

2019 Community Health Implementation Plan
FY 2020–2022

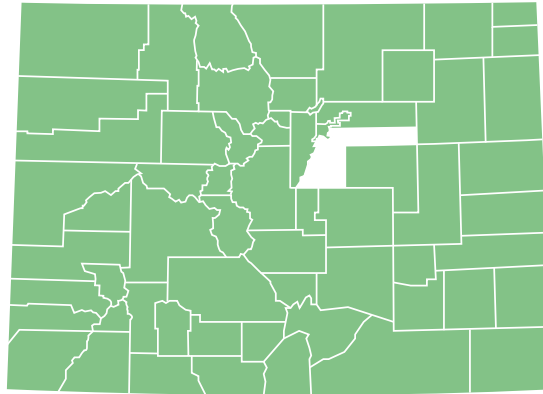
Parker Adventist Hospital



AT A GLANCE:

Parker Adventist Hospital

AREA SERVED: ARAPAHOE AND DOUGLAS COUNTIES



PRIORITIES:



Behavioral Health



Food Security

PARTNERS:

New Day Seventh Day Adventist Church, Mile High Ministries, Doctors Care, Metro Community Provider Network, All Health Network, NAMI Colorado, Douglas County Sheriff Department, South Metro Fire Department, Tri County Public Health, Denver Public Health, Douglas County Public Schools, Denver Public Schools, Littleton Public Schools, Colorado Access, Mile High Health Alliance, American Heart Association, Colorado Wellness

2019 COMMUNITY HEALTH NEEDS ASSESSMENT

PARKER 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

Conclusion 22



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 2, 2019, the Parker Adventist Hospital Board of Directors approved the 2019 Parker Adventist Hospital Community Health Needs Assessment (CHNA) priorities of Behavioral Health and Food Security. 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 Parker 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 Parker Adventist Hospital, local public health departments, community leaders, and partner organizations.

The Parker 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 Parker 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.

On September 18, 2019, our Board of Directors approved the Parker Adventist Hospital Community Health Improvement Plan for FY2020-FY2022.

BEHAVIORAL HEALTH GOALS

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



Our Services and Community

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

Parker Adventist Hospital, located at E-470 and Parker Road, offers leading medical experts, cutting edge technology and a broad array of clinical services. We are committed to excellence in health care. Ranked among the top hospitals in the nation for patient satisfaction, Parker Adventist Hospital performs complex spine surgery along with weight-loss, orthopedic and joint replacement surgery. We have a Level II Trauma Center and are a designated primary stroke center. We also provide high-risk pregnancy care and deliver babies as young as 28 weeks. As a regional medical center, we offer the medical care you need, close to home.

Distinctive Services *Noteworthy areas of care include:*

Center of Bariatric Surgery

- Nationally Certified Bariatric Program by the Joint Commission
- Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP)
- Aetna Institute of Quality for Bariatrics
- Cigna Center of Excellence for Bariatric Surgery

Breast Care Center

- Nationally Accredited Breast Care Centers (Parker, Meridian, Southlands)
 - Accredited Breast Center of Excellence
- ACR Accredited Breast Ultrasound, Breast MRI and Breast Center of Excellence
- Mammography Quality Standards Act (MQSA/FDA) Certified

The Cancer Center at Parker Adventist Hospital

- Accredited Cancer Center by ACR Commission on Cancer
- ACR Accredited for Radiation Oncology

Heart Care

- Accredited Chest Pain Center by Society for Cardiovascular Patient Care (SCPC)
- Gold Performance Achievement Award / Get with the Guidelines / Heart Failure

- Gold Quality Achievement Award / STEMI Receiving Center / American Heart Association
- Primary Stroke Center

Neurology Care

- Primary Stroke Center Certification by the Joint Commission
- Gold Plus & Target Stroke Elite Plus Achievement / Get with the Guidelines / American Heart Association & American Stroke Association

Complex Spine Surgery

- Joint Commission Certified Spine Program
- United Health Premium Surgical Spine Specialty Ctr
- Anthem BlueCross BlueShield, Blue Distinction for Spine Surgery
- Highly trained spine surgeons providing complex and complicated surgery including spinal fusion

Complex Orthopedic Surgery and Joint Replacement Program

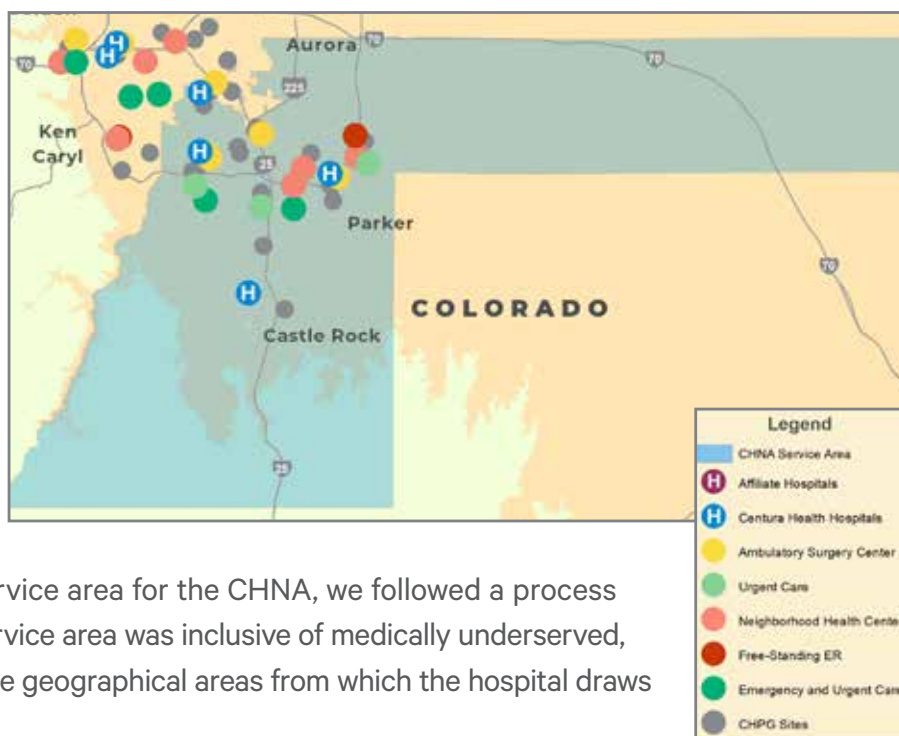
- Joint Commission Certified Joint Replacement Program
- Anthem BlueCross BlueShield, Blue Distinction Center for Knee & Hip Replacement
- Highly trained surgeons providing the most complex orthopedic surgeries

Honors

Parker Adventist Hospital typically receives eleven health care honors annually. In addition to receiving Healthgrades Distinguished Hospital Award for Clinical Excellence™, the hospital is also recognized as one of Healthgrades America's 100 Best Hospitals for Critical Care™ for four consecutive years. Parker Adventist is a Five-Star Recipient for the treatment of heart failure, pneumonia, and esophageal/stomach surgeries.

OUR COMMUNITY

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



To define Parker 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:

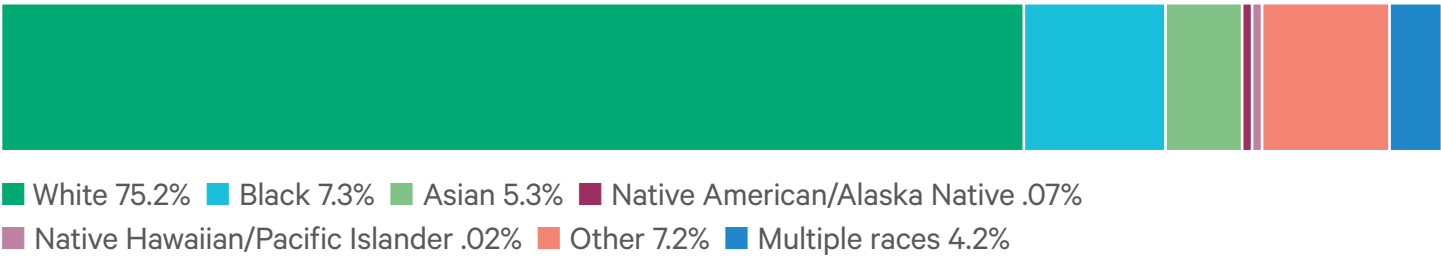
- Opportunities to viably expand outreach of programs to medically underserved populations
- Inpatient admissions
- Coverage of the County by another Centura facility
- Opportunities for collaboration among facilities and with community-based organizations

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 Parker 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 998,316. The demographic makeup of these communities is on the following page.

POPULATION DEMOGRAPHICS IN PARKER ADVENTIST HOSPITAL'S SERVICE AREA

Race



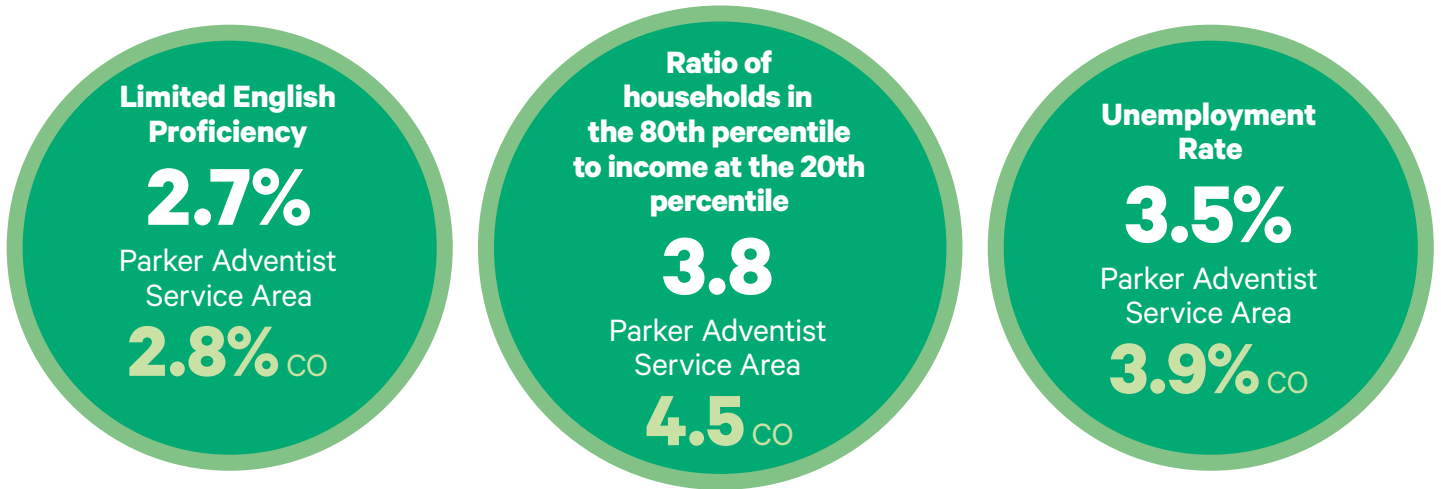
Ethnicity



Some College



High School Graduation Rate



Prioritized Needs and Plans

WORKING WITH COMMUNITY

Parker Adventist Hospital collaborated with Tri County Public Health with their representation on our Advisory Subcommittee. In addition to serving on our Advisory Subcommittee, we agreed with the public health department 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 Parker 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, Parker Adventist Hospital identified Behavioral Health and Food Security as priority focus areas.

After identifying our priorities, we reviewed the assets and gaps identified by the subcommittee to develop the Parker 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

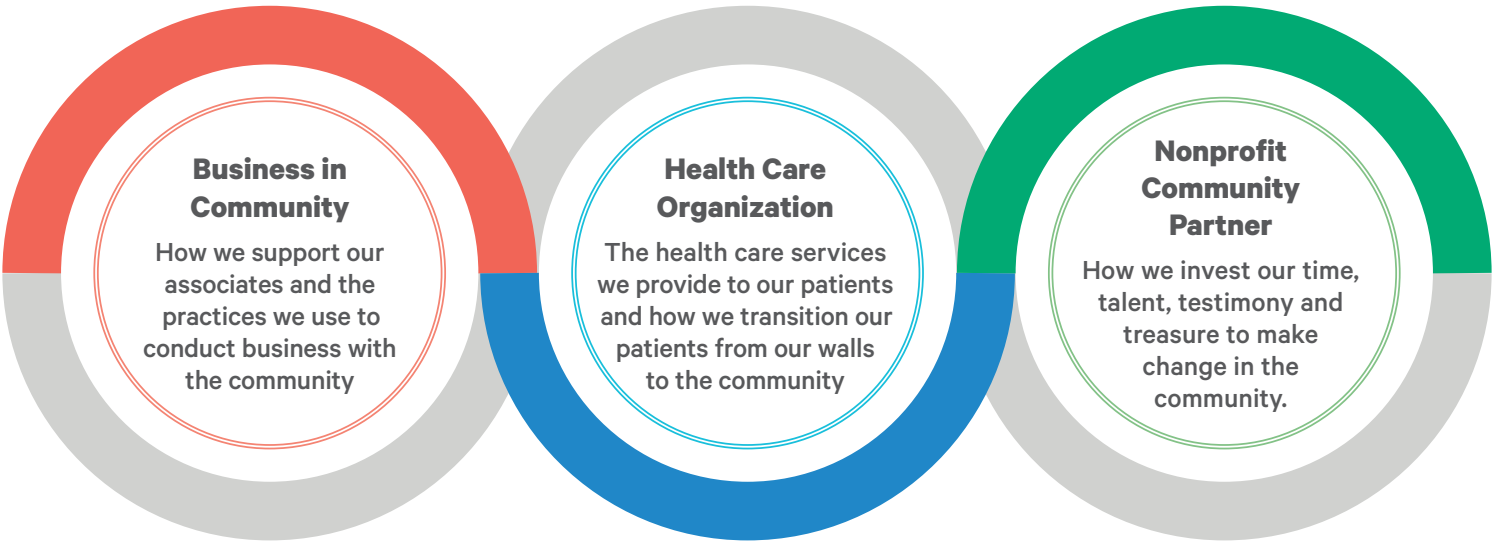
The strategies Parker Adventist Hospital will use to address the health priorities leverages our role as a large business and employer, a health care organization and a nonprofit hospital partner. (See Figure 1) Like our approach toward medicine, we are committed to using evidence-based strategies to 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.

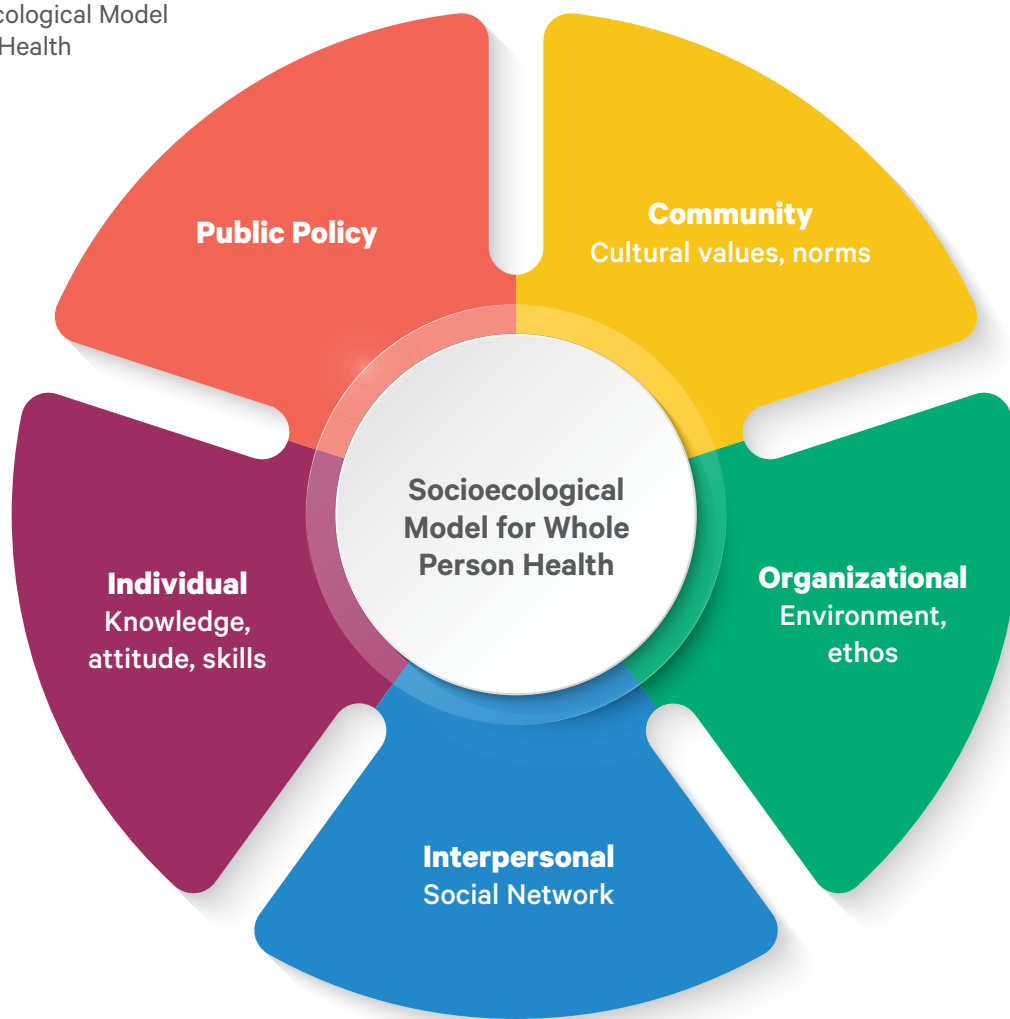
We use the socioecological model to address the health of our communities. This model recognizes the complex interplay between individual, relationship, community and societal factors. Individuals are responsible for making and maintaining lifestyle choices, such as eating healthy foods and refraining 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

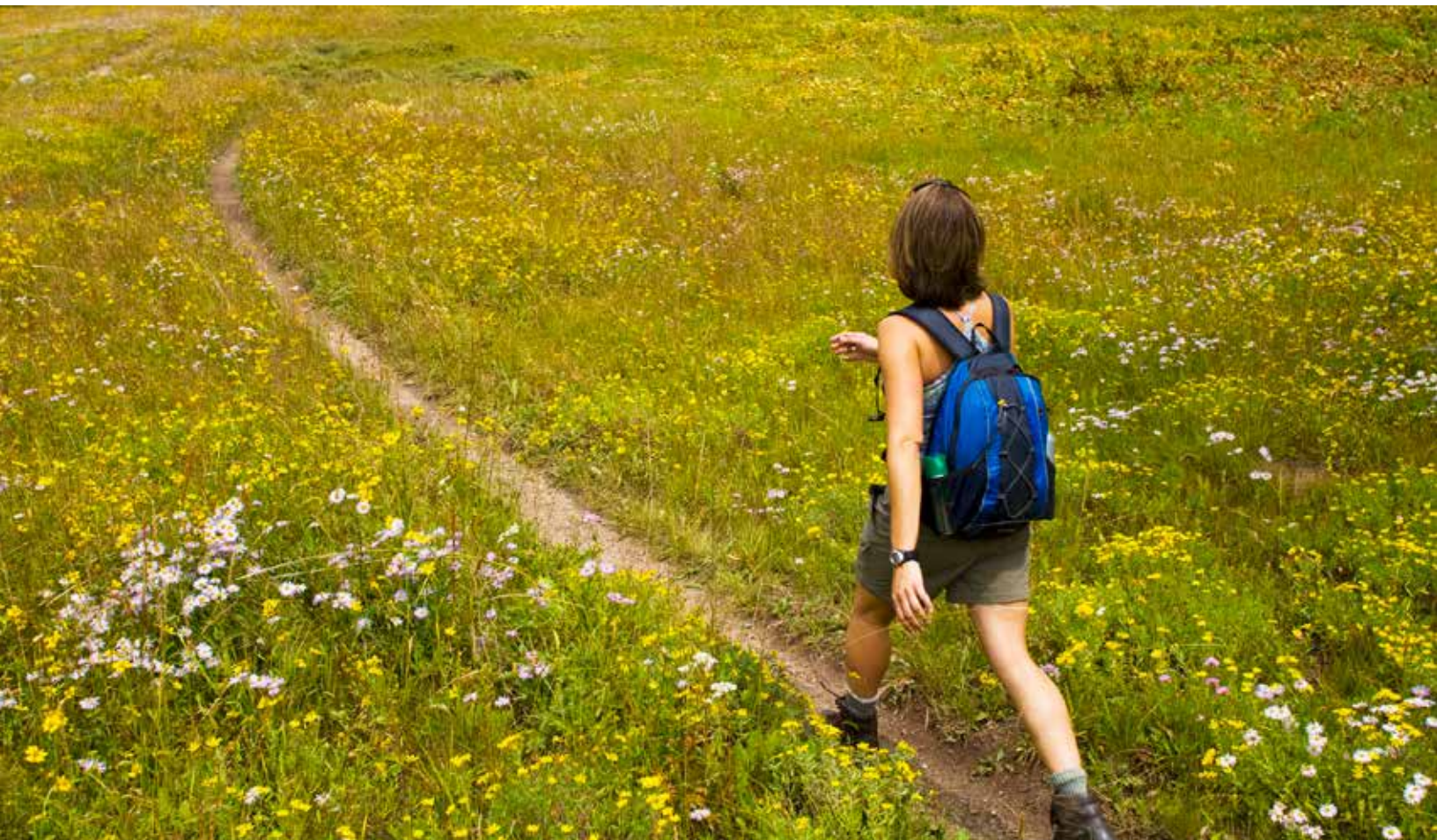
After careful consideration of the available quantitative and qualitative indicators and our Centura Health Mission, Vision, and Values, Parker Adventist Hospital identified Behavioral Health and Food Security as priority focus areas.

At Parker 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 and Food Security 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 Parker Adventist Hospital. The community health data that led to identification of Behavioral Health as a priority included that there are 2,778 mental health hospitalizations per 100,000 population; however, there are only 1.95 providers per 1000 population (CO is at 2.74). The community's suicide rate is 18.4 per 100,000 population, and Colorado ranks as a state highest for suicide. The community's rate of suicide hospitalizations is 42.1 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 18.4% (CO at 19.1%), and adult smoking is at 13.3% (CO 15.6%).

Quantitative population health data was validated and strengthened by qualitative data. Both behavioral health and substance abuse were identified as priorities within community conversations among our CHNA Advisory Subcommittee and the focus groups conducted by Tri County Health Department. These conversations clarified that behavioral health is the greatest community concern. Behavioral health is a large concern due to the suicides of which people are aware and the recognition of the hidden behavioral health needs and the limited availability of behavioral health providers and cost of service provision. Despite limited substance abuse data, the community recognized trends on the horizon of vaping and opioid use that need to be addressed, along with their relation to mental health. The community recognized these are tough issues to address and want to coordinate work to address behavioral health as a community.



Mental Health and Suicide Prevention were identified as a priority in our 2016 Community Health Needs Assessment. Parker Adventist Hospital addressed behavioral health through evidence-based approaches including prevention, education, stigma reduction and resiliency training for community and our caregivers. Through FY18, we reached 71 people with Mental Health First Aid and coordinated our trainings with other providers in the community. 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. Through CPC+ funding, we are in the process of implementing integrated behavioral health care into our ambulatory care settings. We have focused on resiliency training for our associates through the Love Matters Most Day of Service partnering with a local school to give back to the community. Additionally, through participation in the Douglas County Mental Health Alliance, we have developed a Universal Shared Agreement to share information across agencies to better support people in need.

Potential community resources available to address behavioral health include local public health departments and their access to young children and their parents, Mental Health First Aid efforts throughout the community, the Let's Talk CO social media campaign, our school district has efforts to reach students, and law enforcement has access to those incarcerated. Community Clinics and Federally Qualified Health Centers provide integrated care and partner frequently with the mental health centers, which are a significant source of care in the community.

Parker 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 a comment that was shared by a leader in our Advisory Subcommittee, which was that 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.



CHNA PRIORITY: BEHAVIORAL HEALTH (BH)

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

Goal 1: Reach 80% of school-aged youth with a social cohesion and/or resiliency strategy.

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

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

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"> • Review current MHFA plan for community and identify populations of focus for community. • Identify MHFA trainers within community and coordinate outreach. • Develop outreach strategy to reach key audiences for MHFA training. • Provide MHFA training to people serving youth within community. 	<ul style="list-style-type: none"> • # of people working with youth who receive MHFA training • # of people not working with youth who receive MHFA training
Work with state and local leaders to create a sustainable model for MHFA.	Local/State Leaders Community Members	<ul style="list-style-type: none"> • Meet with key coalitions to identify policy strategy for MHFA. • Identify barriers and opportunities related to providing MHFA within CO. • Develop strategy for sustained MHFA within the community. 	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"> • Integrate messaging into Centura Health communications. • Integrate messaging through coalitions. • Use messaging with decision-makers. • Develop a plan to sustain stigma campaign for 3-5 years. 	<ul style="list-style-type: none"> • State survey of stigma associated with behavioral health • # of people reached with messaging



Goal 3: Increase people reporting access to BH 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.	Patients with MH or SUD Diagnosis	Establish plan to support patients with BH needs in the Emergency Department with Screening, Brief Intervention, Referral and Treatment (SBIRT) and Medical Assisted Treatment (MAT) with community partners.	# of people screened and referred to Tx
Develop care program for patients with MH or SUD Dx (primary or secondary) that involves discharge planning process with the Regional Accountable Entity (RAE) or consent to notify RAE within one business day.	Patients with MH or SUD Diagnosis	<ul style="list-style-type: none"> • Map out process for patients identified with MH/SUD Dx with RAE. • Identify how to efficiently and effectively transition patients from hospital to RAE and BH services. 	<ul style="list-style-type: none"> • # of people referred to mental health services • % of people connected to mental health services
Map behavioral health system of care within the community and develop a system to help people navigate care.	Community with BH needs	<ul style="list-style-type: none"> • Engage partners in resource mapping process. • Identify opportunities to support people in the community (vs. hospitals) and ways to navigate them to the right treatment at the right time. 	<ul style="list-style-type: none"> • Behavioral Health screening, referral and access map developed • % of people connected to mental health services
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"> • Develop policy strategy for BH with local and state coalitions. • Work with local communities to identify policy priorities. 	<ul style="list-style-type: none"> • % of people connected to mental health services • Systems established with state agencies to sustain effective mental health programming

PRIORITIZED NEED: FOOD SECURITY

When we began our CHNA process, we could not have predicted that Access to Healthy Affordable Food (Food Security) would be a priority for our community. In fact, during the first review of data, we did not include indicators for Food Insecurity (12.4% in our community; 12.2% in our state). While we are a community of higher incomes, Income Inequity is higher at 3.34 (4.5 in CO). The higher incomes for which our service area is known led us to initially overlook this indicator. Due to our commitment to the community process, we quickly learned from our community and prioritized Food Security as a health need. In Tri County Public Health focus groups, food access arose frequently, as it was recognized that many in our communities were unable to access healthy food due to limited incomes. Additionally, the Hospital Transformation Program highlighted the need for health care to focus on Social Determinants of Health such as food insecurity, recognizing the impact they have on overall health. The Hospital Transformation Program's Community and Health Neighborhood Engagement process also elevated the community's desire to focus on things such as hunger, as without food stability, community members will be less likely to access a medical home and to engage in recommended healthy behaviors.



Food Security was not identified as a priority in our FY16 CHNA. Rather, Nutrition was a priority in the context of Overweight and Obesity prevention. This focus in FY16 helped to elevate that, despite all efforts to improve nutrition, there are financial barriers and access barriers that will not yield the intended results.

Resources available to address or promote the health need in the community include local food pantries; schools which provide free/reduced lunch program and help to enroll children into their programs; Women Infants and Children program supports nutrition education and income supports to purchase foods for families with young children; the Supplemental Nutrition Assistance Program is available to community members who are income eligible (and underutilized in this community); and the CO Blueprint to End Hunger is available as a guide for local community solutions.

Parker Adventist Hospital has focused on a community garden and promoted healthy food options within our food services. As part of Centura Health, we have built a screening for Social Determinants of Health that has been piloted in several hospitals and which provides us with the opportunity to implement within our hospitals. Additionally, as a system of care, our ambulatory practices are positioned to screen for social determinants of health and connect people to available resources.

During our CHNA process and the Hospital Transformation Program process, we heard frequently from community partners that health care should lead the work focusing on Social Determinants of Health as our voice has been missing from some of the conversations. We have listened, and we will prioritize and act.

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 efforts for Y2 and Y3. Strategy will include: 1) Stakeholder engagement 2) Policy 3) Activities for Y2 and Y3 4) Evaluation Plan	SNAP and WIC eligible community members Community Stakeholders	<ul style="list-style-type: none"> • Map food source locations and those which accept SNAP/ WIC. • Join stakeholders to identify strategies to address gaps. 	<ul style="list-style-type: none"> • Hospital strategy to increase SNAP/WIC acceptance in community • Community map of food resources and SNAP/WIC
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"> • # of SNAP/ WIC sites in community • Ability of SNAP/WIC participants to purchase fruits and vegetables
Integrate food access strategies into Parker Adventist Hospital community partnerships.	Partner Organizations Business Partners	<ul style="list-style-type: none"> • Integrate SNAP and WIC EBT use into partnerships in community. • Identify key locations for food distribution partnerships to increase access. 	% of sponsorships/ partnerships that increase food access through SNAP/ WIC acceptance
Work with state and local officials to identify policies to increase and sustain number of SNAP/WIC sale sites and ability to purchase fruits/ vegetables through SNAP/WIC.	SNAP and WIC eligible community members	<ul style="list-style-type: none"> • Develop a list of policy solutions related to SNAP and WIC sales. • Work with community partners to identify the best policies for our community. 	<ul style="list-style-type: none"> • Policies passed to increase access to healthy, affordable foods through SNAP/WIC • SNAP/WIC purchases for fruits/ vegetables

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 where 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"> • Map food source locations and those which accept SNAP/WIC by race/ethnicity/income. • Identify how to add access to healthy, affordable food in food deserts. • Work with partners to eliminate food deserts through identified strategies. 	<ul style="list-style-type: none"> • Community map of food resources and SNAP/WIC • # of produce distribution sites and food distribution sites within community by race/ethnicity/ income
Work with state/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"> • Develop a list of policy solutions related to SNAP/WIC sales. • Work with community partners to identify the best policies for our community. 	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"> • Policies and processes developed • Pounds and nutrient value of food distributed to community
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"> • Assess Centura Health land and community land related to food production. • Identify locations where gardening is possible on Centura Health/community land. • Work with state and local policy makers to address barriers to gardening on Centura/community land, as necessary. 	<ul style="list-style-type: none"> • # of Centura Health facilities producing food • # of new community gardens • Pounds and nutrient value of food distributed to community from Centura gardens

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"> • Update Centura's Electronic Health Record (HER) to identify Social Determinants of Health, including food insecurity • Train associates on Social Determinant of Health screening and referral process • Implement screening for Food Insecurity within hospital/ambulatory practices 	<ul style="list-style-type: none"> • % of patients screened for food insecurity • % of patients screened successfully referred to community resources
Partner with community to increase awareness of impact of hunger on whole person health and identify state/local policies to increase access to SNAP and WIC.	Decision Makers at State and Local Levels	<ul style="list-style-type: none"> • Participate in state/local coalitions addressing food insecurity • Participate in coalitions to address social determinants of health • Implement Blueprint to End Hunger strategies applicable to health care 	<ul style="list-style-type: none"> • # of groups and meetings attended • Policies adopted at state and local levels to increase access

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"> • Review current Centura Health food procurement practices and identify food sources. • Review best practices re: to local food procurement and identify local food sources. • Establish plan to implement local food procurement for hospital facility. • Implement local food procurement purchasing practices. 	% of locally sourced food used by Centura Health

Conclusion

On May 2, 2019, the Parker 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. The CHNA process presents an opportunity for Parker 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

- New Day Seventh Day Adventist Church
- Mile High Ministries
- Doctors Care
- Metro Community Provider Network
- All Health Network
- NAMI Colorado
- Douglas County Sheriff Department
- South Metro Fire Department
- Tri County Public Health
- Denver Public Health
- Douglas County Public Schools
- Denver Public Schools
- Littleton Public Schools
- Colorado Access
- Mile High Health Alliance
- American Heart Association
- Colorado Wellness