci/

Free and Reduced-Price Meals

The number of students eligible for the Free and Reduced-Price Meal (FRPM) program is one indicator of the socioeconomic status of a school district's student population. The percent of students in Adams County eligible for the FRPM program was 54.3%. In Weld County, 42.8% of students were eligible for the program. In Colorado, 41.7% of students were eligible for the FPRM program.

Eligibility for Free and Reduced-Price Meals (FRPM) Program

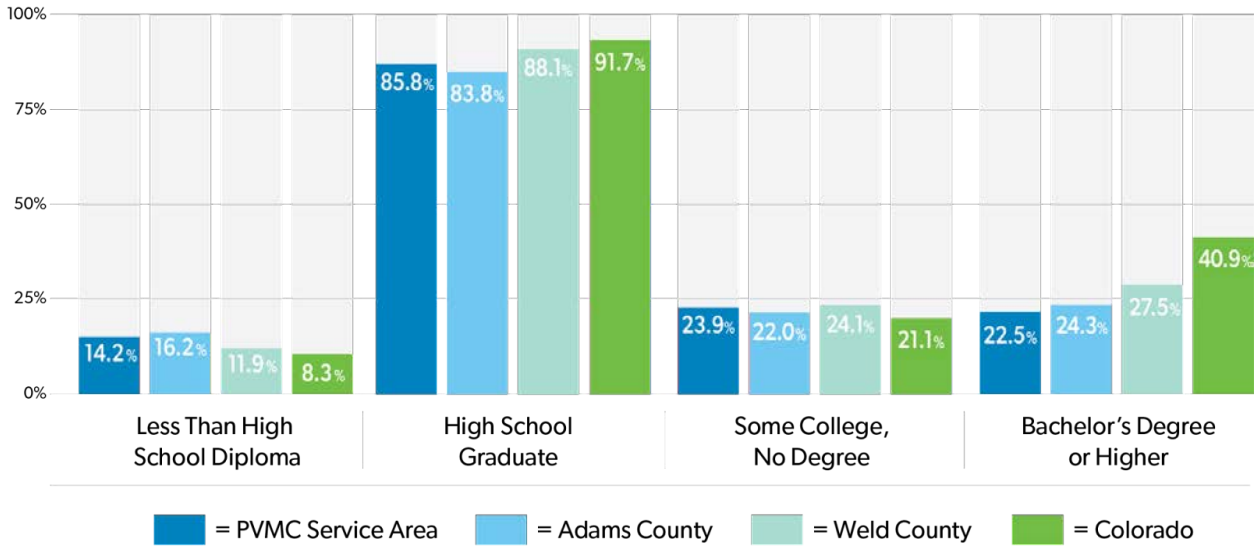
	Percent Eligible Students
Adams County	54.3%
Weld County	42.8%
Colorado	41.7%

Source: National Center for Education Statistics, SCL Health CHNA Database 2017-2018. https://nces.ed.gov/

Educational Attainment

Of the service area population, ages 25 and older, 14.2% had not attained a high school diploma and 85.8% were high school graduates. Just under 24% of the population in the service area had some college with no degree, and 22.5% had a bachelor's degree or higher. Colorado had a higher rate of residents who received a bachelor's degree (40.9%) compared to the service area (22.5%) and had a higher high school graduation rate (91.7%) compared to the service area (85.8%).

EDUCATIONAL ATTAINMENT



Source: American Community Survey, SCL Health CHNA Database 2015-2019. https://data.census.gov/cedsci

Homelessness

A Homeless Point in Time (PIT) Count is a federally mandated count of persons experiencing homelessness at any given night in a community. In 2020, the Weld County PIT Count was January 28, and, given the newness of the Northern Colorado Continuum of Care, only a sheltered count was completed. The total number of sheltered homeless in Weld County at the PIT Count in 2020 was 240 persons. Of the sheltered homeless, 73% were housed in emergency shelters, 15% were chronically homeless and 34% had a disabling condition.

Sheltered Homeless Populations, Weld County, 2020

	Percent
Sheltered in emergency shelter	73%
Sheltered in transitional housing	27%
Chronic homeless	15%
Homeless persons with disabling condition	34%

Source: Northern Colorado CoC, Final Report: 2020 Point in Time & Housing Inventory Count.
https://static1.squarespace.com/static/5da886a66a98d11269213f2b/t/5fb6b8701aa1f505a1eb3d68/1605810305644/2020+HIC++PIT+Count+report_FINAL.pdf

In Adams County, only a sheltered homeless count was conducted in 2021. The total number of sheltered homeless in Adams County at the PIT Count in 2021 was 346 persons.93.6% of the

sheltered homeless were housed in emergency shelters, 21.1% were chronically homeless and 19.9% had a chronic health condition.

Sheltered Homeless Populations, Adams County, 2021

	Percent
Sheltered in emergency shelter	93.6%
Sheltered in transitional housing	6.4%
Chronic homeless	21.1%
Homeless persons with chronic health condition	19.9%

Source: Metro Denver Homeless Initiative, 2021 Sheltered Point in Time Count. https://www.mdhi.org/pit

Access to Health Care

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.

KEY TAKEAWAYS:

ACCESS TO HEALTH CARE

2021 UNINSURED RATES BY REGION

Health Statistics Region	Percentage
1. Northeast	4.8%
2. Larimer County	8.0%
3. Douglas County	3.0%
4. El Paso County	5.2%
5. Central Eastern Plains	5.0%
6. Southeast	7.8%
7. Pueblo County	4.9%
8. San Luis Valley	6.4%
9. Southwest	8.1%
10. Gunnison and Dolores Valleys	7.2%
11. Northwest	7.6%

Health Statistics Region	Percentage
12. I-70 Mountain Corridor	10.2%
13. Upper Arkansas Valley	13.2%
14. Adams County	9.7%
15. Arapahoe County	8.0%
16. Boulder-Broomfield	4.6%
17. Clear Creek, Gilpin, Park, and Teller Counties	7.9%
18. Weld County	5.2%
19. Mesa County	9.8%
20. Denver County	7.5%
21. Jefferson County	3.3%
Colorado	6.6%

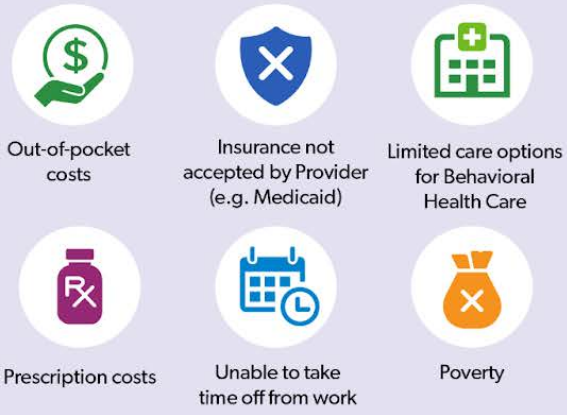
Data from Colorado Health Access Survey 2021 p. 10

2019 vs 2021 Data

Colorado Uninsured Rate Remained Low Despite the Economic Downturn

CHAS Survey 2021

BARRIERS TO CARE



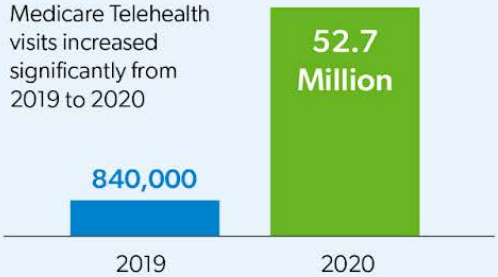
SCL HEALTH

Across our system, addressing **Access to Health Care is a continual strategic priority** for community health improvement. Our approaches emphasize whole person care and attention to address root causes.

- Graduate **Medical Education Training**
- Expanding **Clinical** and **Allied Health Professions Education**
- **Charity Care** and **Government Programs**
- **Subsidized Health Services**
- Access to **Telehealth services**
- **Prevention programs** (e.g. Mammograms, Diabetes Self-Management, Falls Prevention)

MEDICARE TELEHEALTH

Medicare Telehealth visits increased significantly from 2019 to 2020



Behavioral Health Providers experienced highest use, followed by primary care and other specialists.

National study results of the U.S. Dept. of HHS

TO LEARN MORE CONSIDER THESE ADDITIONAL DATA SUPPORTS

Colorado Health Access Survey 2021
https://www.coloradohealthinstitute.org/research/colorado-health-access-survey-2021

Colorado Data and Statistics
https://cdphe.colorado.gov/colorado-data-and-statistics

U.S. Department of Health & Human Services
https://aspe.hhs.gov/reports/medicare-beneficiaries-use-telehealth-2020

Behavioral Risk Factor Surveillance System 2016-2018
https://cdphe.colorado.gov/vision-visual-information-system-for-identifying-opportunities-and-needs

SCL Health
www.sclhealth.org/about/community-benefit

Health Insurance

Health insurance coverage is considered a key component to access health care. The Healthy People 2030 objective is for 92.1% of the population to have health insurance coverage. In the service area, 90.6% of the population were insured. Insurance coverage was higher in Weld County (95.9%) than in Adams County (90.9%). Health insurance coverage ranged from 87.5% in Hudson 80642 to 96.3% in Brighton 80602.

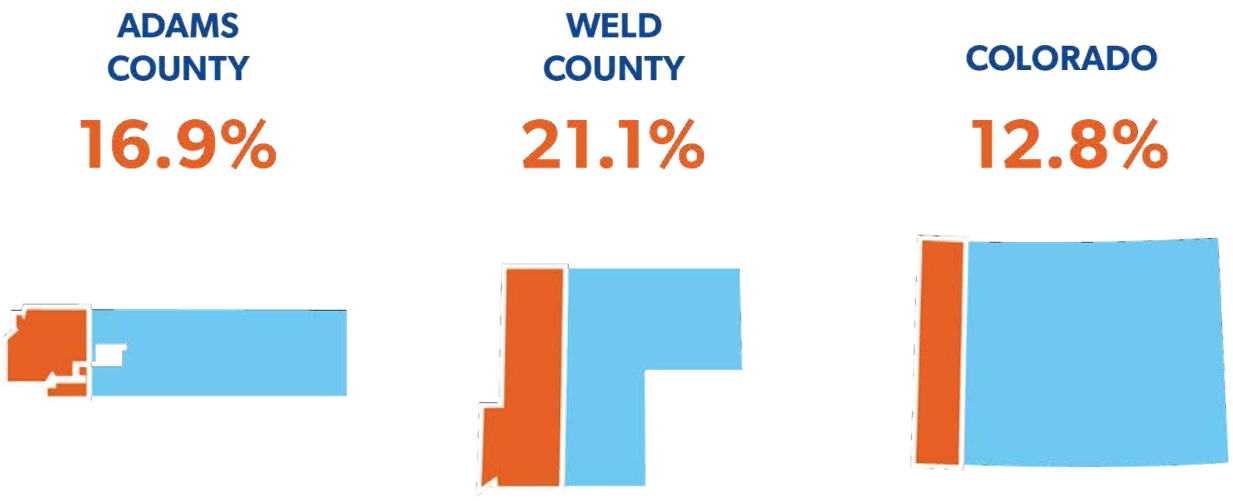
Health Insurance Coverage, Civilian Non-Institutionalization Population

	ZIP Code	Percent
Brighton	80601	91.6%
Brighton	80602	96.3%
Brighton	80603	87.9%
Commerce City	80022	89.3%
Ft. Lupton	80621	90.8%
Henderson	80640	91.7%
Hudson	80642	87.5%
Keenesburg	80643	89.4%
PVMC Service Area		**90.6%**
Adams County		**90.9%**
Weld County		**95.9%**
Colorado		**93.5%**

Source: Colorado Health Access Survey (HSR)/American Community Survey, SCL Health CHNA Database 2015-2019. Colorado Health Access Survey: https://www.coloradohealthinstitute.org/research/CHAS

Approximately 17% of adults in Adams County and 12% of adults in Weld County had an unmet medical need and were not able to afford care. Just under 13% of Colorado residents did not receive needed care.

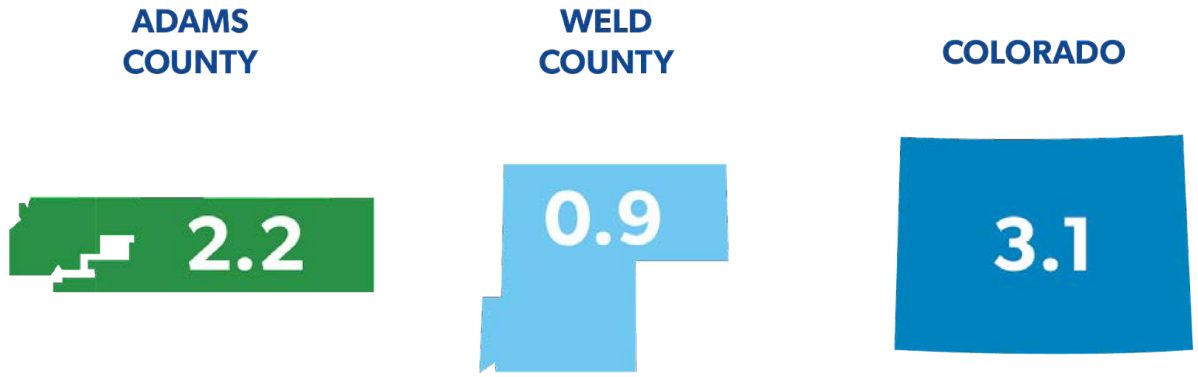
INDIVIDUALS WHO DID NOT GET DOCTOR CARE
that was needed, due to cost – last 12 months



Source: Colorado Health Access Survey, SCL Health CHNA Database 2019 | https://www.coloradohealthinstitute.org/research/CHAS

The primary care physician ratio represents the number of licensed physicians per 1,000 persons. The number of primary care physicians per 1,000 persons in Adams County was 2.2 and in Weld County it was 0.9. There were 3.1 licensed physicians per 1,000 persons in Colorado.

PRIMARY CARE PHYSICIANS RATE
per 1,000 persons



Source: Colorado Health Access Survey, SCL Health CHNA Database 2019 | https://www.coloradohealthinstitute.org/research/CHAS

Emergency Department Utilization

PVMC tracks Emergency Department (ED) utilization through EPIC, its Electronic Medical Record system. Nearly 27% of Adams County residents and 21.4% of Weld County residents visited an emergency room in the last 12 months.

Emergency Department Utilization

	Adams County	Weld County	Colorado
Received care at an emergency room in the last 12 months	26.7%	21.4%	20.8%

Source: Colorado Health Access Survey, SCL Health CHNA Database 2019. https://www.coloradohealthinstitute.org/research/CHAS

Dental Care

About 69% of adults in Adams County visited a dentist within the past 12 months and 73.3% visited a dentist in Weld County. However, 25.5% of adults in Adams County and 16.8% of adults in Weld County did not get the dental care they needed because of cost. Almost 74% of Colorado residents had a dental visit last year and 20.6% needed dental care but did not get it due to cost.

Access to Dental Care

	Adams County	Weld County	Colorado
Adult dental visit in last year	69.1%	73.3%	73.6%
People who needed but did not get dental care due to cost	25.5%	16.8%	20.6%

Source: Colorado Health Access Survey, SCL Health CHNA Database 2019. https://www.coloradohealthinstitute.org/research/CHAS

Birth Indicators

Fertility Rate

In 2019, the general fertility rate, per 1,000 women, ages 15 to 44, in Adams County was 59.5. The rate was 61.5 per 1,000 women in Weld County. Colorado's fertility rate was lower at 53.7 per 1,000 women.

Fertility Rate, per 1,000 Women Ages 15 to 44

	Rate
Adams County	59.5
Weld County	61.5
Colorado	53.7

Source: Colorado Department of Public Health and Environment, Vital Statistics Birth Records, SCL Health CHNA Database 2018. https://cdphe.colorado.gov/vitalrecords

Prenatal Care

Adequate prenatal care can prevent health risks in women and prevent health problems for the mother and child. Slightly more than 90% of women in Adams County received care in the first trimester (9.3% did not) and 92.3% of pregnant women in Weld County received care in the first trimester (7.7% did not).

Received Prenatal Care in 1st Trimester of Pregnancy

	Percent
Adams County	90.7%
Weld County	92.3%
Colorado	89.9%

Source: Pregnancy Risk Assessment Monitoring System, SCL Health CHNA Database 2017-2019.
https://cdphe.colorado.gov/center-for-health-and-environmental-data/survey-research/pregnancy-risk-assessment-monitoring

Low Birth Weight

Low birth weight is a negative birth indicator. Babies born at a low birth weight are at higher risk for disease, disability and possibly death. For this measurement, a lower rate is a better indicator. Adams County had an 8.7% rate and Weld County had an 8.6% rate of low-birth weight among single baby births.

Low Birth Weight Single Births as a Percentage of All Single Births

	Percent
Adams County	8.7%
Weld County	8.6%
Colorado	9.4%

Source: Colorado Department of Public Health and Environment, Vital Statistics Birth Records, SCL Health CHNA Database 2018.
https://cdphe.colorado.gov/vitalrecords

Infant Mortality

The infant mortality rate is the number of deaths of infants (less than one year old) per 1,000 live births. The Healthy People 2030 objective has an infant mortality rate goal of 5.0 per 1,000 live births. The infant mortality rate in Adams County was 5.2 per 1,000 live births and in Weld County it was 4.8 per 1,000 live births. The rates in Weld County are lower than the Healthy People 2030 objective.

Infant Mortality Rate, per 1,000 Live Births

	Rate
Adams County	5.2
Weld County	4.8
Colorado	4.6

Source: National Center for Health Statistics – Mortality Files, SCL Health CHNA Database 2012-2018. https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm

Breastfeeding

Breastfeeding provides considerable benefits to both baby and mother. The Colorado Department of Public Health and Environment recommends babies are fed only breast milk for the first six months of life. 93.4% of infants born in Adams County were breastfed and 92% of infants born in Weld County were breastfed.

Infants Who Were Ever Breastfed

	Percent
Adams County	93.4%
Weld County	92.0%

Source: Pregnancy Risk Assessment Monitoring System, SCL Health CHNA Database 2017-2019. https://cdphe.colorado.gov/center-for-health-and-environmental-data/survey-research/pregnancy-risk-assessment-monitoring

Postpartum Depression

Postpartum depression is defined as depression that occurs after childbirth and can include symptoms such as loss of appetite, intense irritability, and difficulty bonding with the baby. In Adams County, 11.2% of women experienced postpartum depression and 9.6% of women in Weld County experienced postpartum depression.

Postpartum Depression

	Percent
Adams County	11.2%
Weld County	9.6%

Source: Pregnancy Risk Assessment Monitoring System, SCL Health CHNA Database 2017-2019. https://cdphe.colorado.gov/center-for-health-and-environmental-data/survey-research/pregnancy-risk-assessment-monitoring

Mortality/Leading Causes of Death

Age-Adjusted Death Rate

The crude death rate is a ratio of the number of deaths to the entire population. Age-adjusted death rates eliminate the bias of age in the makeup of the populations being compared. When comparing across geographic areas, age-adjusting is typically used to control for the influence that different population age distributions might have on health rates. When adjusted for age, the death rate for Adams County was 764.0 per 100,000 persons and in Weld County the death rate was 646.6 per 100,000 persons.

A premature death rate is a death rate for a person under the age of 75. The premature death rate in Adams County was 318.8 per 100,000 persons and in Weld County the premature death rate was 284.9 per 100,000 persons.

Age-Adjusted Death Rate and Premature Age-Adjusted Death Rate Under Age 75, per 100,000 Persons

	Premature Age-Adjusted Rate	Age-Adjusted Death Rate
Adams County	318.8	764.0
Weld County	284.9	646.6
Colorado	282.0	667.0

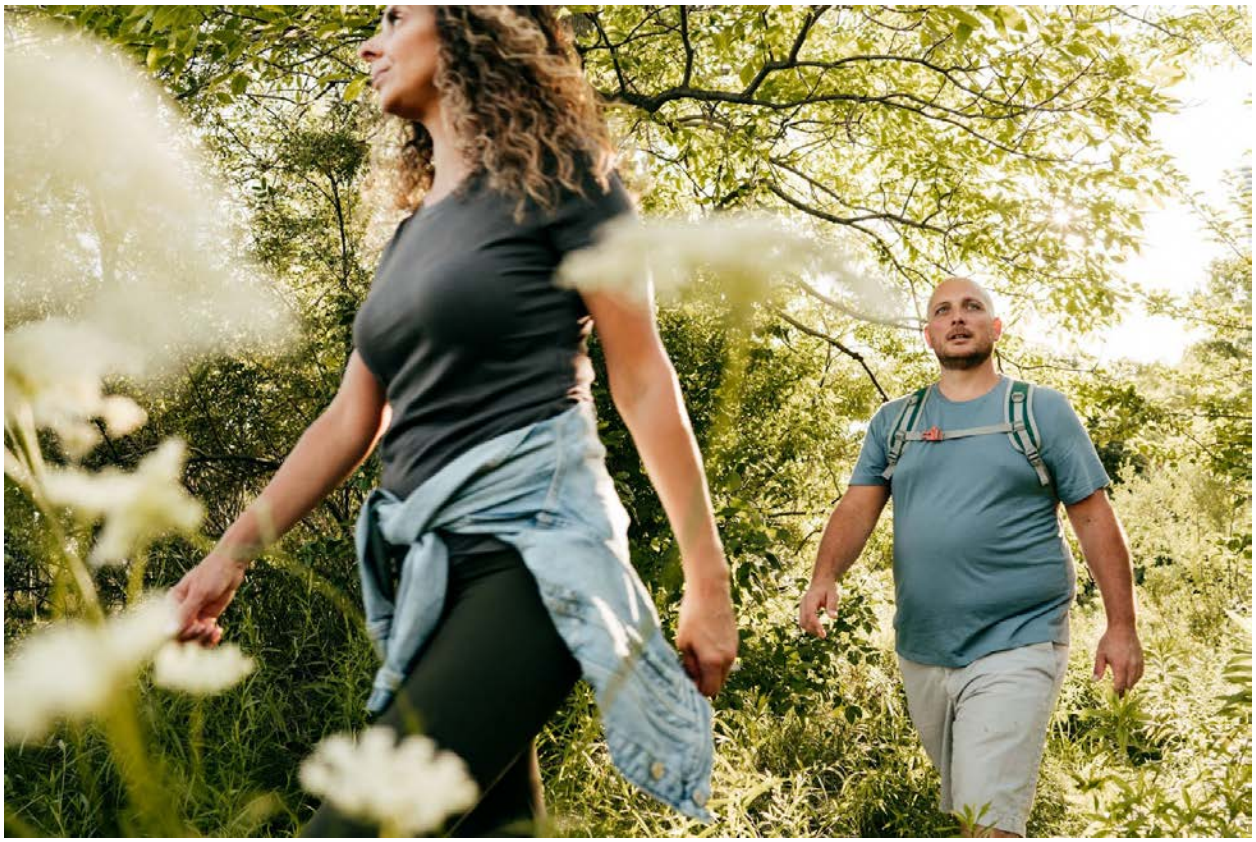
Sources: National Center for Health Statistics – Mortality Files, SCL Health CHNA Database 2016-2018. https://www.cdc.gov/nchs/data_access/Vitalstatsonline.htm
Colorado Department of Public Health and Statistics Death Records, SCL Health CHNA Database 2018. https://cdphe.colorado.gov/vitalrecords

Adams County had higher rates of death than Weld County and the state for the leading causes of death.

Leading Causes of Death, Age-Adjusted Rates for, per 100,000 Persons

	Cancer (All Types)	Diabetes	Heart Attack	Heart Disease	Accidental Falls
Adams County	140.3	24.3	27.6	149.7	17.6
Weld County	133.2	20.9	10.9	115.8	14.8
Colorado	125.1	17.8	15.2	124.7	16.2

Sources: National Center for Health Statistics – Mortality Files, SCL Health CHNA Database 2016-2018. https://www.cdc.gov/nchs/data_access/Vitalstatsonline.htm
Colorado Department of Public Health and Statistics Death Records, SCL Health CHNA Database 2018. https://cdphe.colorado.gov/vitalrecords



Health Behaviors

Fair or Poor Health

When asked to self-report on health status within the past month, 11.8% of adults in Adams County and 11.1% of adults in Weld County indicated they were in fair or poor health. Just more than 9% of adults in Colorado reported poor physical health for 14 or more days within the last month.

Poor Physical Health for 14 or More Days in the Last Month, Adults, Ages 18 and Older

	Percent
Adams County	11.8%
Weld County	11.1%
Colorado	9.1%

Source: Behavioral Risk Factor Surveillance System, SCL Health CHNA Database 2016-2018. https://www.coloradohealthinstitute.org/

Falls

Falls are a leading cause of injury among older adults. The Emergency Department injury rate due to falls was 402.6 per 100,000 persons in Adams County and 420.2 per 100,000 persons in Weld County. In Colorado, the rate was slightly higher at 384.9 per 100,000 persons.

Emergency Department Injury Rate Due to Falls, Age-Adjusted, per 100,000 Persons

	Percent
Adams County	402.6
Weld County	420.2
Colorado	384.9

Source: Colorado Health Information Dataset, SCL Health CHNA Database 2020.
https://cohealthviz.dphe.state.co.us/t/PSDVIP-MHPPUBLIC/views/InjuryIndicatorsDashboard/LandingPage?%3AshowAppBanner=false&%3Adisplay_count=n&%3AshowVizHome=n&%3Aorigin=viz_share_link&%3AisGuestRedirectFromVizportal=y&%3Aembed=y

Overweight and Obesity

28.4% of adults in Adams County and 29.3% of adults in Weld County are obese. In Adms County, 67.6% of residents are overweight or obese, and in Weld County, the percentage of overweight or obese adults is 64.8%. Across Colorado, 58.5% of adults are overweight or obese and 22.6% of Colorado adults are obese.

Obesity and Overweight, Ages 18 and Older

	Adams County	Weld County	Colorado
Adult obesity	28.4%	29.3%	22.6%
Adult overweight or obese	67.6%	64.8%	58.5%

Source: Behavioral Risk Factor Surveillance System, SCL Health CHNA Database 2016-2018.
https://cdphe.colorado.gov/vision-visual-information-system-for-identifying-opportunities-and-needs

Food Environment Index Score

A food environment index is an index of factors that contribute to a healthy food environment. An index score of 10 is the best ranking for a healthy food environment. Adams County had a food environment index score of 8.7 and Weld County had a food environment index score 8.8. Colorado had a food environment index score of 8.4. Weld County had the highest level of food-related cost burden with 13.3% of residents reporting not eating enough food due to lack of income. Adams County had the highest rate of food inaccessibility among low-income residents (5.6%).

Food Environment Index Score

	Rate	Cost Burden	Low Income/Lack of Access
Adams County	8.7	11.6%	5.6%
Weld County	8.8	13.3%	4.9%
Colorado	8.4	9.6%	5.5%

Source: USDA Food Environment Atlas, Map the Meal Gap from Feeding America, SCL Health CHNA Database 2015 & 2017. https://www.ers.usda.gov/data-products/food-environment-atlas/

Physical Activity

Adams County (93.1%) and Weld County (78.3%) have access to locations for physical activity. 23.1% of adults in Adams County were sedentary and did not participate in any leisure time physical activity in the past 30 days. More than 21% of adults in Weld County were sedentary. In Colorado, 90.5% of residents had access to locations for physical activity, and 16.1% of residents reported no leisure time physical activity.

Physical Activity

	Adams County	Weld County	Colorado
Access to locations for physical activity	93.1%	78.3%	90.5%
Adult physical inactivity	23.1%	21.5%	16.1%

Sources: Behavioral Risk Factor Surveillance System, SCL Health CHNA Database 2016-2018. https://cdphe.colorado.gov/vision-visual-information-system-for-identifying-opportunities-and-needs Business Analyst/ Delorme map data, ESRI, & US Census Tigerline Files, 2010 & 2019 https://www.countyhealthrankings.org/reports/state-reports/2020-colorado-report

Chronic and Communicable Diseases

Chronic Disease

Chronic diseases last more than three months, cannot be prevented by vaccines or cured by medication, and they do not disappear. High blood pressure is a precursor to other chronic diseases, including heart disease and stroke. More than 26% of Adams County residents have high blood pressure levels, compared to 25.8% of Colorado residents, ages 18 and older, who have been diagnosed with elevated blood pressure.

Elevated Blood Pressure

	Adams County	Weld County	Colorado
Elevated blood pressure	26.3%	25.1%	25.8%

Source: Behavioral Risk Factor Surveillance System, SCL Health CHNA Database 2015-2017.
https://cdphe.colorado.gov/vision-visual-information-system-for-identifying-opportunities-and-needs
https://cdphe.colorado.gov/vision-visual-information-system-for-identifying-opportunities-and-needs

Among adults in Adams County, 8.4% have been diagnosed with diabetes, which was a lower rate than found in Weld County (8.6%). Three percent of Weld County adults and 3.6% of Adams County adults have been diagnosed with a heart attack. About 11% of adults in Adams County and 8.7% of Weld County adults had been diagnosed with asthma. Rates of arthritis among adults were 21.3% in Adams County and 19.6% in Weld County.

Chronic Diseases, Ages 18 and Older

	Adams County	Weld County	Colorado
Arthritis	21.3%	19.6%	22.8%
Adult asthma	11.3%	8.7%	8.9%
Adult diabetes	8.4%	8.6%	6.8%
Heart attack	3.6%	3.0%	3.3%
High blood pressure	26.3%	25.1%	25.8%
Stroke	2.5%	2.2%	2.2%

Source: Behavioral Risk Factor Surveillance System, SCL Health CHNA Database 2016-2018.
https://cdphe.colorado.gov/vision-visual-information-system-for-identifying-opportunities-and-needs

COVID-19 Indicators

KEY TAKEAWAYS:

COVID-19 IMPACTS

Impacts of COVID-19 Went Beyond Infection

Experiences as a result of COVID-19, Coloradans ages 16+, 2021

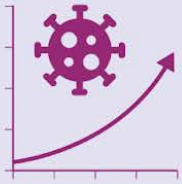
"The pandemic's impact extended well beyond infection rates, touching on employment, finances, mental well-being, and more."

— Colorado Health Access Survey, page 6

- **38.3%** (1.6M people) — Had a decline in mental health, such as anxiety, depression, or loneliness
- **37.7%** (1.6M people) — Continued their job as an essential worker
- **30.3%** (1.3M people) — Had at least one household member who attended school remotely
- **29.3%** (1.3M people) — Had reduced hours/income
- **29.1%** (1.3M people) — Switched to working from home
- **17.4%** (752k people) — Had a decline in physical health
- **17.2%** (738k people) — Struggled to pay for basic necessities
- **16.8%** (723k people) — Struggled to pay rent/mortgage
- **11.9%** (510k people) — Lost a job
- **2.6%** (114k people) — Were treated unfairly due to race/ethnicity

CHORDS Data Show the Disparate Impact of the Pandemic on Front Range Neighborhoods (Colorado Health Institute)

- In the hardest-hit metro neighborhoods, the rate of COVID diagnoses was **10 times greater** than in the ones that fared best.
- A drive of just 10 minutes separates some of the neighborhoods with the highest concentrations of COVID diagnoses from areas that largely escaped the virus.
- The highest diagnosis levels were found in neighborhoods where residents had **lower education levels and with higher concentrations of non-English speakers and people of color**. In these areas, various systemic factors contribute to the disparities, including crowded housing, inability to telecommute, and less access to health care.



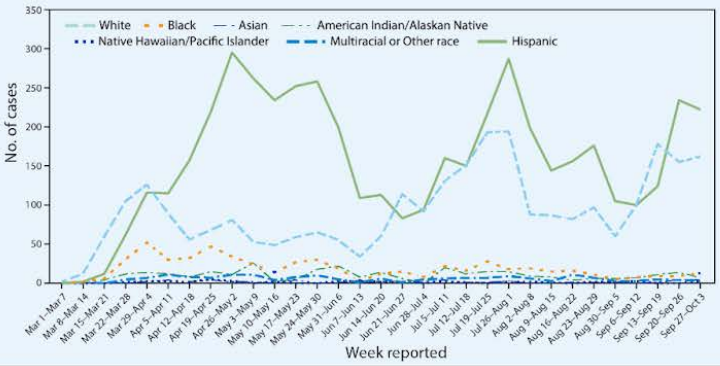
CDC Report

In Denver, Colorado, the **majority of adult COVID-19 cases** (55%), **hospitalizations** (62%), and **deaths** (51%) **were among Hispanic adults, double the proportion of Hispanic adults in Denver** (24.9%).

Among adults with COVID-19, Hispanic persons reported larger household sizes and more known COVID-19 household exposure, working in essential industries, working while ill, and delays in testing after symptom onset.

ADULT COVID-19 CASES

By race/ethnicity and reported week — Denver, Colorado, March 01–October 03, 2020*



COVID-19 Vaccine Event Spot Survey

In March 2021, we surveyed 1,389 of the 5,000 attendees at an SCL Health community vaccination event. In addition to asking attendees about urgent SDoH needs, we asked about other secondary health concerns related to COVID-19. Results were: 44% Social Isolation, 25% Testing Availability, 28% Access to Vaccines.

To Learn More Consider These Additional Data Supports

- **CHORDS Data** Show the Disparate Impact of the Pandemic on Front Range Neighborhoods (Colorado Health Institute)
- CDC weekly report **Spotlight Colorado March 2020**
- **Colorado Health Access Survey 2021**: Navigating Uncharted Waters
- https://coloradohealth.org/reports/coloradans-concerns-needs-and-experiences-during-coronavirus-outbreak

As of July 19th, 2021, there have been 61,552 confirmed cases and 724 deaths from COVID-19-19 in Adams County, and 33,863 confirmed cases and 354 deaths in Weld County. Adams County has fully vaccinated 58.4% and partially vaccinated 64.5% of its population. Weld County has partially vaccinated 56.3% and fully vaccinated 51.2% of its population. There have been 566,670 confirmed cases and 6,886 confirmed deaths of COVID-19 in Colorado as of July 19th, 2021. As of that date, 61.4% of Colorado residents are fully vaccinated and 66.7% are partially vaccinated (one dose).

COVID-19 Number of Cases and Deaths, as of 7/19/21

	Adams County	Weld County	Colorado
Cases	61,552	33,863	566,670
Deaths	724	354	6,886

Source: Colorado Department of Public Health and Environment, SCL Health CHNA Database 2021. https://COVID-1919.colorado.gov/data & https://COVID-1919.colorado.gov/vaccine-data-dashboard

COVID-19 Vaccination Rates, as of 7/19/21

	Adams County	Weld County	Colorado
Fully vaccinated	58.4%	51.2%	61.4%
One dose	64.5%	56.3%	66.7%

Source: Colorado Department of Public Health and Environment, SCL Health CHNA Database 2021. https://COVID-1919.colorado.gov/data & https://COVID-1919.colorado.gov/vaccine-data-dashboard

Cancer

Incidence rates for invasive cancer of any type were 402.6 per 100,000 persons in Adams County and 420.2 per 100,000 persons in Weld County. The rate was 384.9 per 100,000 persons in Colorado.

Cancer Incidence Rate, Age-Adjusted, per 100,000 Persons

	Adams County	Weld County	Colorado
Invasive cancer for all sites combined	402.6	420.2	384.9

Source: Colorado Health Information Dataset, SCL Health CHNA Database 2018. https://cohealthviz.dphe.state.co.us/t/HealthInformaticsPublic/views/COHIDCancerIncidenceRates/CancerIncidences?iframeSizedToWindow=true&:embed=y&:showAppBanner=false&:display_count=no&:showVizHome=no

Health Screening

Health screenings focus on preventive care and use tests, physical examinations or other procedures to detect disease early in people who may not show symptoms. Among female Medicare enrollees, ages 65-74, 35.0% in Adams County and 43.0% in Weld County obtained mammogram breast cancer screening. About 41% of Colorado female Medicare enrollees, ages 65-74, received an annual mammography screening.

Annual Mammography Screening for Female Medicare Enrollees, Ages 65-74

	Adams County	Weld County	Colorado
Annual mammogram, women, ages 65-74	35.0%	43.0%	41.0%

Source: Mapping Medicare Disparities Tool, SCL Health CHNA Database 2017.
https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH-Mapping-Medicare-Disparities

Hospitalization Rates

Adams (0.6 per 10,000 persons) and Weld County (0.9 per 10,000 persons) had low rates of influenza related hospitalizations. Adams County had a higher rate of asthma hospitalization (5.4 per 10,000 persons) than Weld County (3.9 per 10,000 persons). Weld County had a higher rate of COPD hospitalization (10.2 per 10,000 persons) compared to Adams County (9.5 per 10,000 persons). Adams County had lower levels of heat-related hospitalizations and influenza hospitalizations than Weld County.

Hospitalization Rates, Age-Adjusted, per 10,000 Persons* and per 100,000 Persons+

	Adams County	Weld County	Colorado
Asthma hospitalization*	5.4	3.9	4.2
COPD hospitalization*	9.5	10.2	9.5
Heat-related hospitalizations+	1.0	2.1	0.8
Influenza hospitalizations+	0.6	0.9	N/A

Source: Colorado Department of Public Health and Environment, SCL Health CHNA Database 2018.
https://coepht.colorado.gov/asthma & https://coepht.colorado.gov/chronic-obstructive-pulmonary-disease-copd & https://coepht.colorado.gov/heat-related-illness-data

Sexually Transmitted Infections

Rates of HIV and chlamydia were higher in Adams County than in Weld County. Chlamydia had the highest incidence rates of a sexually transmitted infection: 571.2 per 100,000 cases in Adams County and 458.2 in Weld County. Of the most prevalent STDs in Colorado, chlamydia had the highest rate (511.4).

Sexually Transmitted Infection Rates, per 100,000 Persons

	Adams County	Weld County	Colorado
HIV incidence	240.4	89.4	264.2
Chlamydia, ages 13 and older	571.2	458.2	511.4
Gonorrhea, ages 13 and older	159.3	134.9	156.2

Sources: Colorado Department of Public Health and Environment, SCL Health CHNA Database 2018. https://drive.google.com/file/d/1-gL5Ht_Nqdz6gakJZZQb-2H1ujPod8va/view; National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, SCL Health CHNA Database 2016. https://www.cdc.gov/nchhstp/default.htm

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

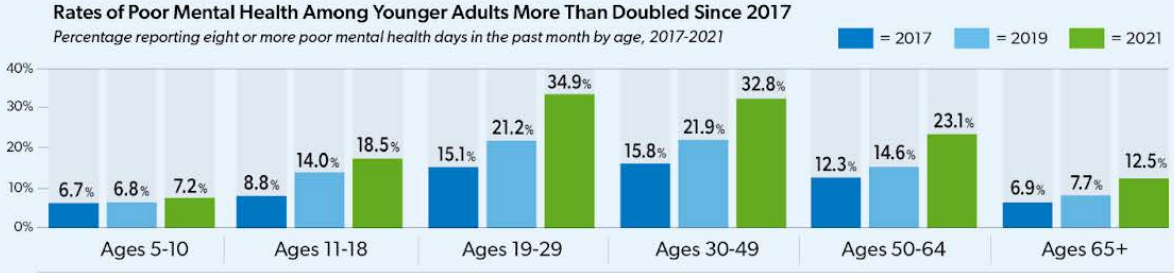
KEY TAKEAWAYS:

MENTAL HEALTH

2019 vs 2021

Rates of Poor Mental Health Among Younger Adults More Than Doubled Since 2017

Percentage reporting eight or more poor mental health days in the past month by age, 2017-2021



Percentage reporting eight or more poor mental health days in the past month

Younger adults were more likely to report needing behavior health services in the next year

Ages 5-10	Ages 11-18	Ages 19-29	Ages 30-49	Ages 50-64	Ages 65+
11.4%	23.2%	33.7%	26.9%	14.5%	5.6%

Data from Colorado Health Access Survey 2021

DRIVERS OF POOR MENTAL HEALTH

- Stigma
- Availability of Providers
- Cost & Insurance Coverage
- COVID-19/ Pandemic
- Lack of Food Security & Housing Stability
- Distrust in Health System

HEALTH EQUITY

- It is important to shine a light on social inequalities that put many people at a disadvantage in achieving mental health and wellbeing: social inequalities like **poverty, financial strain, racism, homelessness, bullying based on sexual orientation**, and **social exclusion due to disability or age**.
- According to the 2021 CHAS survey, both **housing instability (60%)** and **food insecurity (57.4%)** showed **higher percentages of poor mental health days** compared to those having **stable housing (20.9%)** and **food security (20.5%)**

PVMC HIGHLIGHTED PARTNERS

Working with community-based partners is essential to improve the care continuum for those experiencing mental health challenges

Community Reach Center

Denver Health est. 1860 For Life's Journey

Pennock center for counseling

TO LEARN MORE CONSIDER THESE ADDITIONAL DATA SUPPORTS

Colorado Health Access Survey 2021
https://www.coloradohealthinstitute.org/research/colorado-health-access-survey-2021

PULSE (The Colorado Health Foundation) POLL
copulsepoll.org/results

SAMHSA-BH Barometer (CO)
https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/Colorado-BH-BaromterVolume5.pdf

Behavioral Risk Factor Surveillance System 2016-2018
https://cdphe.colorado.gov/vision-visual-information-system-for-identifying-opportunities-and-needs

Mental Health Providers

Mental health providers include psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists who meet certain qualifications and certifications. In Adams County, the number of mental health providers per 1,000 persons was 2.1 and in Weld County the rate was 1.7 per 1,000 persons. Adams County had 0.22 mental health treatment facilities per 10,000 persons. Weld County had 0.33 mental health treatment facilities per 10,000 persons. Colorado had 2.7 mental health providers per 1,000 persons and 0.28 mental health treatment facilities per 10,000 persons.

Mental Health Providers and Facilities

	Adams County	Weld County	Colorado
Mental health providers, per 1,000 persons	2.1	1.7	2.7
Mental health treatment facilities, per 10,000 persons	0.22	0.33	0.28

Sources: Colorado Department of Regulatory Agencies, SCL Health CHNA Database 2020. https://apps.colorado.gov/dora/licensing/Lookup/LicenseLookup.aspx; Substance Abuse and Mental Health Services Administration, SCL Health CHNA Database 2020. https://findtreatment.samhsa.gov/locato

Mental Health Indicators

Various indicators such as suicide rate, counseling rates, and self-reported levels of severe depression or medication rates are used to gauge the proliferation of public and private mental health services in communities.

16.7% of students in Adams County and 16.6% of Weld County students seriously considered suicide within the past year. Just under 32% of students in Adams County and 37.4% of Weld County students reported having severe physical/mental health issues preventing them from normal activity for two or more consecutive weeks. About 17% of Colorado high school students seriously considered suicide within the past year and 34.7% reported severe mental health issues preventing normal activity for at least two weeks.

Mental Health Indicators, Adolescents

	Adams County	Weld County	Colorado
High School students who seriously considered suicide within the past year	16.7%	16.6%	17.5%
High School students with severe physical/mental health issues preventing normal activity for 2+ weeks	31.9%	37.4%	34.7%

Source: Healthy Kids Colorado Survey, SCL Health CHNA Database 2019. https://cdphe.colorado.gov/center-for-health-and-environmental-data/survey-research/healthy-kids-colorado-survey-data

The percentage of the adult population reporting more than 14 days of poor mental health per month was 11.8% in Adams County and 12.6% in Weld County. Nearly 11% of Colorado adults reported frequent mental distress.

Frequent Mental Distress, Adults

	Percent
Adams County	11.8%
Weld County	12.6%
Colorado	10.9%

Source: Behavioral Risk Factor Surveillance System, SCL Health CHNA Database 2016-2018. https://www.coloradohealthinstitute.org/

In Adams County, the age-adjusted suicide rate was 22.0 per 100,000 persons and in Weld County it was 17.0 per 100,000 persons. The rate of ED visits for suicides was 128.5 per 100,000 persons in Adams County and 139.6 per 100,000 persons in Weld County. Just under 16% of adults in Adams County and 14.4% of adults in Weld County were receiving treatment or taking medicine for a mental health condition.

Approximately 51% of people in Adams County and Weld County reported foregoing mental health treatment due to stigma. In Adams County, 12.0% of people reported a time there was a need for mental health counseling or treatment but ultimately did not get it in the past 12 months, and in Weld County 8.2% of people did not get treatment.

The Healthy People 2030 objective is for 68.8% of adults with a serious mental disorder to receive treatment (31.2% who do not receive treatment). While Colorado had a high rate of foregone mental health care due to stigma (47.3%), the other mental health indicators were similar to Adams and Weld Counties.

Mental Health Indicators

	Adams County	Weld County	Colorado
Age-adjusted suicide rate, per 100,000 persons	22.0	17.0	21.4
Rate of suicide ED visits, per 100,000 persons	128.5	139.6	129.5
Adults taking medicine or receiving treatment for any type of mental health condition	15.8%	14.4%	15.0%
Did not get needed mental health care due to stigma in past 12 months	51.2%	51.1%	47.3%
Reported a time there was a need for mental health counseling but did not get it in past 12 months	12.0%	8.2%	13.5%

Sources: Colorado Health Information Dataset, SCL Health CHNA Database 2020. https://www.coloradohealthinstitute.org/ *https://cohealthviz.dphe.state.co.us/t/PSDVIP-MHPPUBLIC/views/InjuryIndicatorsDashboard/LandingPage?%3AshowAppBanner=false&%3Adisplay_count=n&%3AshowVizHome=n&%3Aorigin=viz_share_link&%3AisGuestRedirectFromVizportal=y&%3Aembed=y* https://cohealthviz.dphe.state.co.us/t/HSEBPublic/views/CoVDRS_12_1_17/Story1?:embed=y&:showAppBanner=false&:showShareOptions=true&:display_count=no&:showVizHome=no#4

Behavioral Risk Factor Surveillance System, SCL Health CHNA Database 2016-2018. https://cdphe.colorado.gov/vision-visual-information-system-for-identifying-opportunities-and-needs Colorado Health Access Survey (HSR)/American Community Survey, SCL Health CHNA Database 2015-2019. Colorado Health Access Survey: https://www.coloradohealthinstitute.org/research/CHAS

Substance Use

Substance use refers to the harmful or hazardous use of substances, including alcohol, tobacco and illicit drugs.

Marijuana Use

Just more than 14% of adults in Adams County used marijuana and 12.5% of adults in Weld County used marijuana. Among pregnant women, 5.8% used marijuana in Adams County and 7.7% used marijuana in Weld County. For students, 18.0% reported using marijuana at least once during the past 30 days in Adams County and 20.9% reported using marijuana at least once during the past 30 days in Weld County. Weld County had no marijuana retailers per 1,000 persons.

Marijuana Use

	Adams County	Weld County
Adult marijuana use	14.2%	12.5%
Marijuana use during pregnancy	5.8%	7.7%
Students, at least 1 time during the past 30 days	18.0%	20.9%
Marijuana retailers, per 1,000 population	0.1	0.0

Sources: Behavioral Risk Factor Surveillance System, SCL Health CHNA Database 2016-2018. https://cdphe.colorado.gov/vision-visual-information-system-for-identifying-opportunities-and-needs
Pregnancy Risk Assessment Monitoring System, SCL Health CHNA Database 2017-2019. https://cdphe.colorado.gov/center-for-health-and-environmental-data/survey-research/pregnancy-risk-assessment-monitoring
Healthy Kids Colorado Survey, SCL Health CHNA Database 2019.
https://cdphe.colorado.gov/center-for-health-and-environmental-data/survey-research/healthy-kids-colorado-survey-data
Colorado Department of Regulatory Agencies, SCL Health CHNA Database 2019 https://dora.colorado.gov/

Alcohol Use

Binge drinking is defined as five or more drinks on one occasion for men and four or more drinks for women. The Healthy People 2030 objective is that only 25.4% of adults engage in binge drinking in the past month. In Adams County, 18.6% of adults engaged in binge drinking over the past year and 18.5% of Weld County adults engaged in binge drinking. Heavy drinking is defined as greater than 2 drinks per day for men and greater than 1 drink a day for women. More than 6% of Adams County adults and 7% of Weld County adults engaged in heavy drinking over the past year. More than 25% of students in Adams County had at least 1 drink in the past 30 days, and 32.2% of students in Weld County had at least 1 drink in the past 30 days. Seven percent of Colorado residents reported heavy drinking within the past month and 19.1% reported binge drinking within the past month. Just under 30% of Colorado high school students reported having at least 1 drink in the past 30 days.

Alcohol Use

	Adams County	Weld County	Colorado
Heavy drinking	6.1%	7.2%	7.0%
Students, at least 1 drink in past 30 days	25.4%	32.2%	29.6%
Binge drinking	18.6%	18.5%	19.1%

Sources: Behavioral Risk Factor Surveillance System, SCL Health CHNA Database 2016-2018. https://cdphe.colorado.gov/vision-visual-information-system-for-identifying-opportunities-and-needs. Healthy Kids Colorado Survey, SCL Health CHNA Database 2019.
https://cdphe.colorado.gov/center-for-health-and-environmental-data/survey-research/healthy-kids-colorado-survey-data

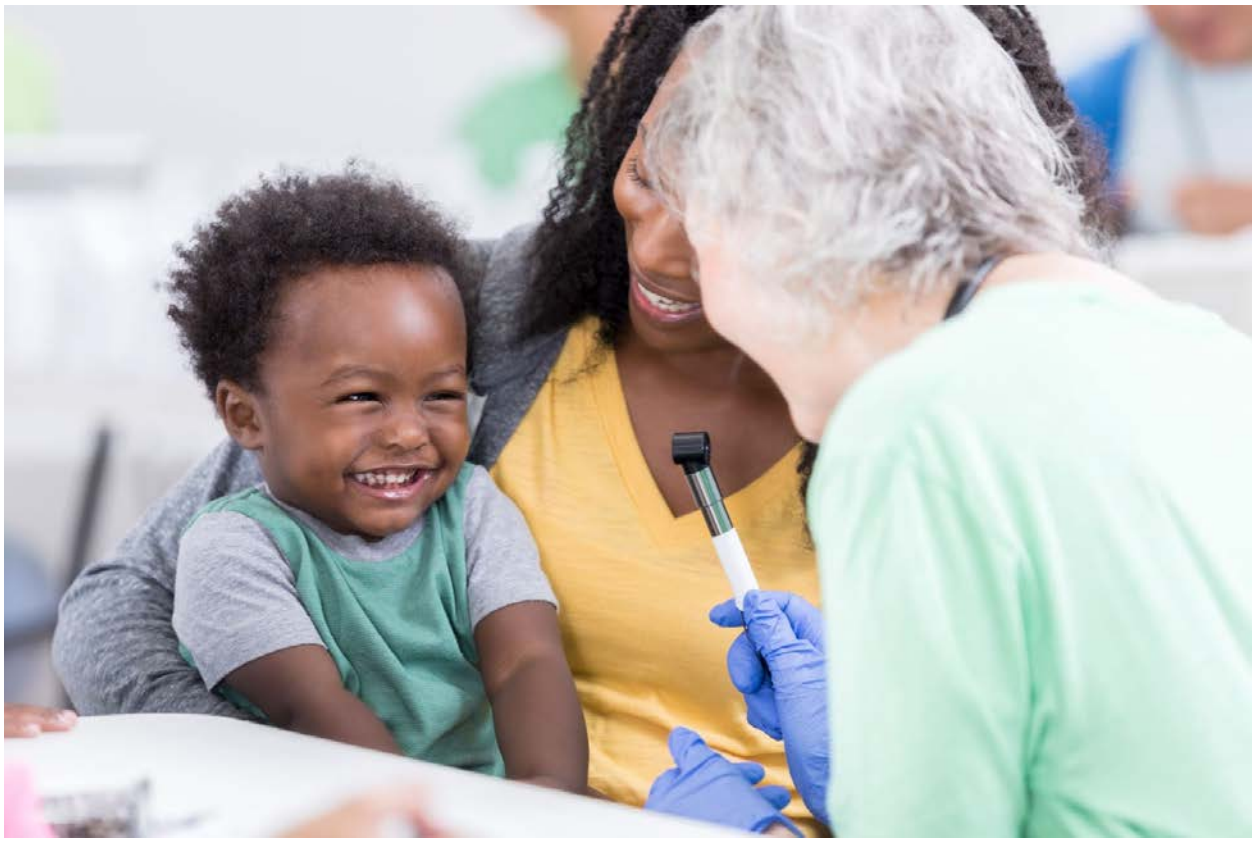
Cigarette/E-Cigarette Smoking

Just under 19% of adults in Adams County and 16.2% in Weld County smoked cigarettes. About 23% of high school students used an E-cigarette in the past 30 days, and 29.3% used an E-cigarette in the past 30 days in Weld County. This was higher than the Healthy People 2030 objective of 5% of the population who smoke cigarettes. Nearly 7% of pregnant women in Adams County and 4.7% in Weld County smoked during their pregnancies. About 4.5% of students in Adams County smoked a cigarette in the past 30 days, and 5.6% of students smoked a cigarette in the past 30 days in Weld County. Fifteen percent of Colorado adults smoke cigarettes and 5.7% of Colorado high school students reported smoking cigarettes one or more times in the past 30 days. Just over 26% of students reported using an electronic vapor product one or more times within the past 30 days, and 6.1% of pregnant women in Colorado reported smoking cigarettes.

Cigarette/E-Cigarette Use

	Adams County	Weld County	Colorado
Adult cigarette use	18.8%	16.2%	15.0%
Pregnant mothers who smoked during pregnancy	6.7%	4.7%	6.1%
Students who used an electronic vapor product one or more times in the last 30 days	23.4%	29.3%	26.1%
Students who smoked cigarettes one or more times in the last 30 days	4.5%	5.6%	5.7%

Sources: Behavioral Risk Factor Surveillance System, SCL Health CHNA Database 2016-2018.
https://cdphe.colorado.gov/vision-visual-information-system-for-identifying-opportunities-and-needs
Pregnancy Risk Assessment Monitoring System, SCL Health CHNA Database 2017-2019.
https://cdphe.colorado.gov/center-for-health-and-environmental-data/survey-research/pregnancy-risk-assessment-monitoring
Healthy Kids Colorado Survey, SCL Health CHNA Database 2019.
https://cdphe.colorado.gov/center-for-health-and-environmental-data/survey-research/healthy-kids-colorado-survey-data



Next Steps

The PVMC service area includes multiple counties with significant community health needs, many of which are tied to health behaviors and environmental or social factors. PVMC and its community partners will, in 2022, engage in the development of a Community Health Improvement Plan (CHIP) to address opportunities for health improvement in the identified priority areas:

- Mental Health
- Access to Healthcare

CHIP efforts include identifying Implementation Strategies that leverage community strengths and partnerships, PVMC's Community Benefit resources and programming, and the input and collaboration among residents of the hospital's service area and the community-based and business organizations that serve those residents.

The CHIP will present a deep dive into the causes and mitigating factors associated with the prioritized health areas, including looking at specific populations, disparities and barriers to improved outcomes. It will also highlight other organizations that are currently addressing similar issues within the community.

For more information, please contact:

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Appendicies

Appendix 1. Community Survey Reports

Community Survey 1

CHI conducted a community survey to more than 300 people in SCL Health's Front Range service region from August 10, 2021, to August 23, 2021. The survey was provided in both English and Spanish. CHI sent the 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 and marketing team assisted with survey dissemination by sending targeted emails to local contacts.

The survey collected 100 responses from residents of 10 counties, with the greatest number of responses coming from Adams, Denver, and Broomfield counties. Where possible, CHI analyzed results by county. Counties with a sample size of fewer than five responses were included only in the overall analysis.

Demographics

More than half (55%) of the 100 survey respondents identified primarily as community members, as opposed to medical providers or representatives of a nonprofit organization, for example. More than 40% of responses came from Adams County, which is served by SCL Health's Platte Valley and Good Samaritan Medical Centers.

More than three-quarters (77%) of respondents were white (non-Hispanic/Latinx), so survey results may favor the experiences of this group. Similarly, women were overrepresented in the survey results, accounting for 80% of the total responses compared with just 19% of participants who identified as men. Compared with adults under age 40, people ages 65 and older were twice as likely to complete the survey, so results may be skewed to reflect opinions more representative of older community members. See Table 1 for a complete list of demographic data.

Table 1. Survey Respondent Demographics

Primary Role in the Community	Percent of Respondents
Community member	55%
Medical provider or clinician	13%
Nonprofit organization representative	11%
Public health worker	9%
Community-based organization representative	6%
Other	6%
Youth/education services representative	0%
County of Residence	**Percent of Respondents**
Adams	43%
Denver	15%
Broomfield	10%
Jefferson	9%
Boulder	7%
Arapahoe	6%
Weld	6%
Douglas	2%
Larimer	1%
Morgan	1%
Race or Ethnicity	**Percent of Respondents**
White, non-Hispanic/Latinx	77%
Hispanic/Latinx	14%
Black/African American	4%
Other (please specify)	3%
Mixed race	2%
American Indian/Alaska Native	0%
Middle Eastern or Northern African	0%
Asian	0%
Age Range	**Percent of Respondents**
25 or younger	0%
26 – 39	15%
40 – 54	31%
55 – 64	22%
65 or older	32%
Gender	**Percent of Respondents**
Female	80%
Male	19%
Prefer not to say	1%

Community Health Concerns

Behavioral health, housing stability and affordability, and COVID-19 were the three most pressing health concerns cited by survey respondents from a list of options. Please see Table 2 for further detail.

Table 2. Three Most Pressing Health Concerns, by SCL Service Region and County

	Most Cited Issue	2nd Most Cited Issue	3rd Most Cited Issue
Overall (all counties)	Behavioral health	Housing stability/ affordability	COVID-19
Adams	Behavioral health (t)	Chronic illnesses (t)	COVID-19
Arapahoe	Housing stability/ affordability	Behavioral health (t)	Food insecurity (t)
Boulder	Housing stability/ affordability	Chronic illnesses (t)	Substance use (t) Access to care (t)
Broomfield	COVID-19 (t)	Behavioral health (t)	Housing stability/ affordability (t) Air pollution/safe drinking water (t)
Denver	Housing stability/ affordability	Behavioral health	Chronic illnesses
Jefferson	COVID-19	Behavioral health	Housing stability/ affordability
Weld	Substance use (t)	Access to health care (t)	Violence/crime (t)

(t) = tied. These topics were chosen by the same percentage of respondents.

Behavioral Health

Behavioral health issues, including suicide, were the most urgent health concerns reported by survey participants. About 43% of all survey respondents considered this a major (top three) issue in their community, with the highest rates of concern expressed among respondents living in Denver, Broomfield, and Arapahoe counties.

Concern over these issues varied by a survey respondent's role in their community. For example, public health workers were more than twice as likely to consider behavioral health a major issue when compared with community members (78% to 31%).

Most survey respondents said members of their community do not have good overall mental health. Almost two-thirds (63%) of all survey respondents rated their community's overall mental health as "fair or poor," with suboptimal ratings the most common among respondents who live in Denver and Arapahoe counties (93% and 83%).

> *"The community suffers from mental health issues but is not aware of them due to [a] lack of information, [not knowing] how to identify the issues/denial, and/or [not having] appropriate ways to address them."*
>
> *– Survey Respondent from Adams County*

Housing

Colorado's housing crisis was a top concern for 41% of all survey participants. This was especially true for those who live in Boulder, Broomfield, Arapahoe, and Denver counties: In each of these areas, at least 50% of respondents chose housing stability and affordability as a major health concern for themselves or for other community members.

COVID-19

The uptick in COVID-19 cases from the rapid spread of the delta variant in 2021 coincided with the survey, which is reflected in heightened concerns expressed about the virus in many communities.

Underserved Populations

About two-thirds (64%) of survey respondents said specific populations in their community were not being adequately assisted by health care services.

People experiencing homelessness, people without insurance, and low-income communities were identified as the three most underserved populations in SCL Health's Front Range service region. See Table 3 for differences by county.

Table 3. Most Underserved Populations, by SCL Service Region and County

	Most Underserved Population	2nd Most Underserved Population	3rd Most Underserved Population
Overall (all counties)	People experiencing homelessness	Uninsured people	Low-income communities
Adams	People experiencing homelessness (t)	Older adults (t)	Uninsured people
Arapahoe	People experiencing homelessness (t)	Hispanic/Latinx people (t)	Black/African American people (t)
Boulder	Low-income communities (t)	Uninsured people (t)	N/A*
Broomfield	People experiencing homelessness	Uninsured people	Low-income communities

Denver	Immigrants/refugees	Low-income communities (t)	Uninsured people (t)
Jefferson	People experiencing homelessness (t)	Low-income communities (t)	Uninsured people
Weld	People experiencing homelessness (t)	Low-income communities (t)	Older adults (t)

(t) = tied. These population groups were chosen by the same percentage of respondents.

N/A = There was a five-way tie among Boulder County respondents for the following underserved populations: Immigrants and refugees, older adults, people experiencing homelessness, Hispanic/Latinx people, and people with disabilities.*

Barriers to Care

Over half (52%) of all respondents said out-pocket-costs were a substantial barrier to getting needed health care, followed by providers not accepting their insurance (37%) and providers not taking on new patients (33%).

Survey respondents in Jefferson (67%) and Weld (83%) counties were most likely to choose out-of-pocket costs as a major barrier to care (see Table 4). Additionally, challenges with out-of-pocket costs were felt more acutely by survey respondents who identify as Black or Hispanic/Latinx, those who are between the ages of 40 and 54, and those who work for a nonprofit organization.

As noted above, about one-third of survey respondents said finding a health care provider who agreed to take their insurance or who was accepting new patients was a barrier to getting needed health care for themselves or other members of their community. Survey respondents who are enrolled in Health First Colorado, the state's Medicaid program, were more likely to report challenges with finding a provider to accept their insurance or take new patients than those with other types of insurance coverage.

Table 4. Substantial Barriers to Care, by SCL Service Region and County

	Biggest Barrier to Care	2nd Biggest Barrier to Care	3rd Biggest Barrier to Care
Overall (all counties)	Out-of-pocket costs	Insurance was not accepted by a provider	Provider was not accepting new patients
Adams	Out-of-pocket costs	Insurance was not accepted by a provider	Provider was not accepting new patients
Arapahoe	Out-of-pocket costs	Mistrust of health care providers (t)	Worried about being treated fairly (t)
Boulder	Out-of-pocket costs	Did not have insurance (t)	Did not know how to find a health care provider (t)

Broomfield	Out-of-pocket costs	Insurance was not accepted by a provider	Mistrust of health care providers
Denver	Insurance was not accepted by a provider (t)	Provider was not accepting new patients (t)	Mistrust of health care providers
Jefferson	Out-of-pocket costs	Insurance was not accepted by a provider	Could not get time off work
Weld	Out-of-pocket costs	Provider was not accepting new patients	Insurance was not accepted by a provider

(t) = tied. These barriers to care were chosen by the same percentage of respondents.

Access to Health Care Services

Perceptions of respondents' access to health care services varied by county and by type of health care service. About one-third (36%) of survey respondents said they did not have access to needed behavioral health services, with people living in Denver, Jefferson, and Adams counties most likely to report access challenges for behavioral health care (see Table 5).

About one in four respondents said they did not have access to needed primary care (23%), specialty care (25%), and culturally competent health care services (24%). People who identify as Black or Hispanic/Latinx were three times as likely to report limited access to culturally competent providers (defined as those who understand their community's needs or speak their language).

Table 5. Lack of Access to Care by Specialty Area, by SCL Service Region and County

	Poor Access to Primary Care	Poor Access to Specialty Care	Poor Access to Behavioral Health Care	Poor Access to Oral Health Care	Poor Access to Culturally Competent Health Care
Overall (all counties)	23%	25%	36%	15%	24%
Adams	26%	26%	40%	12%	16%
Arapahoe	17%	17%	33%	17%	33%
Boulder	43%	43%	29%	43%	29%
Broomfield	10%	10%	10%	10%	20%
Denver	33%	40%	53%	27%	47%
Jefferson	0%	0%	44%	0%	22%
Weld	33%	50%	33%	17%	17%

Community Needs and Services

Survey respondents pointed to three services that are most needed in greater quantities to improve the well-being of community members: mental health services; aging and long-term care services; and social supports, such as housing and food assistance.

Table 6. Community and Health Service Gaps, by SCL Service Region and County

	Most Needed Service	2nd Most Needed Service	3rd Most Needed Service
Overall (all counties)	Mental health services	Aging/long-term care services	Social support services
Adams	Mental health services	Aging/long-term care services	Specialty care services (t) Veteran services (t)
Arapahoe	Mental health services	Social support services (t)	Equity, inclusion, and diversity services (t)
Boulder	Substance use services (t)	Mental health services (t)	Equity, inclusion, and diversity services (t)
Broomfield	Social support services	Child care services	N/A*
Denver	Mental health services	Social support services (t)	Equity, inclusion, and diversity services (t)
Jefferson	Mental health services	Social support services	N/A**
Weld	Substance use services	Mental health services	Aging/long-term care services (t) Veteran services (t)

(t) = tied. These community and health services were chosen by the same percentage of respondents.

N/A = There was a five-way tie among Broomfield County respondents for the following needed services: mental health services; recreational services; environmental services; equity, inclusion, and diversity services; and veteran services. N/A** = There was a three-way tie among Jefferson County respondents for the following needed services: equity, inclusion, and diversity services; child care services; and aging/long-term care services.*

Mental Health

Challenges accessing behavioral health care are due in large part to limited care options. About half (49%) of all survey respondents said there are not enough mental health services in SCL Health's Front Range service region to meet the needs of their community. Gaps in mental health services were most likely to be reported by respondents who live in Jefferson, Weld, and Arapahoe counties. (see Table 6).

Aging and Long-Term Care

One-third (33%) of all survey respondents said their community needs more aging and long-term care services, such as geriatric-specific providers and transportation services, to meet the needs of older adults. Residents of Adams County were the most likely to cite the need for services and supports for aging community members. About one in six (17%) survey respondents said they did not think their community was a good place to grow old or retire because of limited aging services and supports, limited elder-friendly housing options, or both.

Social Supports

The economic and financial impacts of the coronavirus pandemic coupled with Colorado's growing housing affordability crisis have intensified the need for more social support services, such as housing and food assistance programs, along the Front Range. One in four (25%) respondents said there are not enough social support services to meet the needs of community members.Survey respondents in Jefferson and Arapahoe counties were most likely to report a greater need for these services in their communities.

Looking Ahead: Prioritization

When considering the next three years, survey respondents said that it is very important for SCL Health to prioritize actions to further address three pressing health concerns: COVID-19 outbreaks, behavioral health needs, and access to health care services. Leadership and staff at SCL Health's hospitals should consider these suggestions from community members when drafting their CHNA reports and creating implementation plans to address local needs. See Table 7 for a list of top priorities by county.

Health-adjacent issues like housing instability and food insecurity were less likely to be identified by survey respondents as "very important" topics for SCL Health to prioritize compared with physical and mental health concerns. This may be attributed to respondents seeing less of a role for their local hospital to address social issues within their community, rather than beliefs that these issues are not urgent or important.

Table 7. Topics for Prioritization by SCL Health, by SCL Service Region and County

	Highest-Priority Topic	2nd Priority Topic	3rd Priority Topic
Overall (all counties)	Behavioral health	COVID-19 outbreaks (t)	Access to health care (t)
Adams	Chronic illnesses	Behavioral health (t)	Access to health care (t)
Arapahoe	Behavioral health	Substance use (t)	Access to health care (t)
Boulder	COVID-19 outbreaks (t)	Access to health care (t)	Behavioral health (t2) Chronic illnesses (t2)
Broomfield	COVID-19 outbreaks (t)	Air pollution and/or unsafe drinking water (t)	Behavioral health
Denver	Behavioral health	Access to health care	Chronic illnesses
Jefferson	COVID-19 outbreaks (t)	Behavioral health (t)	Access to health care
Weld	Infectious diseases	N/A*	N/A*

(t) = tied. These priority topics were chosen by the same percentage of respondents.

(t2) = tied. These priority topics represent a second tie (for third place) in Boulder County.

N/A = There was a four-way tie among Weld County respondents for the following prioritized topics: COVID-19 outbreaks, substance use, chronic illnesses, and behavioral health.*

Appendix 2. 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

Appendix 3. Key Informant Interview Report

Each interview began by asking participants to name the major health issues affecting individuals in the community. Responses included:

- We have a lot of migrant workers who are afraid to go to the hospital or receive medical care because they may be reported and deported. They don't access care, and neither do their children.
- Diabetes, hypertension, and a lack of ability to get adequate medical care for various reasons including medication availability and personal finances. Also, transportation can be an issue.
- People on a limited income cannot afford transportation companies that charge money.
- We have a history in Adams County of not having good health outcomes for asthma, heart disease and other chronic illnesses.
- Housing and food insecurity are more pronounced now due to the connection with economic insecurity. There is a lack of routine health care, which may impact chronic diseases, including diabetes and heart disease.
- Mental health, substance use and misuse, and Type 2 diabetes.
- Older adult's primary concerns are access to health care, good nutrition and food programs, and affordable services to manage disease processes.
- The overuse of legalized drugs has caused an influx of major problems in our community. More domestic violence, child abuse, and an increase in property thefts, burglaries, and home invasions.
- Diabetes. Depression and anxiety.
- Recovery and substance use.
- Poverty is the biggest barrier. If you are uninsured, you are not able to receive primary care at a rate you should be seeking care. And because of that care ends up in the ED. Also, specialist care can be a huge barrier.
- Among youth it is the level of isolation during the pandemic and the mental health impacts of not being in school or able to associate with their friends. There is a lack of resources for mental health. Available resources are tapped out and when things get bad, and kids experience a long wait to get seen, they end up in the ED on a suicide.
- A lot of families are food insecure.

Interview participants were asked about the most important socio-economic, behavioral, or environmental factors contributing to poor health in the community. Their responses included:

- We are a rural, low-economic status community with a lot of migrant and transient workers. We have oil and gas workers who come in and out and a lot of farming and ranching.
- We have a large Hispanic population, and there are language barriers.
- Substance use, hands down. People are self-medicating. Alcohol is readily

available and socially accessible. We are seeing overdoses, suicide attempts and sometimes gunshots.

- Because of the pandemic we have widespread anxiety and mental health issues among our law enforcement.
- Employment that provides a living wage or more.
- Income, health insurance status, housing issues, and unemployment.
- A low-income impacts good health care access, including transportation, the ability to pay for medications, co-pays and follow-up treatments.
- COVID-19-19 has been a real struggle with access to resources. Some people lost their jobs, their housing, and food banks have been exorbitantly taxed in the region, and some have even closed.
- Housing, working or being able to do some type of productive activity during the day. Our population, there is nothing for them to do, they are not ready for work necessarily, or they might be able to work part time. But there is not a recreation center, which is usually the gateway to being able to work. Volunteer opportunities are not available in our community.
- We have poor air quality, which leads to asthma and heart disease.
- Housing is so expensive throughout the Front Range area. People are being outpriced and cannot afford to rent without working multiple jobs, which puts more strain on families.
- There are resources out there, but people don't know what they don't know. The resources are wonderful if you are aware and connected. Barriers include language, technology, health literacy and navigating some complicated situations. We try to communicate in English and Spanish, but when we are explaining a situation, health literacy comes into play.
- The number of kids who qualify as homeless in the schools has increased.

Who are some populations in your area who are not regularly accessing health care and social services? Responses included:

- Our transient populations, who have many socioeconomic barriers. They don't have the time or the ability to make the time. We also see kids in the community who live with their grandparents or aunts and uncles.
- Our Hispanic population because of language barriers and cultural concerns that they won't be treated the same way as someone who speaks English. So much of health care is technologically driven and this affects the population over 65. They don't have the knowledge base to navigate making appointments. We saw with COVID-19-19 vaccinations it was very technically driven, and seniors struggled with that.
- The Latino populations. They were a difficult population to reach before, and now with COVID-19-19, there are many who prefer to stay under the radar and they aren't getting the help they need.
- Our service area has larger than average number of undocumented individuals and those who are not eligible for Medicaid or other insurance coverage. They tend to stay away and when something happens, they call 911 and end up in the

ambulance. In the ED they will leave without medical permission because they don't want the expense and will sacrifice their health.

- We have a lot of migrant farmworkers and first-generation members looking for work and staying with family. It is a unique phenomenon that you don't see in other metro areas. And we have untreated chronic conditions, like diabetes and people are not seeking proactive care.
- People without health insurance. Over the last year, most people did not undertake routine preventive care, due to fear, or they can't take time off work.
- The uninsured and underinsured who cannot afford to use their insurance because of the copay or deductible costs. Immigrant status, language barriers and race issues impact access to care.
- Historically, young people don't think they have to get testing done, or they ignore symptoms. They don't perceive a need, or they might be uninsured or underinsured.
- Other populations are those just above the federal poverty line, many are parents with young children. They don't make enough to get private insurance and they are not getting insurance from their jobs. That population is always at risk because they are above the point where they qualify for food stamps and medical care.
- There is still a lot of fear for older adults. Seniors feel stuck at home. Prior to the pandemic, they used public transportation but they are fearful now.

How has the COVID-19 pandemic influenced or changed the unmet health-related needs in your community? Responses included:

- With COVID-19, it has been a difficult year. Everyone's mental health has been impacted and people are lonely and scared to go out, even though they are vaccinated.
- For so long doctor offices were closed. And people were afraid to go to the doctor when they did open back up. Those who didn't have access to computers couldn't use telehealth.
- As a school district, we had to supply computers and tech accessories for people. The free lunch program during the pandemic saw a huge increase in use. We had free breakfast and lunch for anyone under 18 and during the pandemic we opened it up to all families in general, 5 days a week.
- People are fearful about accessing health care because they do not know what to expect.
- The need for food and transportation services continue to grow and we can't meet the need. It pays to stay home versus go to work right now and with the rent moratoriums ending in July, people are so far behind on their rent, especially seniors, they won't be able to maintain their homes. Some places are putting seniors in hotels, but that is a small number. With the uptick in the virus, I can see adult day care and senior centers that just opened are being shut back down again. People will go back to being reclusive.
- 60% of our workforce in Adams County are essential workers, meaning our workers never went home. These workers are nurses, emergency medical services,

law enforcement, Amazon distribution workers, and grocery store clerks. We are a county of the working class and during the pandemic, they stayed at work. It is not surprising that they have had harsher health outcomes and that has increased the strain on our community and our mental health challenges. We have had many deaths in our community due to COVID-19-19.

- People stayed away and elective procedures were suspended. There are those who believe the virus is a real threat and those who don't. And in many cases, care has been delayed, essential care, so it becomes more complicated when they do get to the hospital.
- Mental health has suffered and telehealth visits have exploded but not everyone has access to that or is comfortable with telehealth. It has exacerbated the unmet need for everyone but especially people who were struggling before. If coverage was a problem before, it likely still is. People did not go to the doctor in the past year because of uncertainty.
- Transportation is much more difficult due to fear and reduced schedules.
- Mental health services have gotten worse. It was difficult before, with wait lists averaging 3 to 6 weeks. I understand the wait is even longer now.
- There have been increased needs around mental health care, suicide rates have increased, and people are in need of housing and rental assistance. Food insecurity is an issue due to lack of financial resources.
- People of color are more disproportionately impacted because they often live in multigenerational homes and a denser environment. There is a lot of mistrust and questions about the validity of the vaccine and distrust of those who give the vaccine. This is compounded by poor health care delivery in some communities and a lack of education and trust.
- There has been a lot more collaboration on services. We've seen a lot more collaboration with agencies that we didn't see prior to the pandemic.
- There is a lack of general information about the necessity of getting the vaccination; it is not just about you, but for those around you.
- We are seeing an increase in psychotic disorders and substance use disorders. We are not sure why it is happening, partly because people were afraid to access services during the pandemic. With substance use, it is used as a coping mechanism.
- We did not anticipate how helpful and successful telehealth could be. If people don't have transportation or the ability to get to a clinic, telehealth was extremely helpful.
- Childcare was collectively an issue for everyone, regardless of income. But it highlighted the challenges of arranging childcare for persons working minimum wage jobs. It was a disruptive time for kids, and it was complicated to work for family members working multiple jobs, living in multigenerational households. Telehealth was helpful, because it addressed challenges like transportation and made health appointments easier. And for mental health issues, it helped to reduce some of the stigma of seeing someone face to face.

- Everyone is behind on their care. A lot of offices were shut down, and virtual visits are not the same as in person, especially for a child. Even if you are connected to a primary care provider, if you haven't seen that practitioner in two years, we are missing things. We are really behind on preventive health care.

Access to Health Care: Issues, Challenges and Barriers

- Money, time, and not knowing where to go for health care, those can all be barriers. We have employers who don't want to give people time off to go to the doctor, and they are only open during the week.
- For the Hispanic population, it is about having access to someone who speaks Spanish. For those Spanish speaking individuals, health care works differently in other countries, so knowing that is a hurdle for people to jump through.
- For persons over the age of 65, they may need technology training or maybe we need to provide alternatives to making appointments and getting medications that aren't email and computer-based.
- There are many rural areas here, and there are not a lot of options for transportation.
- People don't seek care because they are terrified of the costs. People will stay away even when they have insurance because it doesn't always cover the costs. It is the biggest access issue, staying away because of unknown costs.
- We saw positive increases in Medicaid enrollment every month through the end of 2020. There has been an increase in telehealth services, but not everyone has access to broadband or knows how to use it, because of age issues, language barriers, or literacy levels. Telehealth is something that has gone well, but not for everyone.
- Practitioners are not culturally competent and do not provide relevant care and half of our population are Spanish speakers or Hispanic. As a result, people are not comfortable going to the doctor.
- Getting people back on track with routine care has been a challenge and will be more difficult now as we are heading into a difficult time again with the Delta variant. If there is another surge, it might impact certain populations, especially the elderly. There is considerable variance of vaccination rates in terms of age and ethnicity.
- If you are uninsured, that is a huge barrier to costs, and the same if you are underinsured because your insurance won't cover enough. Rural areas are lacking mental health services.
- People were fearful of going to the hospital and medical offices, so they were not getting their regular checkups. People are getting caught up now, and doctor offices are reaching out to people, asking them to come back. Our cancer department has been very taxed with the amount of testing and we are discovering a lot of new cancer diagnoses. We are also experiencing a lot of new diabetes diagnoses. People come in for a COVID-19 test and come out with a diabetes diagnosis.
- One of the major needs for the community is a cancer center. You must travel 30 to 50 miles to get cancer services because we do not provide radiation or extensive

infusion chairs. To have to travel when you are not feeling well, or traveling when you are sick, that is very challenging.

- There is a connection to accessing health care and accessing healthy food. In the health care setting, I wonder how often people are screened for food insecurity and if they are found to be insecure, how are they referred to resources and what is the follow-up?

Diabetes: Issues, Challenges and Barriers

- The Hispanic population often doesn't want to let anyone know they are sick, especially their kids.
- Screening is very important. There is a portion of the population who are not aware they have diabetes. Diabetes, type 1 and type 2, are both complex conditions that require management outside of the health care facility. We need more intensive diabetes classes. Even before they get to the hospital with a crisis, screening could prevent a lot of people from becoming diabetics. We could catch that before there is a cardiovascular or metabolic catastrophe. It needs more community outreach.
- The need for dialysis is huge in the community and the need continues to grow. It is life sustaining, without it, people will die.
- In Brighton about 1 in 10 adults are diagnosed with diabetes. Diabetes can be related to obesity and overweight issues, or it may be that there are more older adults in that community. In the metro area, our highest rates are among Hispanics and black populations. We also recently looked at the percentage of the population that is prediabetic.
- There are a lot of great medications now for diabetes and we know patients benefit greatly from continuous glucose monitoring systems. The problem is Medicare and Medicaid are not covering the cost. Some of the medications, the older ones that are covered, have a lot of side effects, and are often outdated. The new ones are multifunctional with fewer side effects, and patients get control of their blood sugar and weight. There is even inhaled insulin if people can't give themselves a shot. But it really takes Medicare to come to the forefront and approve medications and devices and then usually private insurances follow suit. In the long run, these medications could save Medicare millions of dollars.
- Information sharing is a tremendous asset and source of prevention when people understand the factors that play into illnesses.
- Poor eating habits are a result of a lack of understanding of the consequences of diabetes. Eating is a coping skill and a
- When people are struggling with substance abuse, they aren't taking care of themselves.
- We are experiencing current workflow challenges. We do not have a consistent workforce. It always fluctuates and that impacts access to care.
- We are seeing delays and difficulty in getting appointments. Especially with specialist appointments. There were already wait lists before the pandemic, and now the delay is even greater with specialist access.

way to comfort ourselves. Some people with diabetes may need mental health support or behavioral intervention to help them with their eating habits and exercise and things that control diabetes.

- Diabetes is a challenge because there are so many components to self-management. Patients are ultimately responsible and need to be accountable and it is a fine balance between offering support and treating diabetes.
- Diabetes is intermingled with cardiac issues, depression, hypertension.
- Type 2 diabetes is impacted by food insecurity and obesity.

Food Insecurity: Issues, Challenges and Barriers

- Populations that struggle with food insecurity are the migrant population, Hispanics come through as farm workers, and the transient oil workers who come and go where the work is. Also, the senior population is impacted by food insecurity.
- We recently started a food drive at the hospital. I was not fully aware of what was happening in our community beforehand. There are a lot of children who rely on school-based meals. There is a need for access to good nutritious food.
- People were uncomfortable going to the grocery store, and they still are. We are delivering food and prescriptions. We have done over 900 trips for people who want vaccinations as well. I think our services delivering food will continue post pandemic. It is a mixture, some is donated food, WIC, Farmers' Markets, and low-income seniors, all individuals who otherwise wouldn't have nutritious food. We deliver hundreds of bags of produce and milk and eggs and meat to individuals who otherwise would go without. Some people are not getting vaccinated and that makes them stay home and they are not able to socialize and get to their medical appointments.
- We do have food insecurity. We've had a lot of additional resources with the pandemic to apply toward food pantries and we know those needs will be continuing, especially with supplemental income and eviction moratoriums ending.
- Even before the pandemic, we had high rates of food insecurity. In Adams County, in 2019 we had 13-15% of high school kids reported as food insecure. And about one in ten adults, over the age of 65, and similar rates for pregnant women are food insecure. And with the pandemic, our numbers have gotten worse. The school did a good job with breakfast and lunch, but it took a while for schools to get plans in place during the pandemic. We have always had difficulty enrolling everyone who is eligible for WIC. In 2017, only 50% of those who were eligible were enrolled.
- Food insecurity will continue to be a problem. If you are struggling with housing costs, one of the easiest things to do is adjust the small daily expenses and food is one of them, so people will go without, or with less, or they are eating poor quality food.
- I don't think we have a good centralized system to distribute food; it isn't well coordinated.
- There is a disconnect with food pantries. The food pantries are privately run and owned and they prefer to receive money donations. They can take that money and go to the foodbank and get food at

discounted rates. But they struggle to keep their doors open sometimes because they lack consistent monetary provisions.

- Families have had to obtain financial assistance. And it is hard to get a job now. Even with jobs reopening, often they are bringing in a new employee at a lower salary. That is a challenge for someone who was a long-term employee, who managed their daily budget and now they have to start over somewhere else at minimum wage.
- We are a federally funded foodbank. We have seen our participation rates decreasing over recent years. It might be related to other resources available in the community, like the expanding benefits of SNAP. A lot of individuals prefer to shop for their own food and freely use the funds provided compared to our program, where we provide preselected shelf stable items selected by the government. During the pandemic, there was an expansion of programs in the community providing hot meals and fresh produce. We are trying to make modifications to our program, but we are federally regulated.
- In the past year, there have been frequent suggestions from clients that there is a lack of cultural diversity in food assistance programs. There is not a lot of cultural sensitivity in the programs, it is more of a one size fits all model in the food provided.
- It was very directly impacted during the pandemic but it seems to be going back to normal now. People can get food, but oftentimes, it is not nutritious, people are eating a lot of fast food and processed food that is high in calories.
- Food insecurity is an issue, but there are programs in our community to address the topic. We have a lot of food banks that are well supported by farmers and grocers. We have WIC and SNAP, though there are requirements about citizenship. We do see unhealthy eating, but I don't see access to food as a large barrier. Even in schools, they are now offering free lunches.
- Everything is free at schools right now, but before, parents had to fill out paperwork and some wouldn't because they didn't want anyone tracking that information from the government. Overall, there is a higher need now than before the pandemic and a lot of people are in a situation of need.

Heart Disease and Stroke, Challenges and Barriers

- Urgent care is not equipped to deal with a heart attack or stroke. Where does one start when there is no health care literacy? It is difficult to navigate.
- The barrier is people don't want to be burdened with the perceived costs of seeking care for something that might turn out to not be a problem, so they resist coming in to get episodic or preventive care out of fear that it is just nothing.
- People are obese and overweight, which puts them in a higher risk category for heart problems.
- We are doing an excellent job with our cardiac rehab program and we've expanded it to congestive heart failure patients. We also have an award-winning stroke program and we have free stroke support groups for the public. We also have free cooking classes, with a chef and a dietician, that make heart healthy food

and recommendations.

- There was a study in Denver, they discovered that many people died of a heart attack at home during the pandemic because they were too afraid to go to the ED because of COVID-19.

Housing: Issues, Challenges and Barriers

- Housing is difficult in Colorado. We have a pretty big homeless population and a lot of individuals living in subsidized housing. In the school, we have about 30 families who are categorized as homeless.
- Colorado is a very expensive place to live, no matter who you are and senior living units fill up quickly. There is a huge wait list for low-income housing and it will continue to be an issue until we can meet the need.
- Sometimes hospitals cannot discharge someone because we lack a place to discharge them to. For example, with the homeless or new moms with babies it is not safe to discharge them without a home. The hospital tries to coordinate a place for them to live when there are no family or friends willing to take them. They are just not discharge appropriate. Community partners can be part of the solution to solve that challenge.
- You need a minimum of $17 an hour to pay for the cost of housing in Adams County.

  We have pretty high rates of evictions and with so many folks making ends meet with the gig economy and their supplemental income falling out the bottom with the pandemic, we are facing difficult times.
- Colorado legalized marijuana 10 years ago and we have had a steady increase of people moving here that our state wasn't prepared for, so housing prices have gone up and incomes have not increased at the same rate. If you pay more for housing, you will pay less for something else and there is a direct relationship with housing and food insecurity. We also think people are trapped in their homes and are experiencing domestic violence.
- We have a growing homelessness issue here. We have a shortage of affordable housing for seniors as well.
- Some communities do not have complementary ancillary services where they live.
- The 211 guide has information about housing. And there are many resource guides in the community, but a lot of them are outdated. There are also significant limitations in terms of which county you live in, what you qualify for, or that there are only certain days when the office is open and you have to fill out an application in person. That part has improved with the pandemic because they now have it online. Once you get plugged in, there are resources, like resume writing, clothing, food, and case management services. But if you don't have a home, you can't really work.
- There is no new affordable housing being built as our community continues to grow. For Section 8 housing, it is a wait of a couple of years. For seniors, we have an abundance of specialized nursing facilities and assisted living care. What we do not have is transitional housing for people transitioning off the streets. We have vouchers for housing, but most landlords are not willing to take the vouchers.

- Our only shelter only takes families, so if you are single or don't have children, you have nowhere to go. We will call around for shelters, but they are a distance away. How do we get people there? If they have a car, they prefer to sleep in their car rather than the shelter.
- If we are going to address housing, then we will not have funds to address anything else. It is such a big-ticket item; it just swallows up everyone's budgets. We find a lot of our patients are being taken advantage of in their leases and they don't feel they have a voice or rights because they are fearful of losing their housing because there are not many other options they can afford.
- Pre-pandemic, we didn't have enough shelter space for the level of homelessness we have in our community and it has gotten more difficult with the pandemic. There have been more resources poured into the community, but the coordination of getting resources into the hands of people who need it is lacking. We are better equipped than before to refer someone to resources than before, but there is still a disconnect. At our schools we haven't laid eyes on kids in over a year. As a result, we are not in touch and may not see issues surface in real time for families in need. Usually, we would proactively reach out to them and assist them. But it is different now.

Mental Health: Issues, Challenges and Barriers

- We do not have a lot of adolescent mental health doctors in the state. There is a lot of social anxiety about coming back to in-person learning after online school. And some are facing a new school, like 6th and 9th graders who will suddenly be thrust into an environment that is new for them. We have one counselor for 600 high school students and one counselor for 400 middle school children. We anticipate there will be a lot of children who will be floundering.
- Like so many communities, there are not enough resources for mental health. It is not unusual to have someone with suicidal ideation who must spend three days in the ED or simply get discharged home because they do not qualify for inpatient facility care. There is stigma around accessing mental health provisions, whether medication or therapy or psychotherapy. Issues include culture and having enough money for services. If you do not have funds to access services, we need to provide that as a community.
- Waiting 2.5 months for an appointment is an eternity when you are waiting for a therapist. If people are having these issues, they need to know where to go and how to make it happen in a timely fashion.
- I've seen a big increase in the number of trips to mental health centers with our riders. People are really struggling with the pandemic, especially older people. They are scared, they listen to the news and it just scares them more. And the variant is scaring them even more than the original pandemic.
- We have a very bifurcated system. People should know if they are having a behavioral health issue to go to a crisis walk-in center versus the ED, but people don't know that, so the ED should be prepared to serve that population. Especially those in the middle of a crisis, they won't be able to figure that out, they will go where there are the brightest lights, and that is the ED.

- Mental health distress has increased over time. For 2019, 32% of high school students reported mental distress and 13% of high school students in Adams County made a suicide plan, and this is probably underreported. Children's Hospital Colorado declared suicide a public health emergency in Colorado. We have seen quite a few recent suicides in Aurora and the metro areas. That is why people are so hopeful that kids will get back to school and some normalcy to their lives.
- There is a high percentage of recent depression or mental health issues being reported among public health departments and people working in health care.
- There is a lack of resources, whether we are talking about insurance coverage, providers, or access to services. We have seen a steady increase in suicides since 2013, so suicide assessments and intervention are critical.
- Telehealth is helping with mental health access, but in general, psychiatrists are a limited resource.
- There are not enough practitioners and as we move toward virtual services, some communities are disadvantaged because they do not have internet or technology to facilitate those appointments.
- There is disbelief and mistrust and not enough education about medications for mental health in communities of color.
- There have been so many more mental health resources made available and hopefully people are getting the care they need. People are starting to get more referrals, and we are seeing more people talk about it with their providers. In Douglas County, the school district reported there is a huge rise in the number of children diagnosed with eating disorders. It is currently 6 times higher than it was prior to the pandemic.
- We have seniors who expressed loneliness. And many seniors have noted their medications have not arrived in the mail and they feel hopelessness. They do not know how to advocate for themselves or know who to contact with a mail delivery service, compared to the local pharmacy they are accustomed to using.
- The process of getting mental health care help when you are in the middle of a crisis is exhausting. By the time you receive help, you aren't interested anymore. When people experience delayed services, they often give up, they return to their substances of choice, what was comforting them before, or they return to the abusive, mental or physical or verbal, relationship they can't get out of. Or they take their own lives.
- There are not enough practitioners for the population. It is critical to have access, so when something does come up, you have the support so things don't worsen. For substance misuse, we have medication assisted treatment programs. We have enough providers who can prescribe the suboxone, but it is the behavioral health piece where we fall short; people need to have access to support.
- More people are struggling and shouldering issues, like housing concerns and food insecurity. Addressing these issues contribute to mental health issues. As we get our eyes back on kids, there are going to be a lot of them in need of services not identified before. Parents may not see the symptoms or think it is something serious. We've only been back a week, but we imagine in the next 30

days, we will see a lot of kids acting out and having behavioral issues. They are suddenly back in a structured environment and have expectations placed on them. As parents were at home with their kids, fatigue may have set in, and they got relaxed and off schedule. Now they are back on a schedule and are expected to behave correctly.

Appendix 4. 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 5. 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 6. Review of Progress

Platte Valley Medical Center developed and approved an Implementation Strategy or Community Health Improvement Plan (CHIP) to address significant health needs identified in the 2018 Community Health Needs Assessment. PVMC addressed: mental health and substance abuse, and heart disease and stroke through a commitment of community benefit programs and resources.

To accomplish the CHIP, goals were established that indicated the expected changes in the health needs as a result of community programs and education. Strategies to address the priority health needs were identified and measures tracked. The following section outlines the significant health needs addressed since the completion of the 2018 CHNA and the 2019 CHIP.

Mental Health and Substance Use

Goal: By 2030, decrease the suicide rate by 4% in Adams and Weld counties (the measure is the annual age-adjusted suicide death rate per 100,000 residents.

Suicide Rates, 2017-2020 Change

	Adams County	Weld County
2017	21.8	16.3
2020	22.0	17.0
Change	↑0.2%	↑0.7%

Goal: by 2030, decrease drug induced deaths by 4% in Adams and Weld counties (the measure is the annual age-adjusted drug induced death rate per 100,000 residents).

Drug-Induced Death Rates, 2017-2020 Change

	Adams County	Weld County
2017	23.5	11.8
2020	26.7	16.7
Change	↑3.2%	↑4.9%

Strategies	Accomplishments
Improve timely access to mental health and substance abuse treatment options.	• Partnered with Denver Health who provides psychiatric consults via Skype and Community Reach (a community-based behavioral health provider) to provide on-site counselors to work with patients that are designated as an M-1 hold. This partnership changed in June, 2020 as we shifted to a partnership with West Pines Behavioral Health for these patients. These patients could be a danger to themselves or others or exhibit other serious mental disabilities. These interventions have been important to improving access to mental health services and improved care coordination leveraged between internal and external organizations. • Participated in the Colorado Hospitals Substance Exposed Newborns Quality Improvement Collaborative (CHoSEN) to improve outcomes for newborns exposed to methamphetamines or opioids prior to birth and decrease length of stay.
Improve Opioid Prescription Safety.	• Participation in the Colorado Alternatives to opioids (ALTO) Project lowered new opioid prescriptions (only 2.26% of new opioid prescription given to discharging patients exceeded 7 days in duration) and increased the percentage of e-prescribing of controlled substances for discharged patients (87.32% in 2020, 80.77% in 2019). • Initiated a program to distribute a NARCAN kit at discharge to any patient admitted with a diagnosis of heroin or opioid overdose. 33 NARCAN Kits have been distributed to date to at-risk patients who are discharged from the Emergency Department or Inpatient Unit. • PVMC actively participated in Weld County Health Department's "Thriving Weld" initiatives and serves on Tri-County Health Department's Overdose Prevention Partnership.
Increase knowledge of signs and symptoms, treatment and resources for mental health and substance use.	• PVMC had four in-person Mental Health First Aid (MHFA) classes scheduled in 2020. Due to the COVID-19 restrictions, all in-person classes were canceled. One virtual class was provided in the fall for ten people. The MHFA class is an evidence-based training programs to community and PVMC associates to address mental health and is offered at no cost. 69 persons attended the training in 2019-2020. • PVMC had scheduled four sets of the evidence based "Aging Mastery Program" curriculum (10 classes each), including a class focused on decreasing social isolation in older adults. However, due to COVID-19 restrictions, the first program was only half completed before we had to cancel the class. A second class was offered virtually in the fall. 47 persons attended the classes in 2019-2020. • The annual Health Fair which had provided in-person Mental Health screenings for participants was canceled due to the COVID-19 pandemic. Grant dollars were given to our local counseling center so that they would be able to assist with the increase need

	for Mental Health services. 518 individuals participated in the Health Fair in 2019. • PVMC sponsored three Question, Persuade, Refer (QPR) trainings in Spring 2021. QPR is an evidence-based suicide prevention training. 70 individuals participated in the training offered by Mental Health Partners.

Heart Disease and Stroke (Cardiovascular Disease)

Goal: By 2030, decrease mortality related to heart disease by 4% (the measure is the annual age-adjusted heart disease death rate per 100,000 residents).

Heart Disease Mortality Rates, 2017-2020 Change

	Adams County	Weld County
2017	128.2	122.2
2020	149.7	115.8
Change	↑21.5%	↓6.4%

Goal: By 2030, decrease mortality related to stroke to 34.8 (the measure is the annual age-adjusted stroke death rate per 100,000 residents).

Stroke Mortality Rates, 2017-2020 Change

	Adams County	Weld County
2017	40.6	42.6
2020	43.8	27.5
Change	↑3.2%	↓15.1%

Strategies	Accomplishments
Increase knowledge about cardiovascular disease in the community.	• Due to COVID-19-19, all of the outreach events in 2020 were canceled. A heart and stroke campaign was launched via the PVMC Facebook page and was targeted to people within a 10 mile radius of the hospital aged 50-65+. Three educational ads were created and reached an average of 3,000 people each. Information shared included the signs and symptoms of a heart attack or stroke and how COVID-19-19 can increase the incidence of strokes. • In 2020, PVMC offered an evidence-based healthy cooking class, “Cooking Matters” to promote heart healthy eating. The program was scheduled to be offered 4 times (6 classes each) but was only offered once due to COVID-19-19 restrictions to 13 participants. The class was not able to be adapted to an online format.
Provide support for caregivers and stroke survivors.	• Provided monthly support Groups for stroke survivors or caregivers. Due to COVID-19-19 restrictions, the in-person meetings were switched to virtual meetings beginning in May 2020.
Improve workforce capacity and competence to provide the best care possible for cardiac event and stroke patients.	• An ultra-low risk chest pain pathway to prevent unnecessary hospital admissions and reduce associated costs was implemented in Q1 2017 and is currently in use. • In order to provide the community with superior cardiac care, PVMC was recertified as a Primary Stroke Center on September 17, 2019 and earned Chest Pain certification in March of 2021.