

2019 Community Health Implementation Plan  
FY 2020–2022

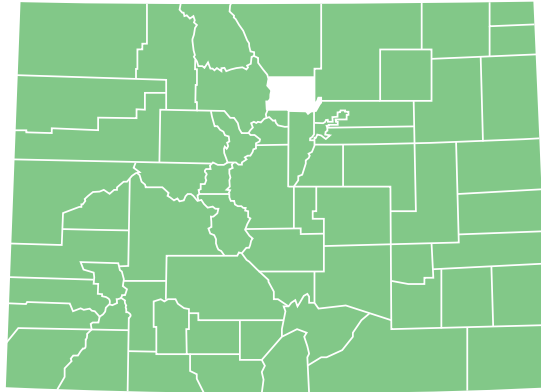
# Avista Adventist Hospital



AT A GLANCE:

# Avista Adventist Hospital

AREA SERVED: BOULDER AND BROOMFIELD COUNTIES



## PRIORITIES:



Behavioral Health



Food Security



Access to Safe and  
Stable Housing  
and Shelter

## PARTNERS:

Mental Health Partners, Colorado Community Health Alliance, Boulder Seventh-day Adventist Church, Chapel Haven Seventh-day Adventist Church, Foothills United Way, Nurse Family Partnership, Broomfield Public Health, Boulder County Public Health, Rocky Mountain Adventist Health, The Natural Funeral, Boulder County Child Welfare, Clinica, Broomfield Community Foundation, City Unite

2019 COMMUNITY HEALTH NEEDS ASSESSMENT

**AVISTA ADVENTIST HOSPITAL**

TABLE OF CONTENTS

Mission, Vision and Values ..... 4

Executive Summary ..... 5

Our Services and Our Community ..... 7

Working with Community ..... 10

How We Make a Difference ..... 10

Our Priorities and Plans ..... 12

- Behavioral Health
- Food Security
- Access to Safe and Stable Housing and Shelter

Conclusion ..... 24





## OUR MISSION, OUR VISION, AND OUR VALUES

### **Mission**

We extend the healing ministry of Christ by caring for those who are ill and by nurturing the health of the people in our communities.

### **Vision**

Every community, every neighborhood, every life – whole and healthy.

### **Values**

Compassion

Respect

Integrity

Spirituality

Stewardship

Imagination

Excellence



# Executive Summary

On May 15, 2019, the Avista Adventist Hospital Board of Directors approved the 2019 Avista Adventist Hospital Community Health Needs Assessment (CHNA) priorities of Behavioral Health, Food Security, and Access to Safe and Stable Housing and Shelter. The CHNA was the third iteration of our process to strategically ignite whole person health in each community we touch. At Centura Health, we are a diverse community of caregivers connected and fueled by our individual passions and purposes to change the world around us. While individually inspired, we are collectively unified by our Centura Health mission. The CHNA process presents an opportunity for Avista Adventist Hospital to fulfill our commitment to our organizational mission to extend the healing ministry of Christ by caring for those who are ill and by nurturing the health of the people in our communities. Based upon the input we received during the CHNA process and by reviewing community assets and gaps, we developed our Community Health Implementation Plan (CHIP), setting our path forward to building wholeness and flourishing communities. This plan is designed to continue to amplify meaningful collaboration among Avista Adventist Hospital, local public health departments, community leaders, and partner organizations.

The Avista Adventist Hospital Community Health Implementation Plan (CHIP) recognizes the health needs prioritized in our CHNA as tough health issues that cannot be solved by any single organization on its own. To positively impact the health priorities requires a collaborative and strengths-based approach. The CHIP elevates those strategies a hospital can implement on its own and with community partners to impact community health.

The strategies Avista Adventist Hospital plans to use to address the health priorities leverages our role as a large business and employer, a health care organization and a nonprofit hospital partner. Like our approach toward medicine, we are committed to using evidence-based strategies to address the health needs of the community.

As Centura Health looked across our system of care throughout Colorado and western Kansas at the health issues rising to the top as potential priorities, we recognized every hospital community had a need related to food security, or access to healthy, affordable foods. At Avista Adventist Hospital, both Cancer and Heart Health did arise as community needs which were not prioritized. For both Cancer and Heart Health, Food Security plays a significant role by assuring that lower income people in the community are able to access healthy foods and, therefore, prevent cancer and cardiovascular disease. Food Security, along with Homelessness, is a Social Determinant of Health and is, therefore, an essential building block toward health and well-being. Food security enables people with limited income to focus on healthy eating by removing cost and transportation barriers related to purchasing healthy food. Additionally, it removes the stressor of whether and how food will be on the table. As a result, our Board of Directors added this as a priority for Avista Adventist Hospital. On September 18, 2019, our Board of Directors approved Food Security as a CHNA priority and our Community Health Improvement Plan for FY2020-FY2022.

## BEHAVIORAL HEALTH GOALS

- **Goal 1:** Reach 80% of school-aged youth with a behavioral health strategy.
- **Goal 2:** Increase capacity of our community to support behavioral health needs through increased awareness of behavioral health and reduced stigma associated with behavioral health.
- **Goal 3:** Increase people reporting access to behavioral health services by 40%.

## FOOD SECURITY GOALS

- **Goal 1:** Increase by 20% the number of produce sites which accept SNAP and WIC at point of purchase.
- **Goal 2:** Increase number of sources of healthy affordable food within the community by decreasing the number of food deserts by 20%.
- **Goal 3:** Decrease the number of community members who are eligible but not enrolled in SNAP by 60%.
- **Goal 4:** Increase use of locally sourced healthy, affordable food within Centura Health by 50%.

## ACCESS TO SAFE AND STABLE HOUSING AND SHELTER GOALS

- **Goal 1:** Increase access to safe and stable housing and shelter within the community.
- **Goal 2:** Increase by 60% the number of community members who are identified for housing insecurity and referred to resources in the community.



# Our Services and Community

## CENTURY LONG LEGACY OF AWARD WINNING SERVICES TO HEAL, INSPIRE AND CONNECT OUR COMMUNITY.

Avista Adventist Hospital is a comprehensive medical center known for its higher level of personalized, whole person care, that's been the hallmark of the organization for more than a century. The 114-bed full service community hospital provides a full range of medical specialties and exceptional health care to the Louisville, Superior, Broomfield and surrounding Boulder County communities. Known for its award winning joint and spine program, as well as its widely recognized New Life Center and the area's largest neonatal intensive care nursery.

**Distinctive Services** *Noteworthy areas of care include:*

### **First-Rate Heart & Vascular**

- Society of Cardiovascular Patient Care
- Chest Pain Center Accreditation

### **Primary Stroke Center**

- Joint Commission: Gold Seal of Approval

### **Award Winning Joint and Spine Program**

- Joint Commission: Gold Seal of Approval

### **Award Winning New Life Center and the area's largest Neonatal Intensive Care Unit**

- Joint Commission: Gold Seal of Approval

### **Award Winning Women's Care**

- AAGL: Center of Excellence in Minimally Invasive Gynecology

### **GI Center of Excellence certified by the American Society for Gastrointestinal Endoscopy**

### **CNOR Strong**

- Recognition of a high level of advanced certification among operating room nurses. Nursing excellence for enhanced patient safety

### **\*NICHE Designated Hospital**

- \*NICHE is the leading nurse driven program designed to help hospitals and healthcare organizations improve the care of older adults.

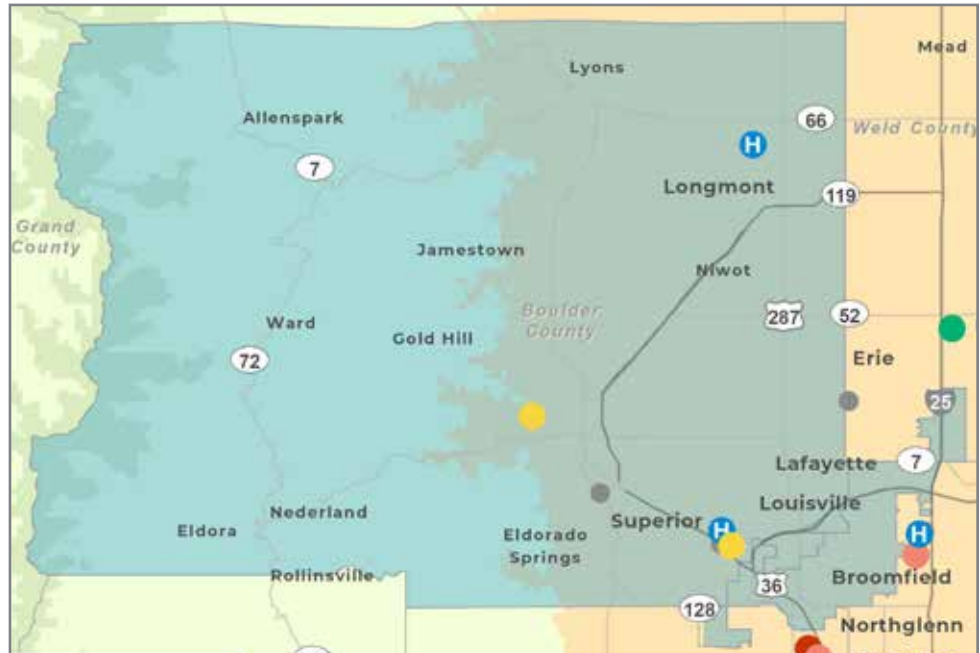
### **Honors**

Healthgrades has named Avista Adventist Hospital among the Top 10% in the nation for Outstanding Patient Experience (2016-2018). The hospital is also honored with five-star awards for its treatment of Pneumonia and Sepsis (2015-2018) – as well as Total Knee Replacement (2016-2018).



## OUR COMMUNITY

At Centura Health and Avista Adventist Hospital, we remain committed to advancing vibrant and flourishing communities. The CHIP helps fuel our caregivers to continuously engage with, understand, and contribute to whole person health in our shared neighborhoods. By focusing on Behavioral Health, Food Security and Access to Safe and Stable Housing and Shelter for the next three years, we are excited to continue to live out our Mission, Vision, and Values every day.



To define Avista Adventist Hospital's service area for the CHNA, we followed a process focused on ensuring that the defined service area was inclusive of medically underserved, low-income and minority populations in the geographical areas from which the hospital draws its patients. We considered four factors:

- Opportunities to viably expand outreach of programs to medically underserved populations
- Inpatient admissions
- Coverage of the County by another Centura facility
- Opportunities for collaboration among facilities and with community-based organizations

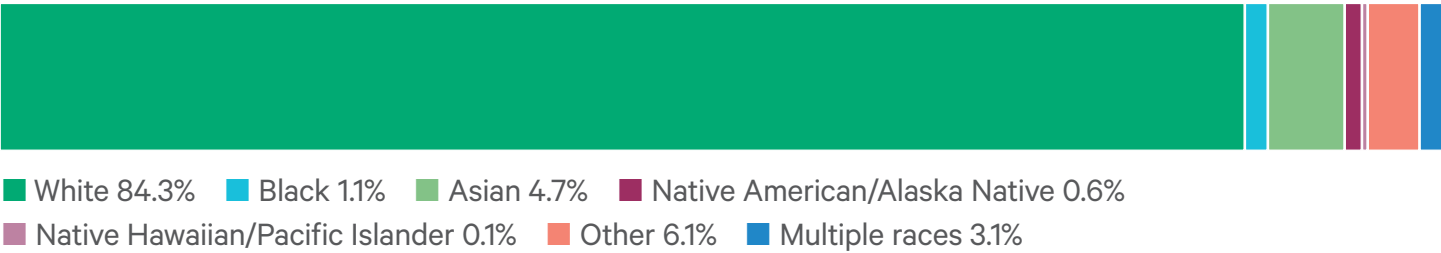
After considering the factors above, we compared the defined geographical service area of the 2016 CHNA to this one to ensure no disadvantaged populations included in the 2016 CHNA were excluded in the 2019 CHNA.

To understand the profile of Avista Adventist Hospital's community we analyzed the demographic and health indicator data of the population within the defined service area. The service area has a total population of 422,294. The demographic makeup of these communities is on the following page.

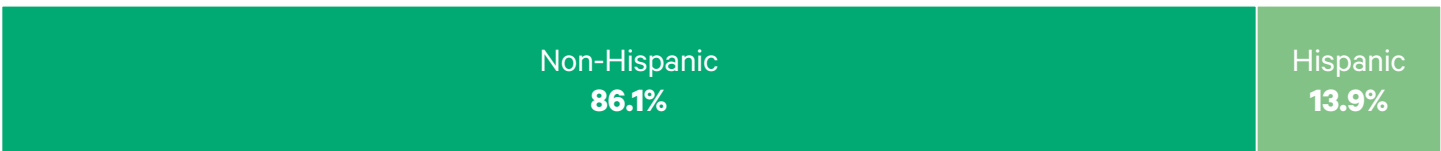


# POPULATION DEMOGRAPHICS IN AVISTA ADVENTIST HOSPITAL'S SERVICE AREA

## Race



## Ethnicity



## Associates Degree or Higher



## High School Graduation Rate



**Limited English Proficiency**

**1.9%**

Avista Adventist Service Area

**2.8%** CO

**Income inequality, or the ratio of households at 80th percentile of income to those at the 20th percentile of income:**

**4.9**

Avista Adventist Service Area

**4.5** CO

**Unemployment Rate**

**3.2%**

Avista Adventist Service Area

**3.9%** CO

# Prioritized Needs and Plans

## WORKING WITH COMMUNITY

Avista Adventist Hospital collaborated with Boulder County Public Health and Broomfield County Public Health with their representation on our Advisory Subcommittee. In addition to serving on our Advisory Subcommittee, we agreed with the public health departments to align community-based efforts in order to address community health holistically and to avoid duplication. We leveraged their qualitative data collected through focus groups to inform our CHNA. We have intentionally aligned strategies, as applicable, to ensure greater movement toward same goals with complementary efforts.

We created a hospital subcommittee to solicit and take into account input from individuals and organizations representing the broad interest of our community to assess the needs of our community. Please see Appendix A for a list of Avista Adventist Hospital's subcommittee members. Our subcommittee:

- Reviewed the quantitative data and provided insight; and
- Prioritized health needs using the Centura Health Prioritization Method;

Our subcommittee met three times for two hours each meeting in order to rank and prioritize health needs, assets and gaps and to design the overarching strategies to be used to address the health needs. After careful consideration of the available quantitative and qualitative indicators and our Centura Health Mission, Vision and Values, Avista Adventist Hospital identified Behavioral Health, Food Security, and Access to Safe and Stable Housing and Shelter as priority focus areas.

After identifying our priorities, we reviewed the assets and gaps identified by the subcommittee to develop the Avista Adventist Hospital Community Health Implementation Plan (CHIP). The CHIP recognizes the health needs prioritized in our CHNA as tough health issues that cannot be solved by any single organization on its own. To positively impact the health priorities requires a collaborative and strengths-based approach. The CHIP elevates those strategies a hospital can implement on its own and with community partners to impact community health.

## HOW WE MAKE A DIFFERENCE

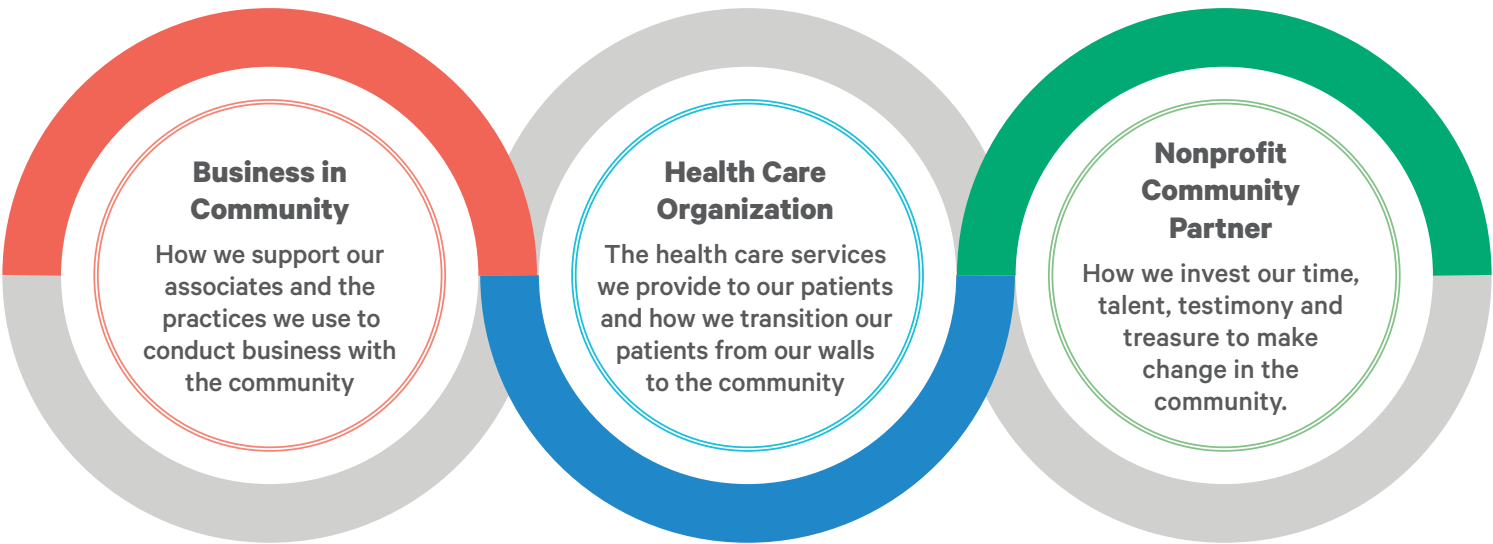
The strategies Avista Adventist Hospital will use to address the health priorities leverages our role as a large business and employer, a health care organization and a nonprofit hospital partner. (See Figure 1) Like our approach toward medicine, we are committed to using evidence-based strategies to address the health needs of the community. Our intent in every strategy is to leverage our strengths and community partnerships, fill gaps and use strategies that catalyze community change.



Our CHNA and CHIP processes integrated in the Colorado Hospital Transformation Program (HTP) Community and Health Neighborhood Engagement process. We value the time and voices of our community. We also believe our community health priorities and strategies should align with and complement HTP clinical strategies to yield the greatest outcomes for those in our communities. To that end, there are HTP metrics included in our CHIP to leverage our role as a health care provider to impact community health priorities.

FIGURE 1: Centura’s Role

HOW WE INVEST IN COMMUNITY HEALTH



In order to support whole person health, we recognize that health is more than the choices an individual makes. Rather, a person’s health is their community, requiring a healthy ecosystem to supporting the mind, body and spirit of individuals.



We use the socioecological model to address the health of our communities. This model recognizes the complex interplay between individual, relationship, community and societal factors. Individuals are responsible for making and maintaining lifestyle choices, such as eating healthy foods and refraining from substance use. However, the ability to make these choices is determined largely by the social environment in which we live (e.g., community norms, laws and policies). It is important to be surrounded by a community supportive of a person’s overall wellbeing. Communities should not have barriers to being healthy based upon a person’s race, ethnicity, income, or where they live, work, play or learn.

Each part of the wheel illustrates the contributing factors to whole person health, each factor influencing the others. Without all portions, the wheel does not smoothly move in a positive direction for whole person health (See Figure 2). Therefore,

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

FIGURE 2: Socioecological Model for Whole Person Health



## PRIORITIZED NEEDS AND PLANS

After careful consideration of the available quantitative and qualitative indicators and our Centura Health Mission, Vision, and Values, Avista Adventist Hospital identified Behavioral Health, Food Security, and Access to Safe and Stable Housing and Shelter as priority focus areas.

At Avista Adventist Hospital, we are collectively unified by our Centura Health Mission: We extend the healing ministry of Christ by caring for those who are ill and by nurturing the health of the people in our communities. This Mission guides and inspires our shared desire to make a difference – one whole person and one healthy neighborhood at a time. We believe that our focus on Behavioral Health, Food Security and Access to Safe and Stable Housing and Shelter will have the greatest impact on our organizational commitment to whole person health.



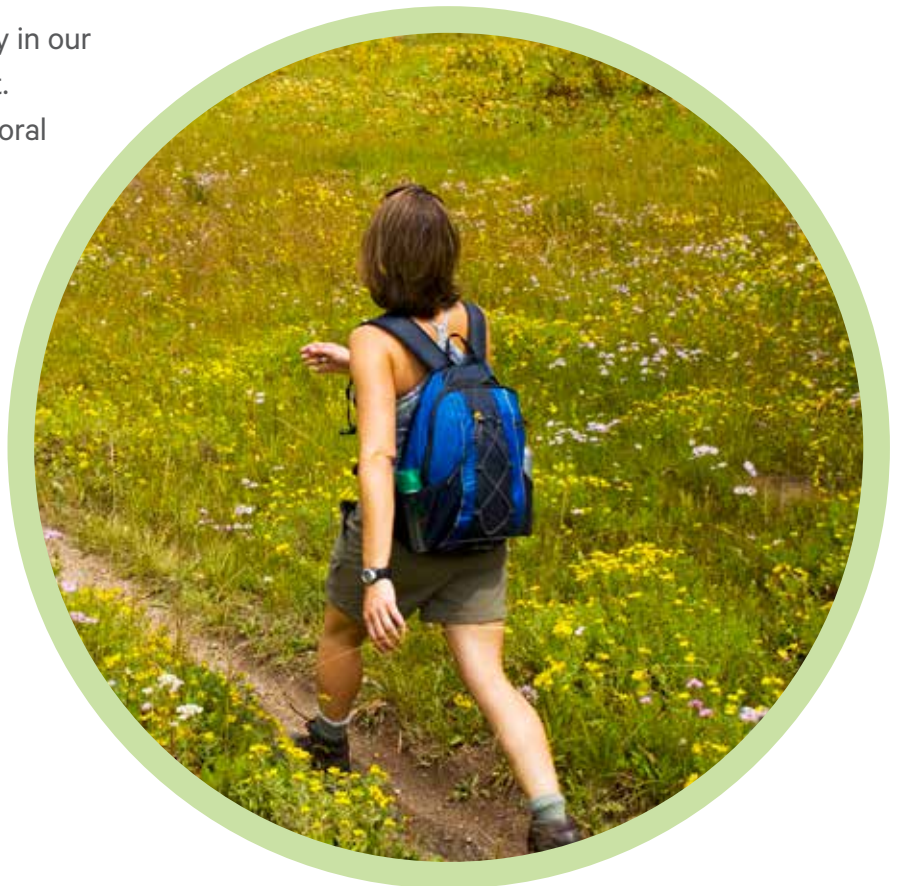
## PRIORITIZED NEED: BEHAVIORAL HEALTH

Both quantitative and qualitative data drove the prioritization of Behavioral Health for Avista Adventist Hospital. The community health data that led to identification of Behavioral Health as a priority included that there are 2,204 mental health hospitalizations per 100,000 population; however, there are only 4.64 providers per 1000 population (CO is at 2.74). The community's suicide rate is 17.9 per 100,000 population, and Colorado ranks as a state highest for suicide. The community's rate of suicide hospitalizations is 37.2 per 100,000 (CO at 52.0). The quantitative population health data available for substance abuse is for alcohol use and tobacco use. Excessive drinking weighted by population is 19.4% (CO at 19.1%), and adult smoking is at 12.5% (CO 15.6%).

Quantitative population health data was validated and strengthened by qualitative data. Both mental health and substance abuse were identified as priorities within community conversations among our CHNA Advisory Subcommittee and the focus groups conducted by Boulder and Broomfield Public Health. These conversations clarified that behavioral health is the greatest community concern. Mental health is a large concern due to the awareness of suicides. The recognition of the hidden mental health needs. While this service area has higher provider availability than many, we still hear that it was difficult to navigate the health system and pay for services. The community emphasized that these are tough issues to address and believe in the importance of coordinating work to have an impact, with solutions spanning from prevention with a focus on youth health and well-being, stigma reduction, screening and treatment.

Behavioral Health was identified as a priority in our 2016 Community Health Needs Assessment.

Avista Adventist Hospital addressed behavioral health through evidence-based approaches including prevention focusing on new moms, education, and stigma reduction. We reached 60 new mothers with the Create Your Life Program. We provided 582 people with supportive therapies to heal mind, body and spirit. We partnered with Metro Denver public health departments to implement the Let's Talk CO stigma reduction campaign, leading to 45,744,882 total impressions. We also received CPC+ funding to integrate behavioral health services into our primary care settings in FY19.





Potential community resources available to address behavioral health include local public health departments which are addressing this priority as part of their Public Health Improvement Plan, which will include a focus on school-age children through the schools. Public Health is working with Human Services to support people in the community who have greater needs through more integrated services. Stigma and community awareness efforts are underway through Mental Health First Aid and the Let's Talk CO social media campaign. A focus on schools has been prioritized for the community. The Mental Health Center and the Federally Qualified Health Centers provide integrated care through partnerships. There are many supports for seniors in the community which can be leveraged to increase resiliency and social cohesion.

Avista Adventist Hospital will leverage our existing efforts with the community and focus on targeting and sustaining these efforts. In addition, as a health care system, we will expand our clinical work to include more behavioral health and substance use screening and referrals to the organizations in the community. As we move forward addressing behavioral health, it is important to recognize two overarching themes from our Advisory Subcommittee: 1) Centura Health is a large system and with our focus on behavioral health with the community, significant changes can occur through our work and our voice regarding the importance of focusing on this issue, and 2) behavioral health should be addressed as part of whole person health, supporting our community's mind, body and spirit in all we do.



# CHNA PRIORITY: BEHAVIORAL HEALTH (BH)

Key: Mental Health (MH) and Substance Use Disorder (SUD)

## Goal 1: Reach 80% of school-aged youth with a behavioral health strategy.

Strategy	Target Population	Action Plan Activity	Metrics
<p>Work with school districts to identify the role of the hospital to support youth, Pre-K – 12.</p> <p>Strategy will include the following:</p> <ol style="list-style-type: none"> <li>1) Stakeholder engagement</li> <li>2) Policy strategy</li> <li>3) Specific plan for Y2 and Y3</li> <li>4) Community input</li> <li>5) Role of Centura Health/Avista Adventist Hospital</li> <li>6) Method for evaluation of success</li> </ol>	School-age youth	<ul style="list-style-type: none"> <li>• Meet with key stakeholders to develop AAH plan.</li> <li>• Develop 3-5 year plan for AAH and schools.</li> </ul>	Plan to reach youth with appropriate BH strategies
Implement strategy to reach youth with BH supports for Y2 and Y3.	School-age youth	To be included after strategy designed for Y2 and Y3.	<ul style="list-style-type: none"> <li>• # of youth reached through programs based upon identified need</li> <li>• Measure of youth resiliency and/or behavioral health status</li> </ul>
Work with state and local officials to support sustainable youth BH programming.	School-age youth	<ul style="list-style-type: none"> <li>• Develop a list of policy solutions related to youth resiliency and social cohesion.</li> <li>• Work with community partners to identify the best policies for our community.</li> </ul>	<ul style="list-style-type: none"> <li>• Policies passed to reach children and sustain best practices</li> <li>• Increase in youth resiliency and/or behavioral health status</li> </ul>



## Goal 2: Increase capacity of our community to support behavioral health needs through increased awareness of behavioral health and reduced stigma associated with behavioral health.

Strategy	Target Population	Action Plan Activity	Metrics
Develop a community strategy for Mental Health First Aid (MHFA) to reach youth and other identified target populations.	Community members	<ul style="list-style-type: none"> <li>• Review current MHFA plan for community and identify populations of focus for community.</li> <li>• Identify MHFA trainers within community and coordinate outreach.</li> <li>• Develop outreach strategy to reach key audiences for MHFA training.</li> <li>• Provide MHFA training to people serving youth within community.</li> <li>• Partner with faith community to reach members of the community with MHFA.</li> </ul>	<ul style="list-style-type: none"> <li>• # of people working with youth who receive MHFA training</li> <li>• # of people not working with youth who receive MHFA training</li> </ul>
Work with state and local leaders to create a sustainable model for MHFA.	Local and State Leaders Community Members	<ul style="list-style-type: none"> <li>• Meet with key coalitions to identify policy strategy for MHFA.</li> <li>• Identify barriers and opportunities related to providing MHFA within CO.</li> <li>• Develop strategy for sustained MHFA within the community.</li> </ul>	Policies passed to sustain MHFA (organizational, state or local policies)
Integrate Let's Talk Stigma Campaign messaging into all work related to behavioral health.	Community Members	<ul style="list-style-type: none"> <li>• Integrate messaging into Centura Health communications.</li> <li>• Integrate messaging through coalitions.</li> <li>• Use messaging with decision-makers.</li> <li>• Develop a plan to sustain stigma campaign for 3-5 years.</li> </ul>	<ul style="list-style-type: none"> <li>• State survey of stigma associated with behavioral health</li> <li>• # of people reached with messaging</li> </ul>





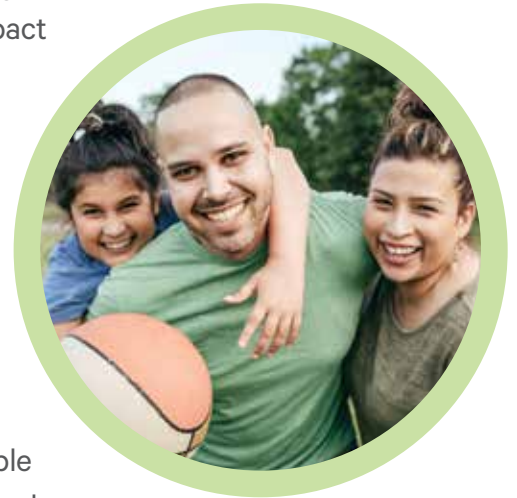
### Goal 3: Increase people reporting access to behavioral health services by 40%.

Strategy	Target Population	Action Plan Activity	Metrics
Partner with community providers to develop a system to reach patients with substance use and behavioral health needs.	Hospital patients with Mental Health or Substance Use Disorder Diagnosis	Establish plan to support patients with mental health needs in the Emergency Department.	# of people screened and referred to Tx
Develop care program for patients with Mental Health (MH) or Substance Use Disorder (SUD) Diagnosis (primary or secondary) that involves discharge planning process with the Regional Accountable Entity (RAE) or consent to notify RAE within one business day.	Hospital patients with Mental Health or Substance Use Disorder Diagnosis	<ul style="list-style-type: none"> <li>• Map out process for patients identified with MH/SUD Dx with RAE.</li> <li>• Identify how to efficiently and effectively transition patients from hospital to RAE and BH services.</li> </ul>	<ul style="list-style-type: none"> <li>• # of people referred to mental health services</li> <li>• % of people connected to mental health services</li> </ul>
Map behavioral health system of care within the community and develop a system to help people navigate care.	Community members with behavioral health needs.	<ul style="list-style-type: none"> <li>• Use existing maps and engage partners in resource mapping process.</li> <li>• Identify opportunities to support people in the community (vs. hospitals) and ways to navigate them to the right treatment at the right time.</li> </ul>	<ul style="list-style-type: none"> <li>• Behavioral Health screening, referral and access map developed</li> <li>• % of people connected to mental health services</li> </ul>
Track and share data re: mental health service needs within the community with state and local leaders to identify systems to increase access.	Policy makers  Community members with MH/ SUD Dx	<ul style="list-style-type: none"> <li>• Develop policy strategy for Behavioral Health with local and state coalitions.</li> <li>• Work with local communities to identify policy priorities.</li> </ul>	<ul style="list-style-type: none"> <li>• % of people connected to mental health services</li> <li>• Systems established with state agencies to sustain effective mental health programming</li> </ul>

## PRIORITIZED NEED: FOOD SECURITY

Healthy food access, a Social Determinant of Health, has been identified as a priority for Centura Health, a health system serving communities across Colorado and western Kansas. As we listened to all of our hospitals' communities, we heard frequently the barriers people face when meeting their basic needs and the impacts these can have on people's health and well-being. Grounded in the faith and traditions of our Adventist and Catholic founders, we are focused on the future of whole health, leveraging our role as an employer, a business and a nonprofit, Christian health system to impact access to healthy, affordable foods; we are an anchor institution whose healing mission and vision focuses on building flourishing communities and whole person care.

This priority will focus on removing those barriers that create food insecurity and promoting access to healthy affordable foods within our communities. In Colorado, 12.9% of our community experiences food insecurity, and it is the same at 12.9% in our service area. In Colorado, 60% of those eligible for the Supplemental Nutrition Assistance Program (SNAP) are enrolled in the program. In Boulder County, 30% of those eligible are enrolled in SNAP; in Broomfield 41% of those eligible are enrolled. Not only is food insecurity an issue in an individual's home or at their table, it is also an economic issue. In Colorado, the lack of enrollment in SNAP results in an estimated loss of grocery sales equal to \$235.2M and economic stimulus of \$421M. In Boulder County, the estimated loss of grocery income is \$22.4 M and economic stimulus is \$40.1 M; in Broomfield the estimates are \$2M and \$3M, respectively.



When conducting the Community Health Neighborhood Engagement Process for the Hospital Transformation Program, communities highlighted the desire for health care to focus on Social Determinants of Health such as food insecurity, recognizing the impact on overall health and well-being. Community members highlighted that, without food stability, community members will be less likely to access a medical home or engage in recommended healthy behaviors.

This priority aligns with our local priorities of Behavioral Health and Access to Safe and Stable Housing and Shelter. Lack of food security presents greater pressure and anxiety to meet basic needs, thus not supporting strong mental health and well-being. Additionally, the inability to have healthy food presents unavoidable financial choices of food or housing, and our community expressed concerns about stable housing.

Food security was not identified as a priority in our FY16 CHNA. However, nutrition was a priority in the context of Overweight and Obesity. This focus in FY16 revealed that efforts to improve nutrition will not yield intended results without addressing food security.

Centura Health has built a Social Determinant of Health screening tool which has been piloted in several hospitals and ambulatory practices. This has provided us with the opportunity to expand the tool into our system to reach more people and connect them to available community resources.

# CHNA PRIORITY: FOOD SECURITY

Key: Supplemental Nutrition Assistance Program (SNAP), Women Infants and Children (WIC) and Electronic Benefits Transfer (EBT)

## Goal 1: Increase by 20% the number of produce sites which accept SNAP and WIC at point of purchase.

Strategy	Target Population	Action Plan Activity	Metrics
Develop a strategy for hospital's role to increase SNAP and WIC acceptance based upon existing community plans within Year 1. Strategy will include: 1) Stakeholder engagement 2) Policy strategy 3) Specific plan for Y2 and Y3 4) Community input	SNAP and WIC eligible community members  Community Stakeholders	<ul style="list-style-type: none"> <li>• Map food source locations and those which accept SNAP and WIC.</li> <li>• Join stakeholders to identify strategies to address gaps.</li> </ul>	<ul style="list-style-type: none"> <li>• Hospital strategy to increase SNAP and WIC acceptance in community</li> <li>• Community map of food resources and SNAP/WIC</li> </ul>
Implement strategy to increase SNAP and WIC within Y2 and Y3.	SNAP and WIC eligible community members	To be included after strategy designed for Y2 and Y3.	<ul style="list-style-type: none"> <li>• # of SNAP and WIC sites within community</li> <li>• Ability of SNAP and WIC participants to purchase fruits and vegetables</li> </ul>
Integrate food access strategies into Avista Adventist Hospital community partnerships.	Partner Organizations  Business Partners	<ul style="list-style-type: none"> <li>• Integrate SNAP and WIC EBT use into partnerships in community.</li> <li>• Identify key locations for food distribution partnerships to increase access.</li> </ul>	% of sponsorships/partnerships that increase food access through location and/or SNAP/WIC acceptance
Work with state and local officials to identify policies to increase and sustain number of SNAP and WIC sale sites and ability to purchase fruits/vegetables through SNAP/WIC.	SNAP and WIC eligible community members	<ul style="list-style-type: none"> <li>• Develop a list of policy solutions related to SNAP and WIC sales.</li> <li>• Work with community partners to identify the best policies for our community.</li> </ul>	<ul style="list-style-type: none"> <li>• Policies passed to increase access to healthy, affordable foods through SNAP and WIC</li> <li>• SNAP/WIC purchases for fruits/vegetables</li> </ul>

## Goal 2: Increase number of sources of healthy affordable food within the community by decreasing the number of food deserts by 20%.

Strategy	Target Population	Action Plan Activity	Metrics
Identify locations at which affordable food access needs to be increased based upon race/ethnicity and income to increase access for food insecure communities.	Low-income community members living in food deserts	<ul style="list-style-type: none"> <li>• Map food source locations and those which accept SNAP and WIC by race/ethnicity and income.</li> <li>• Identify ways to add access to healthy, affordable food in food deserts.</li> <li>• Work with partners to eliminate food deserts through identified strategies.</li> </ul>	<ul style="list-style-type: none"> <li>• Community map of food resources and SNAP/WIC</li> <li>• # of produce distribution sites and food distribution sites within community by race/ethnicity and income</li> </ul>
Work with state and local officials to identify strategies to reduce food deserts within the community.	Low-income community members living in food deserts	<ul style="list-style-type: none"> <li>• Develop a list of policy solutions related to SNAP and WIC sales.</li> <li>• Work with community partners to identify the best policies for our community.</li> </ul>	Policies passed to increase access to healthy, affordable foods
Increase access to healthy, affordable food through Centura Health food production processes.	Centura associates Food Insecure Community Members	Review hospital food production processes and identify ways to distribute safe, unused food into community.	<ul style="list-style-type: none"> <li>• Policies and processes developed</li> <li>• Pounds and nutrient value of food distributed to community</li> </ul>
Explore Centura Health and community land use opportunities for local food production and identify how to increase production of locally sourced fruits and vegetables.	Centura Health Food Insecure Community Members Hospital Community	<ul style="list-style-type: none"> <li>• Conduct assessment of Centura Health land and community land and ability to grow food on identified locations.</li> <li>• Identify locations where gardening is possible on Centura Health land and community land.</li> <li>• Work with state and local policy makers to address barriers to gardening on Centura and community land, as necessary.</li> </ul>	<ul style="list-style-type: none"> <li>• # of Centura Health facilities producing food</li> <li>• # of new community gardens</li> <li>• Pounds and nutrient value of food distributed to community from Centura gardens</li> </ul>



### Goal 3: Decrease the number of community members who are eligible but not enrolled in SNAP by 60%.

Strategy	Target Population	Action Plan Activity	Metrics
Screen households for food insecurity and refer them to food resources in their communities, including identifying eligibility for all available public assistance programs.	SNAP and WIC eligible community members  Food Insecure Patients	<ul style="list-style-type: none"> <li>• Update Centura's Electronic Health Record to assist in identifying Social Determinants of Health, including food insecurity.</li> <li>• Train associates on Social Determinant of Health screening and referral process.</li> <li>• Implement screening for Social Determinants of Health within hospital/ ambulatory practices.</li> </ul>	<ul style="list-style-type: none"> <li>• % of patients screened for food insecurity</li> <li>• % of patients screened successfully referred to community resources</li> </ul>
Partner with community to increase awareness of impact of hunger on whole person health and identify state and local policies to increase access to SNAP and WIC.	Decision Makers at State and Local Levels	<ul style="list-style-type: none"> <li>• Participate in state and local coalitions addressing food insecurity.</li> <li>• Participate in Metro Denver Partnership for Health to address social determinants of health.</li> <li>• Implement Blueprint to End Hunger strategies applicable to health care.</li> </ul>	<ul style="list-style-type: none"> <li>• # of groups and meetings attended</li> <li>• Policies adopted at state and local levels to increase access</li> </ul>

### Goal 4: Increase use of locally sourced healthy, affordable food within Centura Health by 50%.

Strategy	Target Population	Action Plan Activity	Metrics
Implement food procurement practices to prioritize local food sourcing.	Centura associates  Hospital community	<ul style="list-style-type: none"> <li>• Review current Centura Health food procurement practices and identify food sources.</li> <li>• Review best practices related to local food procurement and identify local food sources.</li> <li>• Establish plan for Centura Health implementation of local food procurement for hospital facility.</li> <li>• Implement local food procurement purchasing practices.</li> </ul>	% of locally sourced food used by Centura Health

## PRIORITIZED NEED: ACCESS TO SAFE AND STABLE HOUSING AND SHELTER

Access to safe and stable housing and shelter arose in our CHNA process based upon the review of indicators measuring the Social Determinants of Health of poverty, housing and food insecurity. Upon review of the data and community input through focus groups conducted by Boulder County Public Health, it was clear that affordable housing and homelessness are areas about which the community is very concerned.

In the review of health data during the Community Health Needs Assessment process, metrics related to Social Determinants of Health were presented to our CHNA Advisory Subcommittee. This was done to recognize underlying barriers to being healthy. We know that disease states need to be addressed. We also know that when a person's basic needs are unmet, it is more difficult to maintain one's own health. Social Determinants of Health data presented to the Advisory Subcommittee included that related to hunger and housing stability. In the Avista Adventist Hospital service area, 11.2% of the residents are experiencing hunger (CO is 10.3%). Additionally, the median gross rent for a home in the service area is \$1,417 (CO is \$1,057). Income inequality, a ratio of household income at 80th percentile to income at the 20th percentile, weighted by population was 4.9 (CO is at 4.5). The percentage of children eligible for free/reduced price lunch is 24.6% (CO at 41.6%).

In the Advisory Subcommittee discussions, health would begin conversations, but the inability to access resources or feel stable in an economic environment that is challenging for people of lower incomes would arise during each conversation. The current impact upon overall health status and the potential growth of the issue in the future were factors that led to the prioritization of access to safe, stable housing and shelter.

This is a new priority for Avista Adventist Hospital. It was recognized in the CHNA process that this is not a hospital-only issue to be addressed; it is a collaborative effort in which the hospital will work with other organizations to develop a more concerted and coordinated effort in the community. Existing activities to leverage include the coordinated entry system, the resource centers available to help people navigate their basic needs, a shelter system in Boulder county, and a Regional Affordable Housing Plan. To this, the hospital can add our ability to screen people for basic needs while in our health care system, a focus on transitions to available resources and using the data regarding connection between housing and health to move the community along a path toward longer-term solutions. Additionally, Centura Health's mission on whole person care and wellness in the community will enable us to contribute to efforts to build social cohesion and connectedness within the community.

# CHNA PRIORITY: ACCESS TO SAFE AND STABLE HOUSING AND SHELTER

## Goal 1: Increase access to safe and stable housing and shelter within the community.

Strategy	Target Population	Action Plan Activity	Metrics
Participate in collaborative efforts to address affordable housing and homelessness in Boulder and Broomfield Counties.	Housing insecure community members  Community stakeholders	<ul style="list-style-type: none"> <li>• Participate in existing housing coalition efforts.</li> <li>• Identify baseline for housing instability in the communities.</li> <li>• Identify the role of health care within the housing and homelessness plans for each community.</li> </ul>	<ul style="list-style-type: none"> <li>• Community strategy for housing stability</li> <li>• Role of healthcare within the strategy</li> <li>• Target metrics for the community</li> </ul>
Work with state and local officials to identify strategies to increase housing stability in the community by connecting housing, health outcomes and Centura values/ethnics.	Housing insecure community members  Community Leaders	<ul style="list-style-type: none"> <li>• Meet with local and state decision-makers re: the connection between housing and health and ethnics/values.</li> <li>• Identify policy opportunities at various levels to impact housing stability.</li> <li>• Work with community to advance policy opportunities that align with the community goals and strategy.</li> </ul>	<ul style="list-style-type: none"> <li>• Meetings with key decision-makers</li> <li>• Policy opportunities identified</li> <li>• Policies passed to support housing stability and state and local levels</li> </ul>

## Goal 2: Increase by 60% the number of community members who are identified for housing insecurity and referred to resources in the community.

Strategy	Target Population	Action Plan Activity	Metrics
Screen households for housing insecurity and refer them to resources in their communities.	Housing insecure community members and patients	<ul style="list-style-type: none"> <li>• Update Centura's Electronic Health Record to assist in identifying Social Determinants of Health, including housing insecurity.</li> <li>• Train associates on Social Determinant of Health screening and referral process.</li> <li>• Implement screening for Social Determinants of Health within hospital/ambulatory practices.</li> </ul>	<ul style="list-style-type: none"> <li>• % of patients screened for housing insecurity</li> <li>• % of patients screened successfully referred to community resources</li> </ul>
Partner with community to increase awareness of impact of housing instability on whole person health and identify state and local policies to increase access stable housing.	Decision Makers at State and Local Levels	<ul style="list-style-type: none"> <li>• Participate in state and local coalitions addressing housing insecurity.</li> <li>• Participate in Metro Denver Partnership for Health to address social determinants of health.</li> </ul>	<ul style="list-style-type: none"> <li>• # of groups and meetings attended</li> <li>• Policies adopted at state and local levels to increase access</li> </ul>

# Conclusion

On May 15, 2019, the Avista Adventist Hospital Board of Directors, a board made up of community members, approved our Community Health Needs Assessment. On September 18, 2019, the Board of Directors approved our Community Health Implementation Plan and Food Security as a priority within that plan. The CHNA process presents an opportunity for Avista Adventist Hospital to fulfill our commitment to Centura's organizational mission *to extend the healing ministry of Christ by caring for those who are ill and by nurturing the health of the people in our communities*. The Community Health Implementation Plan (CHIP), sets our path forward to building wholeness and flourishing communities.

We look forward to reporting back annually on the work we do to improve the health of our communities. Together, we can realize our Centura Health Vision that every community, every neighborhood, every life is whole and healthy.





## APPENDIX A: LIST OF SUBCOMMITTEE ORGANIZATIONS

- Mental Health Partners
- Colorado Community Health Alliance
- Boulder Seventh-day Adventist Church
- Chapel Haven Seventh-day Adventist Church
- Foothills United Way
- Nurse Family Partnership
- Broomfield Public Health
- Boulder County Public Health
- Rocky Mountain Adventist Health
- The Natural Funeral
- Boulder County Child Welfare
- Clinica
- Broomfield Community Foundation
- City Unite