Community Health Needs Assessment | 2021

SCL Health
GOOD SAMARITAN

Our mission is you.

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Letter from the President

December 1, 2021

Dear neighbors,

At Good Samaritan Medical Center, we take pride in providing the quality healthcare services our community needs. We've been committed to serving the residents of Adams, Boulder, Broomfield, Gilpin, Jefferson, and Weld counties for more than 17 years and we are steadfast in our obligation to fulfill our mission to "reveal and foster God's healing love by improving the health of the people and communities we serve, especially those who are poor and vulnerable."

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 are most significantly impacting our local population and, in turn, helps us to identify the necessary resources and services to address them.

To understand and work to ease these complex health issues, we collaborated with community leaders, public health officials, and community members to prioritize the revealed health needs according to the highest level of importance in our community. The following were identified and prioritized:

1. Behavioral health
2. Access to healthcare
3. Housing
4. Substance use

In the following pages, you will read about our data collection methodology, community profile and health statistics, and information that we will use to implement our Community Health Improvement Plan (CHIP). The CHIP will direct our resources and outline the actions we will take to address the priority needs identified above.

We are so appreciative of our community partners who wholeheartedly embraced this process with us. We look forward to sharing what we have learned and the steps we plan to take to make a positive impact on the health and wellness of our community.

With gratitude,

Dawn J. Anuszkiewicz

President, Good Samaritan Medical Center

Executive Summary

The 2021 Good Samaritan 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 the hospital's mission, vision and values as a nonprofit, faith-based health organization to "...reveal and foster God's healing love by improving the health of the people and communities we serve, especially those who are poor and vulnerable." 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 Broomfield and Boulder County Public Health Departments, Clinica Family Health Center, 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 Broomfield and Lafayette, Good Samaritan Medical Center (GSMC) has completed its 2021 CHNA and identified these priority areas for health improvement programming from 2022 through 2024:

- Behavioral Health
- Access to Healthcare

Since the Last CHNA (2018)

In 2018, the last time GSMC conducted a CHNA, participants identified Cardiovascular Health and Unintentional Injuries as the top two priorities for Community Health Improvement Planning. These priorities from 2018 remain important to participants in the 2021 CHNA, but two new priorities will replace the 2018 priorities. GSMC's prior community health improvement implementation period, from 2018 to 2021, included multi-level interventions aimed at impacting the following priority areas. Highlights include:

Cardiovascular Health

Play with Heart: GSMC provided a free cardiovascular screen for school-aged athletes in cooperation with the "Play with Heart" organization. This screening helps to identify and address underlying problems so children do not suffer a Sudden Cardiac Arrest event while participating in a sporting event.

Stroke Support Group: GSMC hosts a bi-monthly stroke support group that is facilitated by the Rocky Mountain Stroke Center staff.

No cost training to EMS professionals: The GSMC Emergency Medical Service (EMS) Outreach coordinator provides Cardiopulmonary Resuscitation (CPR), Pediatric Advanced Life Support (PALS), and Advanced Cardiovascular Life Support (ACLS) training and continuing education courses at no cost to local EMS professionals to improve the community workforce competence and provide the best care possible for cardiac event and stroke patients.

Unintentional Injuries

Stop the Bleed: The GSMC Injury Prevention program trains participants on the three quick actions that can be used to stop life-threatening bleeding for a severely injured person.

Aging Mastery Program: GSMC hosts this 10-class, evidence-informed program created by the National Council on Aging to help older adults make the most of their lives as they age. Central to the Aging Mastery philosophy is the belief that modest lifestyle changes can produce big results and that people can be empowered to cultivate health and longevity. The classes are taught in partnership with Boulder County Area Agency on Aging and include topics on exercise, nutrition, finances, advance care planning, community engagement and healthy relationships. The class curriculum on fall prevention is key to injury prevention for older adults.

Child car seat checks: GSMC provides regular child car seat checks for community members to prevent injuries from improperly installed or faulty car seats.

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 service area counties 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 GSMC data findings to Healthy People 2030 objectives.

GSMC conducted targeted interviews to gather information and opinions from 12 persons who represent the broad interests of the community served by the medical center. Community input was gathered at two local events. An online community survey was also used to collect information from 75 community residents of service area 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
- Food insecurity
- Heart disease and stroke
- Housing
- Lung disease
- Mental health
- Overweight and obesity
- Substance use
- Unintentional injuries

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 6, 2021. Their input resulted in the following initial prioritization of the significant health needs:

- Mental health
- Access to health care
- Substance use
- Unintentional injuries
- Overweight and obesity
- Housing

About 275 area residents were engaged at two 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 these needs. Substance use, 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. When respondents were asked to prioritize the needs according to their perceived highest level of importance in the community, mental health, substance use and access to health care were ranked as the top three priority needs. Finally, a community survey was also conducted. Survey respondents were asked to identify the most pressing health concerns from a list of options. Survey respondents identified behavioral health, housing and COVID as the top three issues in the community.

A second round of prioritization consisted of Hospital leaders, departmental representatives, and leaders from the community. This meeting occurred on September 13, 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 health care
3. Housing
4. Heart disease/stroke
5. Diabetes

Additional input regarding the availability of resources from the Good Samaritan Medical Center Senior Leadership Team resulted in Behavioral 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 (Behavioral Health and Access to Healthcare), GSMC 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

Good Samaritan Medical Center (GSMC) is a community-based, acute-care hospital in Lafayette, Colorado. The Medical Center opened on December 1, 2004, and is a member of SCL Health, a nonprofit healthcare system operating primarily in Colorado and Montana. GSMC offers a Primary Stroke Center, an Accredited Chest Pain Center and Cardiovascular Center of Excellence, a Level II Neonatal Care Unit, Level II Trauma Center, Integrative Health and Healing Center and innovative surgical, orthopedic, rehabilitation and women's services. The mission of Good Samaritan Medical Center is to "reveal and foster God's healing love by improving the health of the people and communities we serve, especially those who are poor and vulnerable."

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 CHNA identifies unmet health needs in the hospital's 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 people living in the service area.

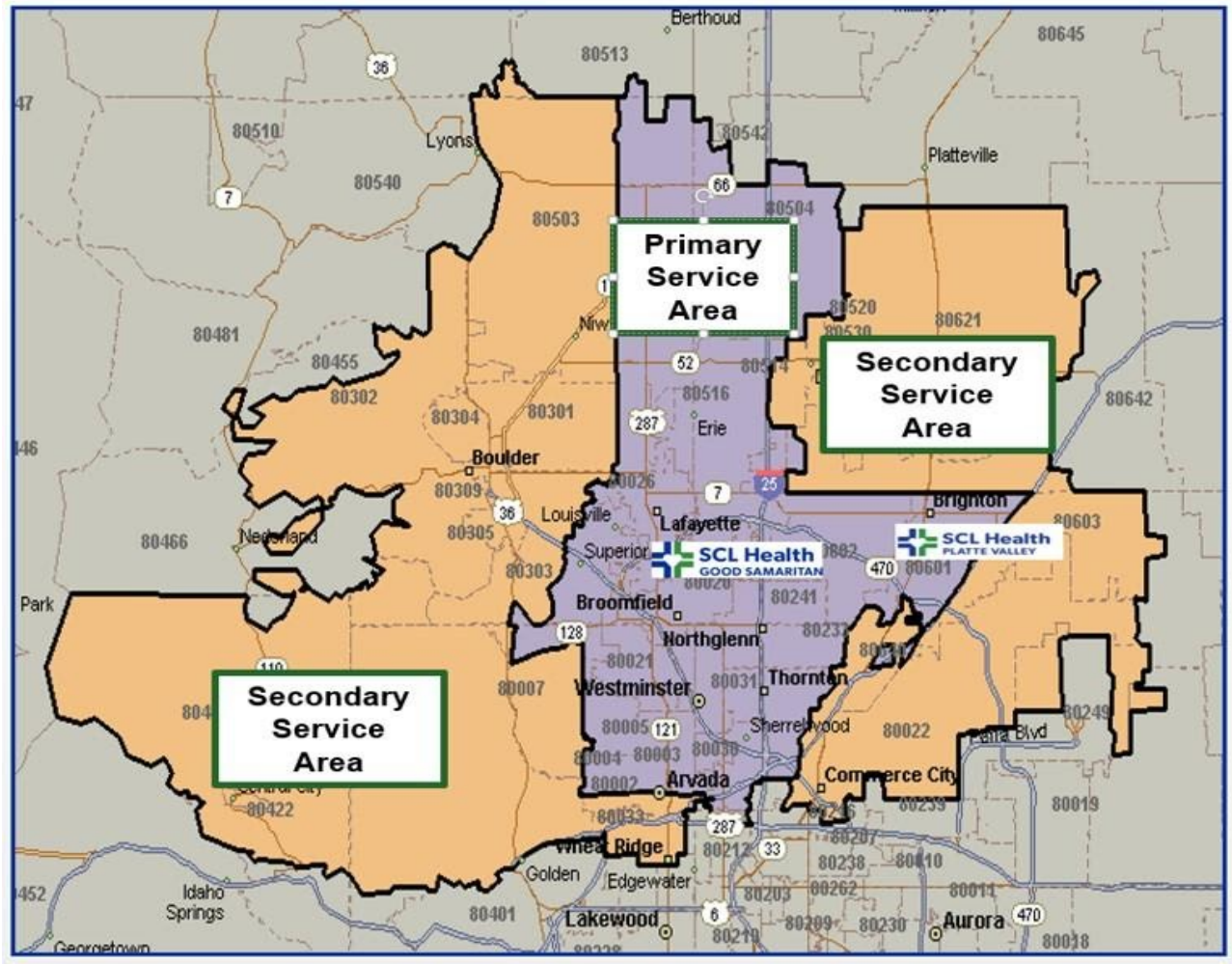
Service Area

Good Samaritan Medical Center is located at 200 Exempla Circle, Lafayette, Colorado 80026. The primary service area includes eighteen communities (including thirty-eight ZIP Codes) in Adams County, Boulder County, Broomfield County, Gilpin County, Jefferson County, and Weld County, Colorado. A majority of patient admissions originate from these communities.

Good Samaritan Medical Center Service Area

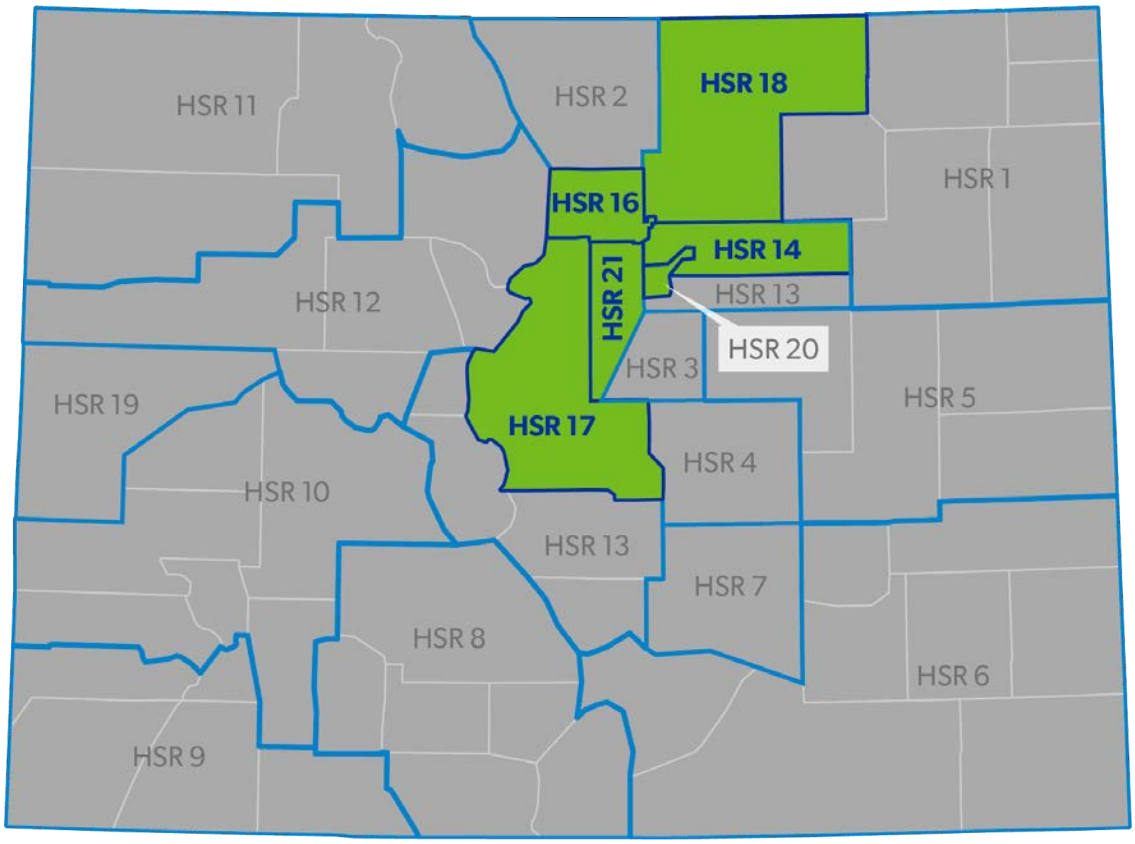
City	ZIP Code	County
Arvada	80002, 80003, 80004, 80005, 80007	Jefferson
Black Hawk	80422	Gilpin
Boulder	80301, 80302, 80303, 80304, 80305, 80310	Boulder
Lafayette	80026	Boulder
Longmont	80501, 80503, 80504	Boulder
Louisville	80027	Boulder
Brighton	80601, 80602, 80603	Adams
Broomfield	80020, 80021, 80023	Broomfield and Jefferson
Commerce City	80022	Adams
Dacono	80514	Weld
Denver	80221, 80229, 80233, 80234, 80260	Denver
Thornton	80241	Adams
Erie	80516	Weld
Frederick	80530	Weld
Golden	80403	Jefferson
Henderson	80640	Adams
Westminster	80030, 80031	Adams
Wheat Ridge	80033	Jefferson

Good Samaritan Medical Center Service Area



Health Statistic Region (HSR)

The Health Statistic Regions (HSR) for Good Samaritan Medical Center are HSR 14 for Adams County, HSR 16 for Boulder County and Broomfield County, HSR 17 for Gilpin County (which also includes Clear Creek County, Park County and Teller County), HSR 21 for Jefferson County, and HSR 18 for Weld County.



Project Oversight

The CHNA process was overseen by:

Peggy Jarrett, MPH, BSN, RN
Regional Director, Community Health Improvement
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 GSMC 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

GSMC conducted targeted interviews to gather information and opinions from persons who represent the broad interests of the community served by the medical center.

Twelve (12) phone interviews were conducted for the CHNA from July to August 2021. Interview participants included a broad range of stakeholders concerned with health and wellbeing in service area 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.

Second, 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, 75 were residents of GSMC's service area counties.

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

Resources to Address Significant Health Needs

Through the interview process, stakeholders identified community resources potentially available to address the significant health needs. The identified community resources are presented in Appendix 4.

Public Comment

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

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

Identification and Prioritization of Significant Health Needs

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

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

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

Priority Health Needs

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

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

Community Meeting to Prioritize Significant Needs

Hospital leaders, departmental representatives, and leaders from the community met on July 6, 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 results. Following the presentation, attendees met in small groups to discuss the 13 community needs. After the small group discussions, they were asked to individually prioritize the top five issues in the Good Samaritan Medical Center service area. The participants in the room were given five voting dots and asked to place a dot next to the five issues of greatest importance. Each dot represented one point. Participants who joined virtually submitted their top five issues in the Google Meet chat. After everyone voted, votes were tallied. The six issues with the highest points became the top six priority needs reflected below.

1. Mental Health
2. Access to Health Care
3. Substance Use
4. Unintentional Injuries
5. Overweight and Obesity
6. Housing

Good Samaritan Medical Center engaged community members at two events to further discuss and prioritize the needs. The first community event was held on August 5, 2021, at the Adams County Senior Resource Fair and engaged 45 people. The second event was August 21, 2021, at the Lafayette Peach Festival and engaged 230 people.

A poster with the top identified issues was used to solicit community input. Community members were asked to think about the biggest problems in the community. They were then given two votes. The problem that they felt was the worst in the community received a number one vote and was worth two points. Their choices for the second biggest problem received a number two vote and was worth one point. The votes were tallied and yielded the following results:

Community Members Prioritization of Community Needs

	Mental Health	Housing	Access	Overweight and Obesity	Substance Use	Unintentional Injuries
#1 Points	202	122	106	60	38	18
#2 Points	71	68	41	35	35	14
Ranking Totals	**273**	**190**	**147**	**95**	**73**	**32**

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 rate 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. Substance use, 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.

Significant Needs	Severe and Very Severe Impact on the Community	Worsened Over Time	Insufficient or Absent Resources
Access to Health Care	62.5%	12.5%	62.5%
Housing	87.5%	75.0%	82.5%
Mental Health	87.5%	75.0%	87.5%
Overweight and Obesity	0%	0%	12.5%
Substance Use	100%	85.7%	100%
Unintentional Injuries	12.5%	28.6%	42.9%

The interview respondents were also asked to prioritize the health needs according to 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. Mental health, substance use and access to health care were ranked as the top three priority needs in the service area. Calculations resulted in the following prioritization of the significant health needs:

Significant Needs	Priority Ranking (Total Possible Score of 4)
Mental Health	4.00
Substance Use	3.86
Access to Health Care	3.75
Unintentional Injuries	3.50
Housing	3.43
Overweight and Obesity	2.83

Survey respondents were asked to identify the most pressing health concerns from a list of options. The top three identified needs are identified by county.

	Most Cited Issue	2nd Most Cited Issue	3rd Most Cited Issue
Adams County	Behavioral Health	Chronic Illnesses	COVID-19
Boulder County	Housing	Chronic Illnesses	Substance Use, Access to Care
Broomfield County	COVID	Behavioral Health	Housing, Pollution
Jefferson County	COVID	Behavioral Health	Housing
Weld County	Substance Use	Access to Health Care	Violence/Crime

Prioritized Needs

A second round of prioritization consisted of Hospital leaders, departmental representatives, and leaders from the community. A list of the meeting participants and their organizational affiliations can be found in Appendix 5. The meeting occurred on September 13, 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, the attendees were given time to discuss the six issues and were asked to individually prioritize the top two issues in the Good Samaritan Medical Center surrounding area.

The participants that were in the room were asked to rank their number one and number two issues for the community. The number one issue was given two points and the number two issue was given one point. People who joined virtually, submitted their top two issues, in order, in the Google Meet chat. The top priority needs identified were:

1. Behavioral Health
2. Access to Health Care
3. Housing
4. Substance Use

Additional input regarding the availability of resources from the Good Samaritan Medical Center Senior Leadership Team resulted in Behavioral 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, GSMC 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 hospital's CHIP Implementation Strategy associated with the 2018 CHNA addressed:

- Cardiovascular Health
- Unintentional Injuries

Impact was planned through a commitment of community benefit programs and resources. The impact of the actions that GSMC used to address these significant health needs can be found in Appendix 6.

Cardiovascular Health

Play with Heart: GSMC provided a free cardiovascular screen for school-aged athletes in cooperation with the "Play with Heart" organization. This screening helps to identify and address problems so that children do not suffer a Sudden Cardiac Arrest event while participating in a sporting event.

Stroke Support Group: GSMC hosts a bi-monthly stroke support group that is facilitated by the Rocky Mountain Stroke Center staff.

No cost training to EMS professionals: The GSMC Emergency Medical Service (EMS) Outreach coordinator provides Cardiopulmonary Resuscitation (CPR), Pediatric Advanced Life Support (PALS), and Advanced Cardiovascular Life Support (ACLS) training and continuing education courses at no cost to local EMS professionals to improve the community workforce competence and provide the best care possible for cardiac event and stroke patients.

Unintentional Injuries

Stop the Bleed: The GSMC Injury Prevention program trains participants about the three quick actions that can be used to stop life-threatening bleeding in a severely injured person.

Aging Mastery Program: GSMC hosts this 10-class course that was created by the National Council on Aging to help older adults make the most of their lives as they age. The classes are done in partnership with Boulder County Area Agency on Aging. The class on fall prevention is key to injury prevention for seniors.

Child car seat checks: GSMC provides a child car seat check for community members to prevent injuries from improperly installed or faulty car seats.

Community Profile

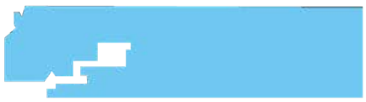
Population

On average, from 2015 to 2019, the population of the GSMC service area was 1,111,074.

TOTAL POPULATION

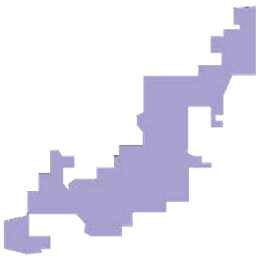
GSMC SERVICE AREA
1,111,074

ADAMS COUNTY
504,108

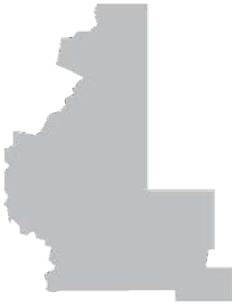


BOULDER COUNTY
322,510

BROOMFIELD COUNTY
67,886



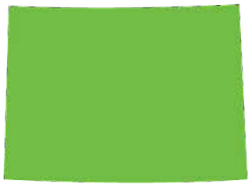
GILPIN COUNTY
6,018



JEFFERSON COUNTY
574,798

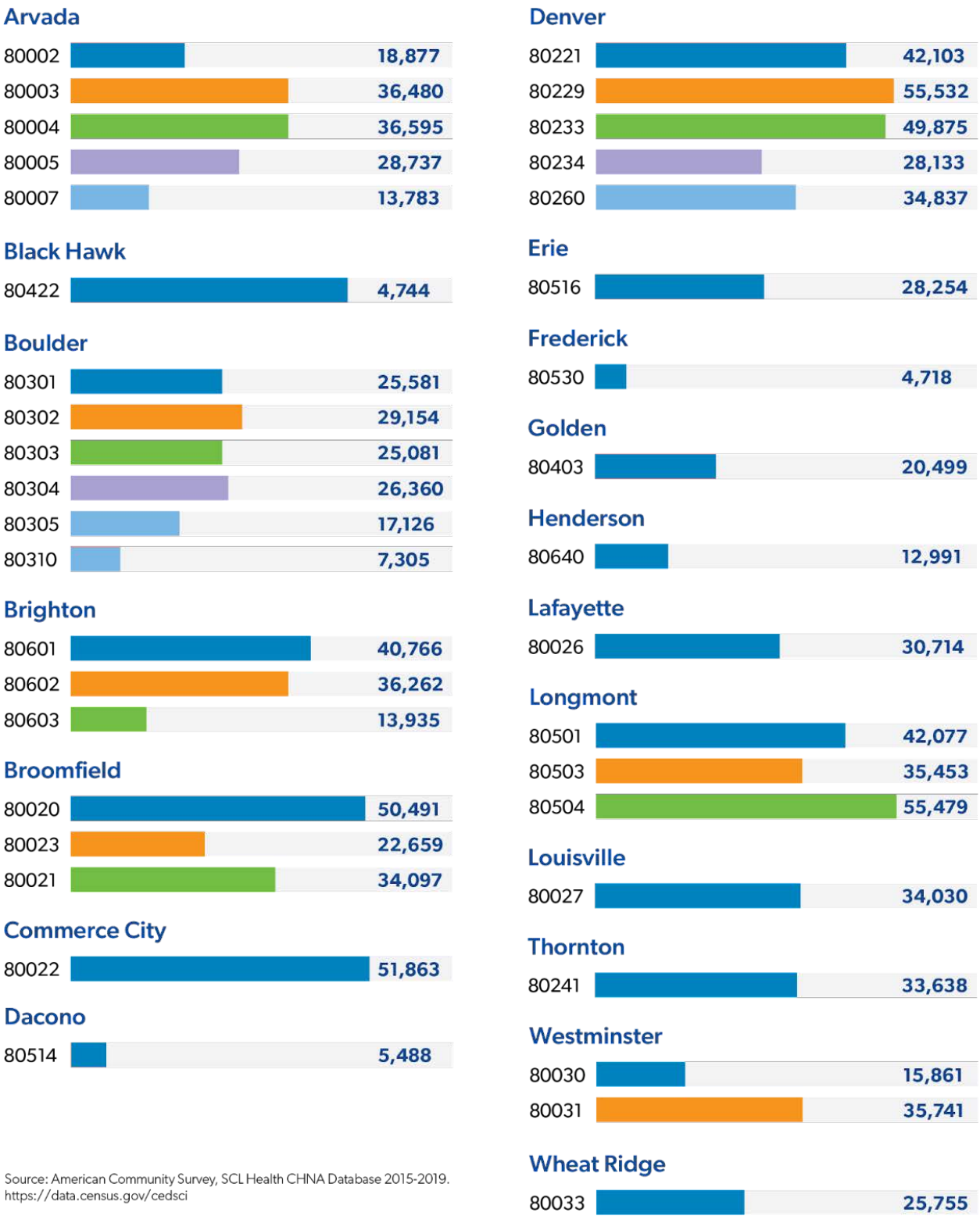
WELD COUNTY
305,345

COLORADO
5,610,349



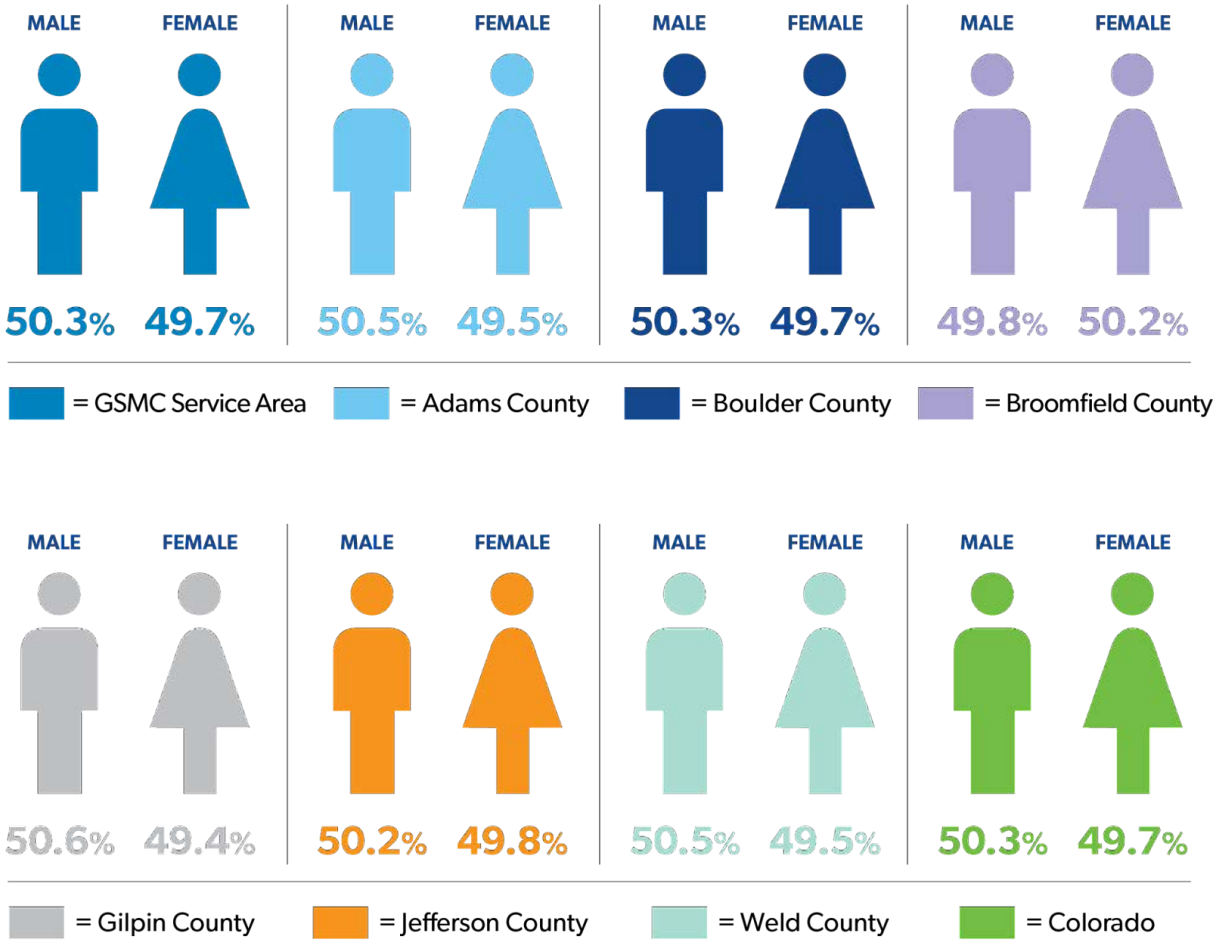
Source: Colorado Health Access Survey, SCL Health CHNA Database 2019 | https://www.coloradohealthinstitute.org/research/CHAS

POPULATION, BY ZIP CODE



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

POPULATION BY GENDER



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

Youth ages 0 to 19 comprise 26.5% of the population in the service area. Just over 61% of the population was 20 to 64 years old, and 12.6% were ages 65 years and older. Adams and Weld Counties had the highest percentage of youth, ages 0-19, (29.3%). Gilpin County had the highest percentage of seniors (17.9%) as a proportion of the total population.

POPULATION, BY AGE

GSMC Service Area

Ages 0-19	294,435	26.5%
Ages 20-34	246,658	22.2%
Ages 35-44	152,217	13.7%
Ages 45-54	144,440	13.0%
Ages 55-64	134,440	12.1%
Ages 65 +	139,995	12.6%

Gilpin County

Ages 0-19	921	15.3%
Ages 20-34	662	11.0%
Ages 35-44	963	16.0%
Ages 45-54	1,089	18.1%
Ages 55-64	1,306	21.7%
Ages 65 +	1,077	17.9%

Adams County

Ages 0-19	147,704	29.3%
Ages 20-34	114,433	22.7%
Ages 35-44	74,104	14.7%
Ages 45-54	63,014	12.5%
Ages 55-64	53,940	10.7%
Ages 65 +	50,915	10.1%

Jefferson County

Ages 0-19	87,944	22.2%
Ages 20-34	63,228	20.3%
Ages 35-44	91,968	13.4%
Ages 45-54	104,038	13.6%
Ages 55-64	124,731	14.6%
Ages 65 +	102,889	16.0%

Boulder County

Ages 0-19	76,435	23.7%
Ages 20-34	78,370	24.3%
Ages 35-44	40,643	12.6%
Ages 45-54	42,249	13.1%
Ages 55-64	40,959	12.7%
Ages 65 +	44,184	13.7%

Weld County

Ages 0-19	89,466	29.3%
Ages 20-34	65,649	21.5%
Ages 35-44	41,527	13.6%
Ages 45-54	37,252	12.2%
Ages 55-64	35,115	11.5%
Ages 65 +	36,336	11.9%

Broomfield County

Ages 0-19	17,107	25.2%
Ages 20-34	14,052	20.7%
Ages 35-44	10,047	14.8%
Ages 45-54	9,640	14.2%
Ages 55-64	8,011	11.8%
Ages 65 +	9,029	13.3%

Colorado

Ages 0-19	1,406,793	25.1%
Ages 20-34	1,249,477	22.3%
Ages 35-44	764,183	13.6%
Ages 45-54	713,520	12.7%
Ages 55-64	702,670	12.5%
Ages 65 +	773,706	13.8%

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 Boulder (80310-University of Colorado) had the smallest percentage of youth (0.3%) in the service area. Boulder (80310-University of Colorado) also had the smallest percentage of seniors (0.0%). Wheat Ridge (80033) had the highest percentage of seniors (19.8%) in the service area. The service area had a median age of 36.4 years.

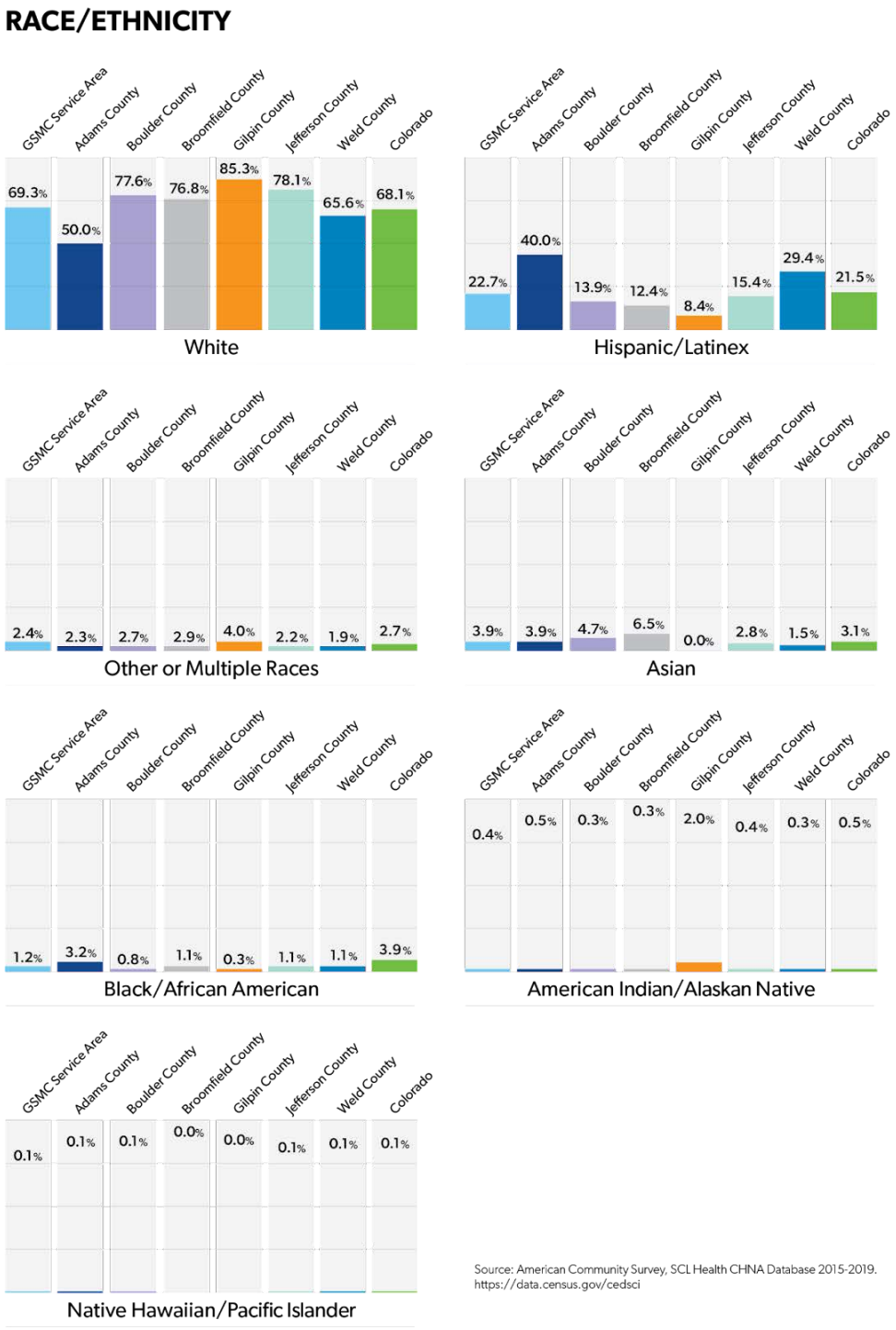
City	ZIP Code	County	Ages 5-17	Ages 65+	Median Age
Arvada	80002	Jefferson	19.2%	12.9%	35.3
Arvada	80003	Jefferson	21.2%	14.8%	37.0
Arvada	80004	Jefferson	19.4%	19.1%	41.9
Arvada	80005	Jefferson	21.2%	18.3%	43.8
Arvada	80007	Jefferson	27.7%	12.6%	38.4
Black Hawk	80422	Gilpin	13.9%	18.3%	9.3
Boulder	80301	Boulder	14.7%	14.4%	37.5
Boulder	80302	Boulder	7.1%	11.5%	25.0
Boulder	80303	Boulder	11.8%	15.5%	30.0
Boulder	80304	Boulder	19.9%	14.8%	40.9
Boulder	80305	Boulder	17.4%	14.5%	36.4
Boulder	80310	Boulder	0.3%	0.0%	9.4
Brighton	80601	Adams	27.1%	10.1%	33.4
Brighton	80602	Adams	27.7%	9.9%	37.6
Brighton	80603	Adams	27.1%	10.1%	35.1
Broomfield	80020	Broomfield	22.4%	11.9%	38.1
Broomfield	80023	Broomfield	29.0%	16.3%	41.5
Broomfield	80021	Jefferson	17.9%	12.9%	35.5
Commerce City	80022	Adams	32.8%	7.9%	31.6
Dacono	80514	Weld	28.6%	8.1%	32.0
Denver	80221	Adams	22.2%	11.7%	34.4
Denver	80229	Adams	27.3%	8.2%	31.6
Denver	80233	Adams	26.3%	10.2%	2.5
Denver	80234	Adams	23.6%	11.9%	34.9
Denver	80260	Adams	29.8%	9.7%	31.1
Erie	80516	Weld	28.6%	10.5%	37.5

Frederick	80530	Weld	21.1%	12.7%	37.7
Golden	80403	Jefferson	20.7%	15.3%	41.7
Henderson	80640	Adams	31.3%	7.0%	32.4
Lafayette	80026	Boulder	23.1%	3.8%	39.6
Longmont	80501	Boulder	22.7%	4.9%	37.5
Longmont	80503	Boulder	22.6%	16.2%	42.1
Longmont	80504	Boulder	26.7%	11.8%	37.2
Louisville	80027	Boulder	25.1%	11.5%	39.4
Thornton	80241	Adams	25.1%	11.3%	36.7
Westminster	80030	Adams	24.5%	3.6%	35.7
Westminster	80031	Adams	21.7%	16.0%	38.1
Wheat Ridge	80033	Jefferson	18.8%	19.8%	41.7
Adams County			27.0%	10.1%	33.8
Boulder County			19.4%	13.7%	36.6
Broomfield County			23.2%	3.3%	37.8
Gilpin County			13.6%	17.9%	49.0
Jefferson County			20.0%	17.9%	40.3
Weld County			26.3%	1.9%	34.4
GSMC Service Area			**22.3%**	**12.6%**	**36.4**
Colorado			**22.5%**	**13.8%**	**36.7**

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

Race and Ethnicity

In the service area, 69.3% of the population is White, 22.7% are Hispanic/Latinx, 3.9% are Asian, and 1.2% are Black/African American. The service area had a greater percentage of White, Latinx, and Asian-American individuals than Colorado overall.



Over half of the population in Commerce City (53.4%) is Hispanic or Latinx. Broomfield 80023 had the highest percentage of Asians (7.4%) in the service area. Golden (80403) had the highest percentage of Whites (90.9%) and Commerce City (80022) had the largest percentage of African Americans (4.7%) in the service area.

Race/Ethnicity by Place

City	ZIP Code	White	Hispanic/Latinx	Black	Asian
Arvada	80002	70.4%	26.4%	0.4%	1.2%
Arvada	80003	67.1%	24.3%	2.2%	3.7%
Arvada	80004	81.9%	12.6%	1.4%	0.9%
Arvada	80005	87.4%	8.3%	1.5%	1.9%
Arvada	80007	83.4%	10.5%	0.0%	3.8%
Black Hawk	80422	83.3%	9.3%	0.1%	0%
Boulder	80301	83.5%	10.3%	0.6%	3.1%
Boulder	80302	84.1%	6.2%	1.4%	4.9%
Boulder	80303	80.3%	8.4%	1.1%	6.1%
Boulder	80304	79.6%	13.3%	0.7%	.5%
Boulder	80305	83.6%	4.8%	0.5%	5.9%
Boulder	80310	70.7%	11.9%	1.6%	13.0%
Brighton	80601	56.3%	36.0%	1.6%	3.0%
Brighton	80602	72.1%	16.9%	1.2%	6.9%
Brighton	80603	61.3%	35.4%	1.5%	.7%
Broomfield	80020	76.2%	13.7%	0.9%	6.0%
Broomfield	80023	77.2%	10.5%	1.0%	7.4%
Broomfield	80021	78.1%	11.6%	0.8%	6.0%
Commerce City	80022	37.5%	53.4%	4.7%	1.6%
Dacono	80514	63.9%	32.7%	0.6%	2.4%
Denver	80221	35.9%	59.8%	1.5%	1.3%
Denver	80229	37.4%	54.8%	1.8%	2.9%
Denver	80233	60.0%	32.5%	1.9%	2.6%
Denver	80234	62.4%	26.8%	2.5%	5.7%
Denver	80260	36.1%	56.6%	.8%	3.1%
Erie	80516	81.8%	9.9%	0.1%	6.2%
Frederick	80530	72.9%	20.6%	0.0%	3.1%

Golden	80403	90.9%	5.1%	0.5%	1.6%
Henderson	80640	50.6%	43.9%	1.3%	2.6%
Lafayette	80026	75.9%	15.5%	0.6%	3.9%
Longmont	80501	63.0%	31.6%	1.4%	1.7%
Longmont	80503	81.6%	11.1%	0.8%	4.2%
Longmont	80504	71.7%	21.8%	0.5%	2.8%
Louisville	80027	79.7%	6.9%	0.4%	0.1%
Thornton	80241	69.3%	20.3%	2.1%	5.4%
Westminster	80030	47.2%	43.7%	.0%	2.9%
Westminster	80031	66.0%	23.6%	1.5%	6.6%
Wheat Ridge	80033	72.8%	22.2%	0.9%	1.2%
Adams County		50.0%	40.0%	3.2%	3.9%
Boulder County		77.6%	13.9%	0.8%	4.7%
Broomfield County		76.8%	12.4%	1.1%	6.5%
Gilpin County		85.3%	8.4%	0.3%	0.0%
Jefferson County		78.1%	15.4%	1.1%	2.8%
Weld County		65.6%	9.4%	1.1%	1.5%
GSMC Service Area		**69.3%**	**22.7%**	**1.2%**	**3.9%**
Colorado		**68.1%**	**21.5%**	**3.9%**	**3.1%**

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

Language

In the service area, 87.9% of the population, ages 5 years and older, speak only English in the home. Just under 18% speak a language other than English at home, and 12.1% of the population speaks Spanish at home. Adams County had the highest rate of residents speaking a language other than English at home (29.0%) and Gilpin County had the lowest (6.7%). Adams County had the highest rate of residents who speak Spanish at home (23.6%) and Gilpin County had the lowest rate of residents who speak Spanish at home (2.7%).

Language Spoken at Home, Population 5 Years and Older

	GSMC Service Area	Adams County	Boulder County	Broomfield County	Gilpin County	Jefferson County	Weld County	Colorado
Speaks language other than English at home	17.5%	29.0%	15.7%	12.2%	6.7%	10.6%	19.3%	16.9%
Speaks Spanish at home	12.1%	23.6%	8.7%	5.1%	2.7%	6.3%	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, GSMC has prioritized SDoH areas in food access, access to care, education and economic stability.

[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%**
Locked 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

Broomfield FISH

Sister Carmen Community Center

CLINICA family health

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 2021, the federal poverty threshold for one person was $12,880, and for a family of four it is $26,500.[2] In the service area, 9.2% of the population was living at or below 100% of the Federal Poverty Level (FPL), and 22.1% were considered low-income (living at or below 200% FPL). These poverty rates were lower than the county rates. Of the counties in the service area, Adams County had the highest rate of residents living below 200% of the federal poverty level (29.0%) and Broomfield County had the lowest rate (13.6%). Boulder County had the highest rate of residents living below 100% of the federal poverty level (11.7%) and Gilpin County had the lowest (4.9%).

Ratio of Income to Poverty Level, Total Population

	Below 100% Poverty	Below 200% Poverty
Adams County	10.8%	29.0%
Boulder County	11.7%	23.2%
Broomfield County	5.6%	13.6%
Gilpin County	4.9%	15.3%
Jefferson County	7.1%	18.4%
Weld County	10.0%	26.5%
GSMC Service Area	**9.2%**	**22.1%**
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, Boulder (University of Colorado) 80310 (11.9%) and Westminster 80030 (6.7%) had the highest unemployment rates and Black Hawk had the lowest unemployment rate (1.2%). Among the counties in the service region, Gilpin County had the lowest unemployment rate (1.5%) and Boulder County had the highest (4.2%). The unemployment rate for the hospital service area was 4.0%. Colorado had a higher unemployment rate (4.3%) than the service area.

[2] https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines/prior-hhs-poverty-guidelines-federal-register-references/2021-poverty-guidelines

Unemployment Rate of Civilian Labor Force

City	ZIP Code	Total Population	Unemployment Rate
Arvada	80002	18,877	3.7%
Arvada	80003	36,480	4.0%
Arvada	80004	36,595	4.6%
Arvada	80005	28,737	3.4%
Arvada	80007	13,783	1.9%
Black Hawk	80422	4,744	1.2%
Boulder	80301	25,581	3.8%
Boulder	80302	29,154	4.6%
Boulder	80303	25,081	4.1%
Boulder	80304	26,360	3.7%
Boulder	80305	17,126	4.4%
Boulder	80310	7,305	11.9%
Lafayette	80026	30,714	3.1%
Longmont	80501	42,077	5.1%
Longmont	80503	35,453	4.0%
Longmont	80504	55,479	3.9%
Louisville	80027	34,030	3.2%
Brighton	80601	40,766	4.0%
Brighton	80602	36,262	2.6%
Brighton	80603	13,935	3.9%
Broomfield	80020	50,491	3.4%
Broomfield	80023	22,659	2.8%
Broomfield	80021	34,097	3.1%
Commerce City	80022	51,863	4.9%
Dacono	80514	5,488	4.7%
Denver	80221	42,103	3.4%
Denver	80229	55,532	3.6%
Denver	80233	49,875	4.1%
Denver	80234	28,133	3.7%
Denver	80260	34,837	3.3%
Thornton	80241	33,638	3.4%

Erie	80516	28,254	3.7%
Frederick	80530	4,718	3.9%
Golden	80403	20,499	3.5%
Henderson	80640	12,991	4.5%
Westminster	80030	15,861	6.7%
Westminster	80031	35,741	4.4%
Wheat Ridge	80033	25,755	4.1%
Adams County		504,108	4.0%
Boulder County		322,510	4.2%
Broomfield County		67,886	3.2%
Gilpin County		6,018	1.5%
Jefferson County		574,798	3.6%
Weld County		305,345	4.1%
GSMC Service Area		**1,111,074**	**4.0%**
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. Adams County had the highest rate of students eligible for free and reduced- price meals (54.3%) and Broomfield County had the lowest (18.1%). Just under 42% of Colorado students were eligible for the FRPM program.

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

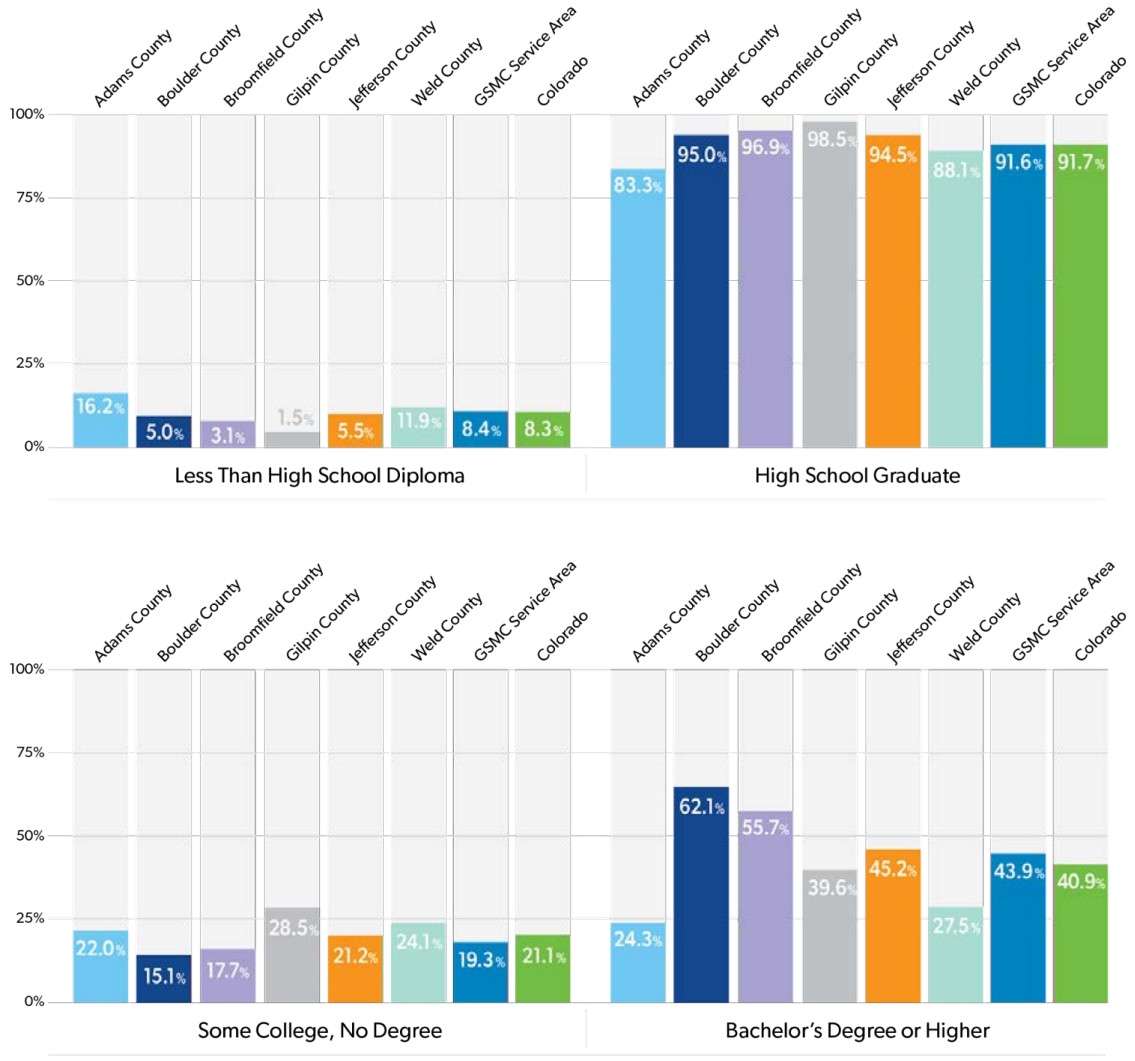
County	Percent Eligible Students
Adams County	54.3%
Boulder County	26.5%
Broomfield County	18.1%
Gilpin County	35.2%
Jefferson County	31.9%
Weld County	42.8%
Colorado	**41.7%**

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

Educational Attainment

Among the service area population, ages 25 and older, 8.4% had not attained a high school diploma. 91.6% of adults were high school graduates. 19.3% of the population in the service area had some college with no degree, and 43.9% had a bachelor's degree or higher. Boulder County had the highest rate of bachelor degree attainment among its residents (62.1%), and Adams County had the lowest (24.3%). Adams County had the highest rate of adults without a high school diploma (16.2%) and Gilpin County had the lowest rate (1.5%). Gilpin County had the highest high school graduation rate (98.5%) and Adams County had the lowest (83.8%).

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. About 73% of the sheltered homeless were housed in emergency shelters, 15% were chronically homeless and 34% had a disabling condition.

Sheltered Homeless Populations, Weld County, 2020

Indicator		Number or Percent
Sheltered homeless at PIT County		240
Sheltered in emergency shelter		73%
Sheltered in transitional housing		27%
Chronically homeless		15%
Homeless persons with chronic health 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

Sheltered Homeless Populations, Metro Denver, 2021

Indicator	Adams County	Boulder County	Broomfield County	Jefferson County
Sheltered homeless at PIT Count	346	464	24	376
Sheltered in emergency shelter	93.6%	61.4%	100%	45.1%
Sheltered in transitional housing	6.4%	38.6%	0%	54.9%
Chronically homeless	21.1%	19.0%	0%	16.4%
Homeless persons with disabling condition	29.0%	76.4%	0%	57.1%

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

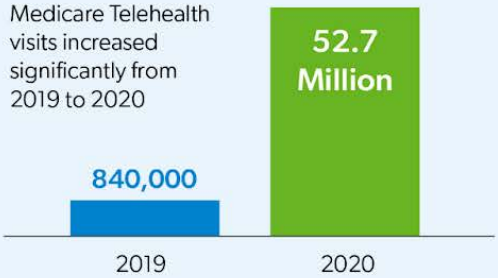
SCL HEALTH

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, 93.8% of the population was insured. Insurance coverage in HSR 16 (Boulder and Broomfield Counties) was 94.7%. Insurance coverage was higher in HSR 18, Weld County (95.9%) than in HSR 14, Adams County (90.9%). Insurance coverage was highest in HSR 21, Jefferson County (97.4%), and lowest in HSR 17, Gilpin County (88.2%). Health insurance coverage ranged from 85.3% in Denver 80260 to 99.4% in Boulder 80310. Colorado had 93.5% insurance coverage across the state.

Health Insurance Coverage, Civilian Non-Institutionalization Population

City	ZIP Code	Percent
Arvada	80002	88.3%
Arvada	80003	93.0%
Arvada	80004	94.3%
Arvada	80005	96.1%
Arvada	80007	98.0%
Black Hawk	80422	93.9%
Boulder	80301	94.4%
Boulder	80302	96.1%
Boulder	80303	95.3%
Boulder	80304	94.7%
Boulder	80305	97.8%
Boulder	80310	99.4%
Brighton	80601	91.6%
Brighton	80602	96.3%
Brighton	80603	87.9%
Broomfield	80020	95.9%
Broomfield	80023	97.3%
Broomfield	80021	94.5%
Commerce City	80022	89.7%
Dacono	80514	92.0%
Denver	80221	87.3%
Denver	80229	86.7%

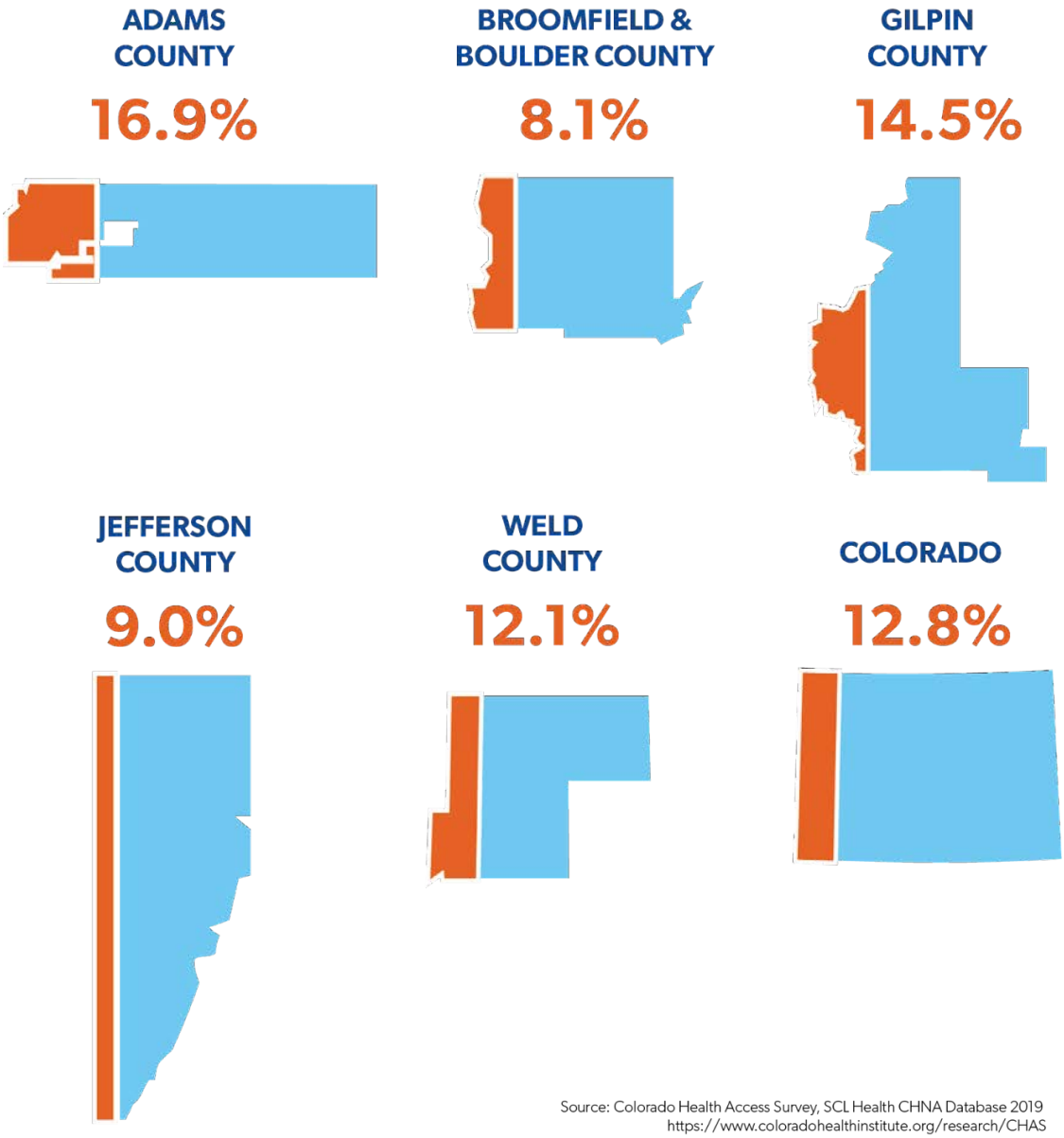
Denver	80233	92.0%
Denver	80234	92.9%
Denver	80260	85.3%
Erie	80516	97.4%
Frederick	80530	96.0%
Golden	80403	98.2%
Henderson	80640	91.7%
Lafayette	80026	96.0%
Longmont	80501	90.5%
Longmont	80503	97.1%
Longmont	80504	94.0%
Louisville	80027	97.2%
Thornton	80241	95.4%
Westminster	80030	90.3%
Westminster	80031	94.2%
Wheat Ridge	80033	94.2%
HSR 14, Adams County		90.9%
HSR 16, Boulder and Broomfield County		94.7%
HSR 17, Gilpin County (inclusive of Clear Creek, Park, and Teller Counties also)		88.2%
HSR 21, Jefferson County		97.4%
HSR 18, Weld County		95.9%
GSMC Service Area		**93.8%**
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
American Community Survey: https://data.census.gov/cedsci/

Nearly 15% of adults in HSR 17 (Gilpin, Clear Creek, Park and Teller Counties) and 12% of adults in HRS 18, Weld County had an unmet medical need and were not able to afford care. HSR 16 (Boulder and Broomfield Counties) had the lowest rates of foregone medical care due to cost among counties in the service area (8.1%), and HSR 14, Adams County had the highest rate (16.9%). Just under 13% of Colorado residents did not get needed care.

INDIVIDUALS WHO DID NOT GET DOCTOR CARE

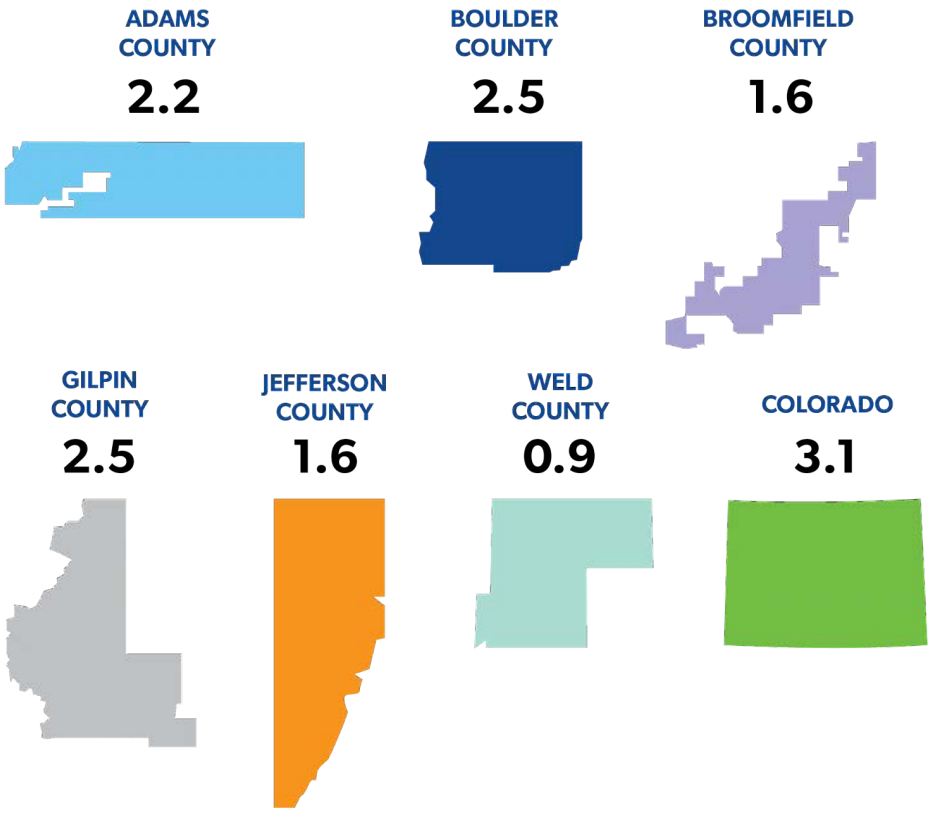
that was needed, due to cost – last 12 months



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. Weld County had the lowest rate of primary care physicians in the service at 0.9 per 1,000 persons and Gilpin and Boulder Counties had the highest rate of physicians at 2.5 per 1,000 persons. 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

GSMC tracks Emergency Department (ED) utilization through EPIC, its Electronic Medical Record system. Adams County had the highest rate of emergency room visits among its population (26.7%) and Broomfield and Boulder Counties had the lowest rate (17.7%). Just under 21% of Colorado residents visited an emergency room in the last 12 months.

Emergency Department Utilization

	HSR 14, Adams County	HSR 16, Boulder and Broomfield Counties	HSR 17, Gilpin County (inclusive of Clear Creek, Park and Teller Counties also)	HSR 21, Jefferson County	HSR 18, Weld County	Colorado
Received care at an emergency room	26.7%	17.7%	18.2%	18.8%	21.4%	20.8%

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

Dental Care

More than 18% of adults did not get the dental care they needed in HSR 16, (Boulder and Broomfield Counties) because of cost. HSR 17, Gilpin County, had the highest rate of foregone dental care due to cost (26.4%), and HSR 18, Weld County, had the lowest rate (16.8%). HSR 16, (Boulder and Broomfield Counties) had the highest rates of adult dental visits (82.1%), and HSR 14, Adams County had the lowest (69.1%). Nearly 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

	HSR 14, Adams County	HSR 16, Boulder and Broomfield Counties	HSR 17, Gilpin County (inclusive of Clear Creek, Park and Teller Counties also)	HSR 21, Jefferson County	HSR 18, Weld County	Colorado
Adult dental visit in last year	69.1%	82.1%	70.2%	77.2%	73.3%	73.6%
People who needed but did not get dental care due to cost	25.5%	18.2%	26.4%	16.9%	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 Colorado was 59.5. In the service area, Gilpin County had the lowest general fertility rate in the service area (29.8 per 1,000 women), and Weld County had the highest fertility rate (61.5 per 1,000 women).

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

County	Rate
Adams County	59.5
Boulder County	37.4
Broomfield County	43.4
Gilpin County	29.8
Jefferson County	51.5
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. 90.1% of women in HSR 16 (Boulder and Broomfield Counties) received care in the first trimester (8.9% did not). HSR 17, Gilpin County, had the lowest rate of prenatal care among pregnant women in the service area (88.3%) and HSR 21, Jefferson Count,y had the highest rate (94.7%). 89.9% of pregnant women in Colorado received prenatal care (10.1% did not).

Received Prenatal Care in 1st Trimester of Pregnancy

HSR	Percent
HSR 14, Adams County	90.7%
HSR 16, Boulder and Broomfield Counties	90.1%
HSR 17, Gilpin County (inclusive of Clear Creek, Park and Teller Counties also)	88.3%
HSR 21, Jefferson County	94.7%
HSR 18, 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. Boulder County had a 7.8% rate and Broomfield County had a 9.3% rate of low-birth weight among single baby births. Gilpin County had the highest rate of low-birth-weight single births (14.3%), and Boulder County had the lowest rate (7.8%). 9.4% of Colorado births were low weight.

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

County	Percent
Adams County	8.7%
Boulder County	7.8%
Broomfield County	9.3%
Gilpin County	14.3%
Jefferson County	8.8%
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 Boulder County was 3.7 per 1,000 live births and in Weld County it was 4.8 per 1,000 live births. The rates in all counties except Adams County are lower than the Healthy People 2030 objective. Jefferson County had the lowest infant mortality rate (3.6), and Adams County had the highest infant mortality rate (5.2). Colorado had an infant mortality rate of 4.6.

Infant Mortality Rate, per 1,000 Live Births

County	Rate
Adams County	5.2
Boulder County	3.7
Broomfield County	N/A
Gilpin County	N/A
Jefferson County	3.6
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 HSR 14, Adams County, were breastfed and 93.7% of infants born in HSR 21, Jefferson County, were breastfed. HSR 18, Weld County, had the lowest rate of service area breastfeeding (92%), and HSR 16 (Boulder and Broomfield Counties) had the highest rates of breastfeeding (96.5%).

Infants Who Were Ever Breastfed

HSR	Percent
HSR 14, Adams County	93.4%
HSR 16, Boulder and Broomfield Counties	96.5%
HSR 17, Gilpin County (inclusive of Clear Creek, Park and Teller Counties also)	92.9%
HSR 21, Jefferson County	93.7%
HSR 18, 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 irritability, loss of appetite, intense irritability, and difficulty bonding with the baby. In HSR 16 (Boulder and Broomfield Counties), 10.3% of women experienced postpartum depression. HSR 21, Jefferson County, had the highest rate of postpartum depression among the counties in the service area (13.3%), and HSR 17, Gilpin County, had the lowest rate (7.8%) of women experiencing postpartum depression.

Postpartum Depression

HSR	Percent
HSR 14, Adams County	11.2%
HSR 16, Boulder and Broomfield Counties	10.3%
HSR 17, Gilpin County (inclusive of Clear Creek, Park and Teller Counties also)	7.8%
HSR 21, Jefferson County	13.3%
HSR 18, 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 Boulder County was 554.9 per 100,000 persons and in Broomfield County the death rate was 558.3 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 Boulder County was 205.4 per 100,000 persons and in Broomfield County the premature death rate was 209.6 per 100,000 persons. Adams County had the highest premature age-adjusted death rate among the counties in the service region (318.8 per 100,000 persons), and Boulder County had the lowest (205.4 per 100,000 persons). Adams County had the highest age-adjusted death rate (764.0 per 100,000 persons), and Gilpin County had the lowest (444.3 per 100,000 persons). Colorado had the second highest age-adjusted death rate (667.0 per 100,000 persons) and the third highest premature age-adjusted death rate (282.0 per 100,000 persons).

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

County	Premature Age-Adjusted Rate	Age-Adjusted Death Rate
Adams County	318.8	764.0
Boulder County	205.4	554.9
Broomfield County	209.6	558.3
Gilpin County	217.9	444.3
Jefferson County	257.4	649.5
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

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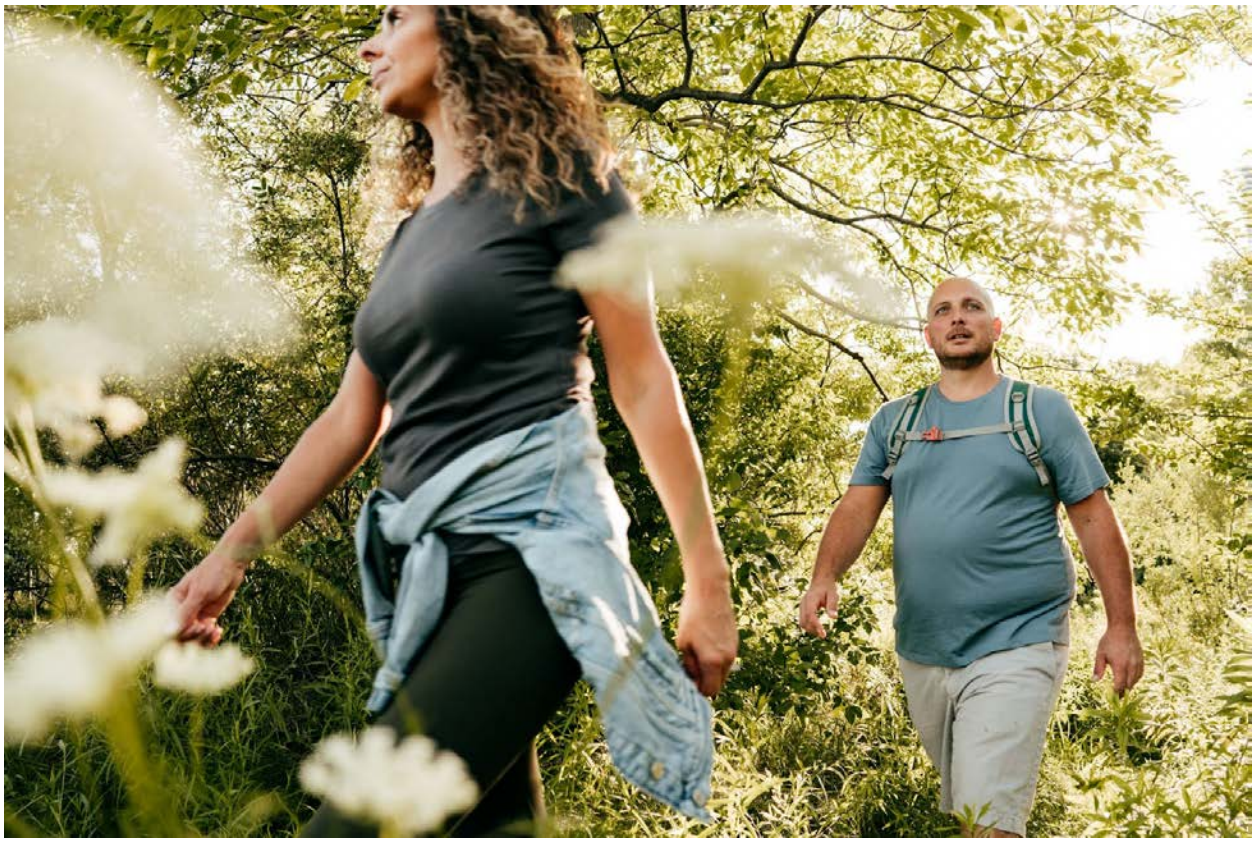
Among service area counties, Adams County had the highest rate of cancer deaths (140.3 per 100,000 persons), diabetes (24.3 per 100,000 persons), heart attack (27.6 per 100,000 persons), and heart disease (149.7 per 100,000 persons). Jefferson County had the highest death rate due to accidental falls (22.8 per 100,000 persons).

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
Boulder County	116.4	10.6	16.1	106.8	14.8
Broomfield County	113.3	12.1	18.3	91.5	15.1
Gilpin County	105.4	N/A	N/A	107.0	N/A
Jefferson County	117.2	12.0	8.1	127.2	22.8
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 2020. https://cdphe.colorado.gov/vitalrecords



Health Behaviors

Fair or Poor Health

When asked to self-report on health status within the past month. Adams County had the highest rate of self-reported poor physical health (11.8%), and Broomfield County had the lowest rate (8.2%). 9.1% 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

County	Percent
Adams County	11.8%
Boulder County	8.6%
Broomfield County	8.2%
Gilpin County	8.9%
Jefferson County	9.1%
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. Weld County had the highest Emergency Department injury rate due to falls in the service area (420.2 per 100,000 persons), and Gilpin County had the lowest rate (282.9 per 100,000 persons). In Colorado the rate of falls leading to injuries was 384.9 per 100,000 persons.

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

County	Percent
Adams County	402.6
Boulder County	404.8
Broomfield County	337.2
Gilpin County	282.9
Jefferson County	394.7
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

In the service area, Adams County had the highest rate of overweight or obese adults as a percentage of the population (67.6%), and Weld County had the highest rate of adult obesity (29.3%). Just more than 58% of Colorado is overweight or obese and 22.6% of the population is obese.

Obesity and Overweight, Ages 18 and Older

	Adams County	Boulder County	Broomfield County	Gilpin County	Jefferson County	Weld County	Colorado
Adult obesity	28.4%	13.8%	19.2%	*22.8%	21.6%	29.3%	22.6%
Adult overweight or obese	67.6%	47.1%	57.8%	*58.6%	57.5%	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
*Estimate for Gilpin County is from data at the Health Statistic Region (HSR) level.

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. In the service area, Gilpin

County had the highest food index score (9.1), and Boulder County had the lowest food index score (8.3). Colorado had a food environment index score of 8.4. Gilpin County had the lowest rate of food inaccessibility among low-income residents (0.0%) and Adams County had the highest rate of food inaccessibility (5.6%). Weld County had the highest rate of adults reporting eating less than they should due to lack of money (13.3%) and Jefferson County had the lowest rate of adults reporting eating less than they should due to lack of money (6.3%).

Food Environment Index Score

County	Rate	Cost Burden	Low Income/Access
Adams County	8.7	11.6%	5.6%
Boulder County	8.3	6.7%	3.1%
Broomfield County	8.6	6.7%	5.2%
Gilpin County	9.1	8.2%	0.0%
Jefferson County	8.6	6.3%	4.0%
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

In the service area, Boulder County had the lowest rate of physical inactivity (9.8%), and Broomfield County had the highest level of accessibility to locations for physical activity (99.5%). Slightly more than 90% of Colorado residents had access to locations for physical activity and 16.1% of Colorado residents reported no leisure time physical activity.

Physical Activity

	Adams County	Boulder County	Broomfield County	Gilpin County	Jefferson County	Weld County	Colorado
Access to locations for physical activity	93.1%	96.2%	99.5%	81.7%	99.2%	78.3%	90.5%
Adult physical inactivity	23.1%	9.8%	11.5%	*17.7%	14.0%	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*

*Estimate for Gilpin County is from data at the Health Statistic Region (HSR) level

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. Gilpin County had the highest rates of elevated blood pressure (33.7%) among its residents, whereas Boulder County had the lowest (22.6%). Just under 26% of Colorado residents (ages 18 and older) have been diagnosed with elevated blood pressure.

Elevated Blood Pressure

	Adams County	Boulder County	Broomfield County	Gilpin County	Jefferson County	Weld County	Colorado
Elevated blood pressure	26.3%	22.6%	23.9%	*33.7%	24.6%	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
*Estimate for Gilpin County is from data at the Health Statistic Region (HSR) level.

Among service area counties, Gilpin County had the highest rate of arthritis (29.1%), heart attack (3.7%) and elevated blood pressure (33.7%). Boulder County had the lowest rate of stroke (1.2%), heart attacks (2.0%) and adult asthma (6.7%). Adams County had the highest rate of asthma (11.3%). Weld County had the highest rates of diabetes (8.6%). Colorado had higher rates of arthritis and high blood pressure than other chronic conditions.

Chronic Diseases, Ages 18 and Older

	Adams County	Boulder County	Broomfield County	Gilpin County	Jefferson County	Weld County	Colorado
Arthritis	21.3%	19.0%	24.5%	*29.1%	24.2%	19.6%	22.8%
Adult asthma	11.3%	6.7%	8.0%	*6.9%	9.7%	8.7%	8.9%
Adult diabetes	8.4%	5.9%	5.9%	*4.0%	6.3%	8.6%	6.8%
Heart attack	3.6%	2.0%	3.5%	*3.7%	3.2%	3.0%	3.3%
High blood pressure	26.3%	22.6%	23.9%	*33.7%	24.6%	25.1%	25.8%
Stroke	2.5%	1.2%	1.4%	*2.5%	2.3%	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
*Estimate for Gilpin County that is data at the Health Statistics Region (HSR) level

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

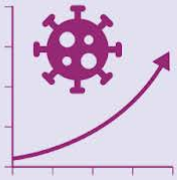
"The pandemic's impact extended well beyond infection rates, touching on employment, finances, mental well-being, and more."

— 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.



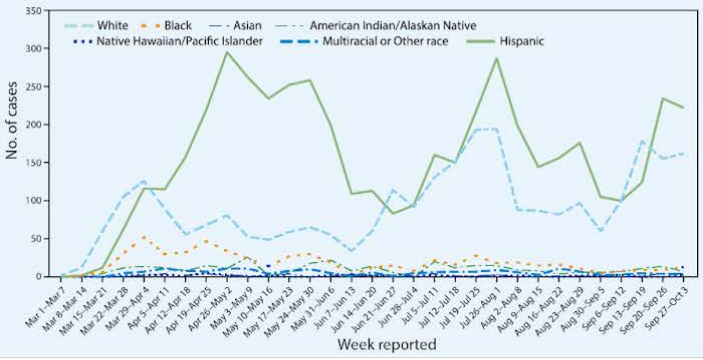
CDC Report

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 in Adams County, and 49,393 confirmed cases and 810 deaths in Jefferson County. Boulder County has fully vaccinated 73.3% and partially vaccinated 78.3% of its population. Broomfield County has partially vaccinated 80.2% and fully vaccinated 75.4% of its population. Broomfield County had the highest rate of fully vaccinated residents (75.4%), whereas Weld County had the lowest (51.2%). Gilpin County has had the least amount of COVID-19 related deaths (3), whereas Jefferson County has had the most (810). Broomfield County also had the highest rate of partial vaccination among its residents, with 80.2% being partially vaccinated. There have been 566,670 confirmed cases and 6,886 confirmed deaths of COVID-19 in Colorado as of July 19th, 2021. Just over 61% 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	Boulder County	Broomfield County	Gilpin County	Jefferson County	Weld County	Colorado
Cases	61,552	24,286	5,065	285	49,393	33,863	566,670
Deaths	724	235	76	3	810	354	6,886

Source: Colorado Department of Public Health and Environment, SCL Health CHNA Database 2021. https://covid19.colorado.gov/data & https://covid19.colorado.gov/vaccine-data-dashboard

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

	Adams County	Boulder County	Broomfield County	Gilpin County	Jefferson County	Weld County	Colorado
Fully vaccinated	58.4%	73.3%	75.4%	56.7%	68.4%	51.2%	61.4%
One dose	64.5%	78.3%	80.2%	60.8%	72.8%	56.3%	66.7%

Source: Colorado Department of Public Health and Environment, SCL Health CHNA Database 2021. https://covid19.colorado.gov/data & https://covid19.colorado.gov/vaccine-data-dashboard

Cancer

Incidence rates for invasive cancer of any type were 404.8 per 100,000 persons in Boulder County, and 337.2 per 100,000 persons in Broomfield County. Gilpin County had the lowest rate of cancer incidence (282.9 per 100,000 persons) in the service and Weld County had the highest rate (420.2 per 100,000 persons).

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

	Adams County	Boulder County	Broomfield County	Gilpin County	Jefferson County	Weld County	Colorado
Invasive cancer for all sites combined	402.6	404.8	337.2	282.9	394.7	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, the rate of mammogram breast cancer screening ranged from 27% in Gilpin County to 49% in Broomfield County. 41.0% of Colorado female Medicare enrollees received an annual mammography screening.

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

	Adams County	Boulder County	Broomfield County	Gilpin County	Jefferson County	Weld County	Colorado
Annual mammogram	35.0%	47.0%	49.0%	27.0%	42.0%	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 County had the highest rate of asthma hospitalizations (5.4 per 10,000 persons. Weld County had the highest area rates of COPD hospitalizations (10.2 per 10,000 persons), heat-related hospitalizations (2.1 per 10,000 persons), and influenza hospitalizations (0.9 per 10,000 persons). Colorado had an asthma hospitalization rate of 4.2 per 10,000 persons, COPD hospitalization rate of 9.5 per 10,000 persons, and a rate of 0.8 per 10,000 persons for heat-related hospitalization.

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

Cause	Adams County	Boulder County	Broomfield County	Gilpin County	Jefferson County	Weld County	Colorado
Asthma*	5.4	3.1	2.9	0.0	3.4	3.9	4.2
COPD*	9.5	7.0	7.3	N/A	4.3	10.2	9.5
Heat-related+	1.0	N/A	N/A	0.0	0.5	2.1	0.8
Influenza+	0.6	0.6	0.0	0.0	0.2	0.9	N/A

Source: Colorado Department of Public Health and Environment, SCL Health CHNA Database 2020-2021. 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, chlamydia and gonorrhea were highest in Adams County compared to other service area counties. Chlamydia had the highest incidence rates of a sexually transmitted infection: 571.2 per 100,000 persons in Adams County and 458.2 per 100,000 persons in Weld County. Gilpin County had the lowest rates of gonorrhea (49.2 per 100,000 persons), and chlamydia (65.6 per 100,000 persons) among the counties in the service area.

Sexually Transmitted Infection Rates, per 100,000 Persons

	Adams County	Boulder County	Broomfield County	Gilpin County	Jefferson County	Weld County	Colorado
HIV incidence	240.4	161	101.2	152.8	164.9	89.4	264.2
Chlamydia, ages 13 and older	571.2	433.8	371.8	65.6	229.9	458.2	511.4
Gonorrhea, ages 13 and older	159.3	79.3	82.5	49.2	71.4	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, SJH 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

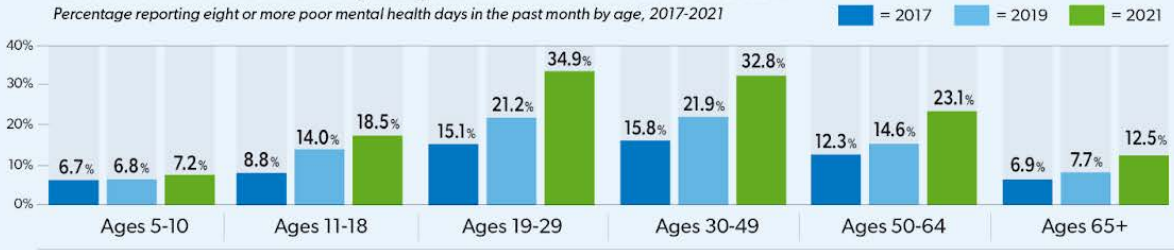
KEY TAKEAWAYS:

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%)**

GSMC HIGHLIGHTED PARTNERS

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

Broomfield PUBLIC HEALTH

BOULDER COUNTY PUBLIC HEALTH

Mental Health PARTNERS
Healthy minds, healthy lives, healthy communities

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. Boulder County had the most mental health providers (6.3 per 1,000 persons) in the service area and Weld had the fewest (1.7 per 1,000 persons). Gilpin County had the most mental health treatment facilities at 1.66 per 10,000 persons and Boulder County had the least (0.12 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	Boulder County	Broomfield County	Gilpin County	Jefferson County	Weld County	Colorado
Mental health providers, per 1,000 persons	2.1	6.3	3.5	3.5	3.1	1.7	2.7
Mental health treatment facilities, per 10,000 persons	0.22	0.12	0.15	1.66	0.23	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/locator

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. HSR 17, Gilpin County, had the highest rate of high school students reporting severe mental health issues (39.2%), whereas HSR 16 (Broomfield and Boulder Counties) had the lowest rates (31.0%). HSR 17, Gilpin County, also had the highest rate of high school students who seriously considered suicide within the past year (22.3%). More than 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

	HSR 14, Adams County	HSR 16, Boulder and Broomfield Counties	HSR 17, Gilpin County (inclusive of Clear Creek, Park and Teller Counties also)	HSR 21, Jefferson County	HSR 18, Weld County	Colorado
Seriously considered suicide within the past year (reported by HSR)	16.7%	16.4%	22.3%	17.3%	16.6%	17.5%
Severe physical/mental health issues preventing normal activity for 2+ weeks (reported by HSR)	31.9%	31.0%	39.2%	34.4%	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 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). HSR 16 (Boulder and Broomfield Counties) had the highest rates of foregone mental health treatment due to stigma (57.6%), and HSR 21, Jefferson County (43.2%) had the lowest rate of foregone mental health counseling or treatment. Boulder County had the lowest rate of suicide related ER visits (89.1 per 100,000 persons), and Broomfield County had the lowest suicide rate (8.6 per 100,000 persons). While Colorado had a high rate of foregone mental health care due to stigma (47.3%), the other mental health indicators were relatively similar to the specific counties in this report.

Mental Health Indicators

	Adams County	Boulder County	Broomfield County	Gilpin County	Jefferson County	Weld County	Colorado
Age-adjusted suicide rate, per 100,000 persons	22.0	17.7	8.6	N/A	19.3	17.0	21.4
Rate of suicide ED visits, per 100,000 persons	128.5	89.1	111.1	N/A	137.4	139.6	129.5
Adults taking medicine or receiving treatment for any type of mental health condition	15.8%	13.2%	17.4%	14.3%	12.9%	14.4%	15.0%
Did not get needed mental health care due to stigma in past 12 months *(reported by HSR)*	51.2%	57.6%		52.8%	43.2%	51.1%	47.3%
Reported a time there was a need for mental health counsel-ing but did	12.0%	17.7%		6.5%	15.8%	8.2%	13.5%

not get it in past 12 months *(reported by HSR)*						

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

The percentage of the adult population reporting more than 14 days of poor mental health per month was 10.0% in Boulder County and 11.8% in Adams County. Broomfield County had the highest level of frequent mental distress among adults (15.4%) in the service area, and Jefferson County had the lowest level of frequent mental distress among adults (9.8%). Just under 11% of Colorado adults reported frequent mental distress.

Frequent Mental Distress, Adults

County	Percent
Adams County	11.8%
Boulder County	10.0%
Broomfield County	15.4%
Gilpin County	*10.3%
Jefferson County	9.8%
Weld County	12.6%
Colorado	**10.9%**

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

*Estimate for Gilpin County is from data at the Health Statistic Region (HSR) level.

Substance Use

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

Marijuana Use

Gilpin County had the highest rate of adult marijuana use (20.9%) and marijuana use during pregnancy (16.5%) among service area counties. Broomfield and Boulder counties had the highest rates of student marijuana usage (22.6%) in the service area, and Gilpin County had the most marijuana retailers at 1.2 per 1,000 persons.

Marijuana Use

	Adams County	Boulder County	Broomfield County	Gilpin County	Jefferson County	Weld County
Adult marijuana use	14.2%	18.5%	15.2%	*20.9%	18.6%	12.5%
Marijuana use during pregnancy *(reported by HSR)*	5.8%	11%		16.5%	12.2%	7.7%
Students, at least 1 time during the past 30 days *(reported by HSR)*	18.0%	22.6%		21.4%	19.5%	20.9%
Marijuana retailers, per 1,000 persons	0.1	0.2	0.0	1.2	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/
*Estimate for Gilpin County is from data at the Health Statistic Region (HSR) level

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. Heavy drinking is defined as more than two drinks per day for men and more than one drink a day for women. In the service area, HSR 16 (Boulder and Broomfield counties) had the highest rates of drinking among students with 36.6% of students reporting having had at least 1 drink in the past 30 days. HSR 21, Jefferson County, had the highest level of binge drinking (21.4%) in the service area. 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 high school students reported having at least 1 drink in the past 30 days in Colorado.

Alcohol Use

	Adams County	Boulder County	Broomfield County	Gilpin County	Jefferson County	Weld County	Colorado
Heavy drinking	6.1%	8.2%	3.6%	*7.8%	8.2%	7.2%	7.0%
Students, at least 1 drink in past 30 days (reported by HSR)	25.4%	36.6%		26.1%	30.1%	32.2%	29.6%
Binge drinking	18.6%	18.7%	14.3%	*16.2%	21.4%	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
*Estimate for Gilpin County is from data at the Health Statistic Region (HSR) level

Cigarette/E-Cigarette Smoking

The Healthy People 2030 objective is 5% of the population who smoke cigarettes. All service area counties exceed this rate. 8% of pregnant mothers in Jefferson County and 7.8% in Gilpin County smoked during their pregnancy. Among students who reported using an E-cigarette in the past 30 days, rates ranged from 23.4% in HSR 14, Adams County, to 29.3% in HSR 18, Weld County. HSR 17, Gilpin County, had the highest rates of students reporting smoking cigarettes in the last 30 days (8.7%).

About 15% 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. 26.1% 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	Boulder County	Broomfield County	Gilpin County	Jefferson County	Weld County	Colorado
Adult cigarette use	18.8%	9.5%	12.5%	*17.1 %	14.2%	16.2%	15.0%
Pregnant mothers who smoked during last trimester of pregnancy *(reported by HSR)*	6.7%	6.8%		7.8%	8.0%	4.7%	6.1%
Students who used an electronic vapor product one or more times in the last 30 days *(reported by HSR)*	23.4%	27.4%		28.6%	26.0%	29.3%	26.1%
Students who smoked cigarettes one or more times in the last 30 days *(reported by HSR)*	4.5%	6.2%		8.7%	4.1%	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
*Estimate for Gilpin County is from data at the Health Statistic Region (HSR) level

Next Steps

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

- Behavioral Health
- Access to Healthcare

CHIP efforts include identifying Implementation Strategies that leverage community strengths and partnerships, GSMC'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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SCL Health, Good Samaritan Medical Center and Platte Valley Medical Center

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SCL Health

Appendicies

Appendix 1. Community Survey Reports

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.

> *"It is so unaffordable to live here, which impacts everything, including health."*
>
> *– Survey Respondent from Denver County*

> *"Lack of affordable housing and adequate wages are the primary factors driving poverty in our community. People will never be able to focus on health when they can't meet their basic human needs. Housing needs to be at the top of the list for priorities."*
>
> *– Survey Respondent from Broomfield County*

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.

> *"COVID-19 has a significant impact and has caused further stress and behavioral health issues."*
>
> *– Survey Respondent from Broomfield County*

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 survey 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 more than three times as likely as their white peers 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 (see Table 6).

> *"Mental Health continues to be stigmatized; it's difficult to know how our communities mental health is fairing with many not willing to disclose mental health challenges."*
> – *Survey Respondent from Denver County*

> *"Covid-19 has drastically increased mental health concerns and feelings of isolation."*
> – *Survey Respondent from Denver County*

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. 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 community.

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

Name	Title	Organization
Megan Billesbach	Community Liaison, Region 6	Colorado Community Health Alliance
Monica Buhlig	Group Director of Community Health, Denver Metro Group	Centura Health
Nikki Crouse	Senior Services Manager	City and County of Broomfield
Saphia Elfituri	Community Liaison, Region 6	Colorado Community Health Alliance
Kathy Escobar	Pastor	The Refuge
Jennifer Korbelik	Communities that Care Facilitator	Boulder County Public Health
Nikole Mateyka, LCSW	Supervisor of Transition of Care and Maternity Care	Colorado Community Health Alliance
Mardi Moore	Executive Director	Out Boulder County
Cynthia Nelson, RN, BSN	Telemetry Night Shift SSC	Good Samaritan Medical Center
Lark Rambo	Executive Director	Coal Creek Meals on Wheels
Michelle Ryan	Regional Community Partner	Behavioral Health Group, LLC
Julia Zigarelli, PhD	Associate Director, Renee Crown Wellness Institute	University of Colorado, Boulder

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've seen an increase in drugs and alcohol use, substance abuse, obesity, and quite a few people have become homeless.
- With the social determinants of health, housing is the largest barrier. Also, access to specialists, and getting connected to the right person at the right time. Sometimes, after discharge from the hospital, there may be a follow-up appointment, but because of transportation issues, or other barriers, they don't make the appointment. On a larger scale, there is a need for wraparound services and supports. People need assistance with medication management, food, and follow-up appointments.
- Children need long-term services and supports, wraparound care and residential placements. There are so few options, we have to resort to out of state options.
- We are seeing lots of loneliness and increased dementia.
- Mental health, and some of those things that impact health and stability, such as hunger and housing.
- There is a lack of cultural competency with our doctors.
- Behavioral health is the main issue and substance use disorder. There are so many substances that are being mixed with fentanyl now.
- Mental health access and support systems. There is a lack of affordable high quality mental health services and we've seen a significant rise in substance use.
- Unstable people with mental health and physical health issues living in their cars.
- Mental health, economic and health disparities. We have a large Latinx population who are undocumented and are monolingual Spanish. They experience many barriers, which became very apparent with COVID.
- Isolation, lack of access to nutritious food, mobility issues.

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

- Economic issues. People lost their jobs with the pandemic.
- If you have housing stability, everything else falls into place. If you do not have stable housing, you do not prioritize your health care; when you are in a housing crisis, everything else goes on the backburner.
- About 50% of individuals who qualify for WIC and SNAP are not accessing benefits.
- For communities of color, and different socioeconomic classes, not everyone has access to care. We experienced medical care deserts during COVID vaccinations. Many people were not close enough to a provider to easily get the vaccine.
- Inflation and the cost of living are challenges. Being unemployed or underemployed impacts the ability to get resources.

- Behavioral issues.
- A lot of people are just getting by and they are not able to make ends meet. They are above the poverty line, but they are worried, am I stable in my home? Can I keep my house warm at night? Can I keep my family fed? There is insufficient income to get by.
- Poverty, lack of access, transportation.
- Transportation and housing.
- Employment options for people who are re-entering society after incarceration.
- There is extreme disparity with wealth status in terms of access to care for behavioral health disorders and homelessness issues.
- Transportation is a huge issue; many clients can't get to the grocery store or their doctor's appointments. We have people who can't afford to move, but their homes are in disrepair. So much of their limited resources are going into their housing and they can't then also pay for medications, food, etc.

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

- Women during that prenatal period. We try very hard to find those folks, but sometimes they show up in the health care system for the first time in the ED, in labor. There may be substance use issues or behavioral health issues that leave them leery of connecting with providers.
- Many people wait until they are really sick before accessing care. We expect that to increase in the next several months with the rent moratorium expiring.
- Seniors are an underserved population, that doesn't ask for a lot. Many seniors do not have family close by or systems in place to advocate for themselves to get the health care or social services they need.
- A lot of immigrant communities are more hesitant to access services and social resources. The system is designed to be less representative of these communities. If you are not legal, you are less likely to access services. Even if you have legal status, immigrants still don't feel confident accessing services because our healthcare system is designed differently. Also, our health care workforce does not yet reflect our population.
- Trans people, nonbinary people, the undocumented and monolingual Spanish speakers. When you look at the LGBTQ community, they are some of the poorest, so fear of a copay keeps them from going to the doctor. The trans population does not feel comfortable with signing up for Medicaid or accessing the doctor's office where you have a birth certificate and medical record that says you are male, but you identify as female. Everyone is uncomfortable and worse, not treated as their identified gender during the medical appointment.
- The homeless population is not accessing medical care because they are not encouraged to go. They don't feel well treated by medical establishments, so they shy away from medical appointments. They don't really want to face what is happening in their lives and if they show up for their medical appointment, they have to face it.
- Those in socioeconomic classes that are less educated, less aware of access to resources and those who speak a language other than English. We are an overwhelmingly white identifying

county, so there are invisible populations in our county who are not receiving the same access and awareness and visibility around resources.
- Our unhoused residents have a lot of barriers to access. They don't have access to technology. And people who are working and their employment makes it difficult to get an appointment because of long hours and transportation issues.
- The undocumented, monolingual Spanish speaking population do not access the system due to language barriers, fear, and a lack of information about services.
- There are so many barriers for seniors and those with disabilities. They may be hearing impaired, or not have access to technology, or transportation, and they have limited financial resources.

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

- We are seeing a lot more alcoholics in the hospital. People staying home during the pandemic were often noncompliant with things they should have done to proactively take care of their health, specifically persons with diabetes and those with heart failure.
- In the community, our resource bucket is really taxed right now, more than ever with COVID. We run into organizations that say we can't take your referral because we don't have the resources to meet the needs. In general, the pandemic exacerbated the unmet needs in the community. Some people had difficulty connecting with telephonic care and some rural practitioners had difficulty with the transition.
- Across the behavioral health realm, organizations are having difficulty hiring people. A lot of providers experienced fatigue, and organizations are having difficulty filling positions. We hear that some job openings in the community aren't receiving a single applicant. This will continue to impact access issues.
- There is a fair amount of fear about going out, especially for seniors. In large part, for those who do not have a social system already set up, it set them up for feeling lonely and not knowing who to turn to or know how to ask for what they need.
- It has both exacerbated and grown significantly. Also, there is a hesitancy in using resources. People are less confident in institutions due to policy and political changes. As a result, there is a lack of understanding and trust. This includes immigration enforcement, eligibility for programs based on immigration status, and whether accessing one resource will make you ineligible for others.
- The mental health of the LGBTQ community has been greatly impacted. Suicides have increased in our county and we know many of them are LGBTQ. We know that prior to the pandemic, our population suffered from loneliness, more so than other populations, and that has only increased with the pandemic. The wait time to get into therapy covered by Medicaid is about 2 to 3 months if you are not actively suicidal or homicidal. If you are LGBTQ or undocumented, the chances of getting a culturally competent therapist in that time frame is low.
- Mental health and behavioral health and suicide ideation issues have increased.
- The shift to technology has helped with resources but it is hard to know the impact on under-resourced people. They may not have a phone or internet. For seniors who live alone,

technology can be a huge barrier. The inability to go into doctor offices easily because they are closed or have limited hours or have gone to all electronic visits out of need, makes it hard on seniors. And everyone is experiencing more trauma

- We really noticed that those people who were already vulnerable economically really struggled with job losses.
- Isolation among seniors is so much worse. And underlying health issues are exacerbated because they are hesitant to seek out services, or even go to the grocery store.

Access to Health Care: Issues, Challenges and Barriers

- Food and housing take priority over health. Also, there are transportation issues, especially for the rural communities. We also see people who leave the hospital feeling great and make plans to be more proactive, but then we don't hear from them again until there is another major health crisis that happens in their lives.
- For the underserved populations, there is a lot of mistrust of health care agencies, doctors and the entire health care system. The medical costs are a barrier and can make care cost prohibitive. The fact that there are so many kinds of doctors out there if you are dealing with a variety of comorbidities, you have multiple providers for multiple issues and that can be confusing. It is difficult to get transportation to all the locations and maintain communication between providers on what is prescribed and how the medications may interact with one another.
- Barriers are immigration status or having family members who have immigration issues. The cost of care, especially for mental health care.
- During the pandemic, it was made very clear that vaccine equity is racial equity, and that is important. But no one is including LGBTQ in their equity work. We need to be seen in the medical industry. Some trans people refuse to go to the doctor because they do not want to deal with being mistreated. It is so common that it is driving up the costs in EDs and it ends up as uncompensated care and that is because trans people don't feel they are seen when they walk in. We need culturally competent practitioners. People won't go to just anyone for their care.
- There is a lack of education and awareness on how to access services that may be accessible in the community. In Boulder County, Spanish is the second highest spoken language and there is not enough being done for the Spanish speaking population.
- Being able to get through the system. Knowing who to call, who takes what insurance, or if you have no insurance, how do you get qualified with Medicaid and get enrolled properly? Who takes Medicaid, who is a good practitioner and doesn't have a long wait list to get in?
- Low-income residents that don't have employment that offer health insurance and those not insured because of the cost of health care. Immigration status and language barriers are a challenge.
- A lot of our clients have limited resources and they don't know how to navigate the healthcare system and how to access their Medicare and Medicaid. Especially people who may be hard of hearing and can't speak effectively with people on the phone. Knowing what services are eligible for and how to acquire them can be a challenge.

Housing and Homelessness: Issues, Challenges and Barriers

- There are not enough housing resources available, so there is a supply and demand issue. Also, because housing is so nuanced, there are so many eligibility and housing types, it is difficult to navigate the system.
- People struggle with housing and rental prices and they just keep going up. Even with affordable housing, that really hasn't been that well defined. It is based on what a project will cost, then a percentage lower is offered as affordable housing. But that doesn't mean it is affordable for many people. There is a great divide between those that are doing well and those that are not. It doesn't seem like there is much middle ground.
- Some of the greatest barriers are the cost of entry – the down payment for a house or first and last month's rent. That cost of entry is often a barrier in addition to or exclusive of monthly payments. Often, people may be able to afford their rent, month to month, but they cannot also afford the additional cost of first and last month's rent.
- The average house here costs $1.2 million and rent is about $2,000/month for a one bedroom and there is no rent control. Many of the people who work in our county live outside the county and commute in. And transportation access is an issue. It is critical that we ask if someone is housed. That is critical because sometimes that is the only touchpoint someone has with our system to receive help.
- We aren't seeing enough affordable housing being built and maintained. Due to the pandemic, we are seeing skyrocketing rents and house prices.
- There are very few or no openings in emergency shelters. There are resources for families, but for individual people who don't have children and aren't working, it is impossible to find them a placement. And the length of time to get disability or even apply is several years; that system is completely overwhelmed. Single people are vulnerable because they don't qualify for many of the programs.
- The cost of housing is incredibly high in our county and rents continue to increase. Pre-COVID we had families with limited incomes who, with the pandemic, have lost their jobs, are on the verge of losing their housing, and rent is increasing. It puts additional strain on families. Also, we see a number of transient youth, moving from home to home with their families due to the high cost of living and that creates a lot of health risks.
- Affordability and home maintenance are issues.

Mental Health: Issues, Challenges and Barriers

- It was a big issue during the pandemic and a lot of people turned to drinking to cope. We don't have the support system in place for all the mental health needs in the community. Many nurses are not specially trained to deal with mental health issues. We do the best we can with what we have. Mental health services is an area where we are failing people.
- There can be a gap in services for those who are experiencing co-morbidities and mental health issues. People may have intellectual disabilities, a traumatic brain injury, or dual diagnosis mental health issues and it is difficult to find a provider that is all encompassing and understands how to meet the needs of these unique populations. Finding a provider that is a fit for both diagnoses can be a challenge.

- We've seen an increased ability to openly talk about mental health. During the pandemic, it has taken such a toll on mental health, so it has become a topic that's more openly discussed. We've seen depression, suicide and people who are completely desperate and they do not know where to turn to obtain help. It is still looked down upon to say you need mental health help.
- Cost, access in a timely manner and the stigma associated with it. Some mental health centers provide safety net services, but the majority are private pay. And we are seeing more practitioners move to out-of-pocket payment models. Our governor's office did a lengthy and informative assessment on this phenomenon.
- They do not feel wanted or accepted and they do not feel safe asking for help, mainly because of the stigma, whether it is real or perceived. It takes extra effort for a clinician or anyone who is trying to help them to feel they can trust that individual. I would say that the stigma around mental health has decreased, especially during the pandemic, but we have a long way to go. I don't know if the person on the street who is suffering has noticed a difference.
- Schools are under-resourced, and the community at large does not have enough youth focused mental health practitioners to meet the needs of our kids. Multiple identifying statuses, like minority statuses, LGBTQ, or persons of color, are struggling to find providers that share their identity like biracial and bilingual. They can't access resources because their culture and language are not shared.
- It is hard to make an appointment and it is difficult to get one in an appropriate amount of time. There are transportation issues related to making an appointment, changes of staff with county mental health practitioners, and payment barriers. Even low-cost treatment, at $20 is a barrier. There are multiple forms to fill out to get that low-cost appointment and some people are concerned about completing those forms and sharing that documentation.
- With youth, ages 12 to 24, there is stigma, and barriers to accessing services, including a lack of availability or providers and services that feel relevant or accessible to teens. The services that do exist don't feel like a good fit with teens. It is hard to find practitioners who work well with teens. With the Latinx population, there is a fair amount of stigma as well from a cultural perspective.
- Isolation, access to services, lack of family support or not having social connections are all barriers.

Overweight and Obesity: Issues, Challenges and Barriers

- You can educate people, but you can only do so much with that. It comes down to their willingness to change.
- Some barriers with our chronic disease management team include struggling to get people engaged. Often when patients leave the hospital, we can't re-engage with them and we aren't sure why.
- We know what we should eat. But those getting financial assistance are often looking for the cheapest food to spread their resources.
- It's been on our radar for a while, so we've seen some improvement as more people understand healthy eating. But the cost of affordable foods and access to affordable food is important to

recognize. The same for physical activity. We need more options in our community that are safe and accessible at multiple times of the day that don't require payment.

- Those with substance abuse disorder, they often come in emaciated but once they get stable and start to eat, they gain weight quickly. Sometimes the weight gain can be a deterrent to treatment, so we need to do a lot of counseling around that and nutritional education and let them know that the weight gain is temporary. It is common to gain weight when people stop doing drugs, but with lifestyle changes, hopefully the weight decreases.
- Obesity rates in young people are increasing.
- Due to a disability some individuals lack access to nutritious food and have an inability to prepare healthy foods, even if they get groceries delivered.

Substance Use and Misuse: Issues, Challenges and Barriers

- With telehealth, it encouraged people who were normally afraid to walk into a room full of strangers for AA or NA. During the pandemic, people could participate anonymously on a computer screen. That helped some people. For others, they were used to going to a physical location and meeting friends and saw it as a support group. They found Zoom and virtual meetings intimidating and isolating and many relapsed.
- Alcohol is an issue and we are also seeing a lot of marijuana use. We are also seeing an increase in the use of drugs. The people who are using drugs are neglecting their health problems. People are malnourished, but they just want to get high.
- There is a lot of work being done and opportunities to help with stigma and provide supportive systems. For instance, with our prenatal efforts, we will support moms even if they are actively using.
- It has been somewhat normalized in the pandemic. People shared how they were spending their time or dealing with such a difficult, chronic long-term time, and it seemed like a collective way society dealt with it and it was normalized in social media and people's conversations.
- Fentanyl is being cut into street drugs. It is cheaper to put fentanyl into products than opioids or heroin because they are more expensive to manufacture. Detox is getting better, there were not enough services before, but there are a few more now and they accept Medicaid for a minimal number of days for medical detox. It is not long enough, but it is an option at least.
- We have seen an increased use with youth. Hospitals can only hold teens admitted for an overdose for a short period of time and then they have to refer out to the community. But there are not enough recovery centers and rehabilitation providers to meet the needs of young people in the high school and college years. We are seeing an increase in comorbidities with mental health and substance use and more youth are reporting higher rates of depression and suicidality. There is an increased risk of life loss or serious self-harm or injury.
- We have problems with low barrier intake facilities for those who really want to get into treatment programs. To actually get that person into treatment, especially if they are Medicaid, is nearly impossible. Parents are calling frantically; family members are trying to come up with the money to get them into a cash facility.
- Boulder County has a high level of substance use and a culture that is accepting of substance use. Community norms around alcohol use, and marijuana use to some extent, is highly

promoted. It is everywhere you go, even at the movie theaters. It is a challenge to talk to young people about not using it when it is everywhere.

Unintentional Injuries: Issues, Challenges and Barriers

- We are a trauma hospital, so we see a variety of injuries. We've seen an increase in suicide attempts since the pandemic. It may be self-inflicted or from medication. There are a wide variety of reasons, bullying from other kids, being stuck at home and not allowed to go to school to get away from their parents, kids don't know what to do, so they take drugs to escape. They don't know what else to do in their hopelessness. There has been an increase in suicide attempts with adolescents.
- One of the leading causes of unintentional injuries is in the aging population. We need to be keenly aware and create safe places for them. The cost of housing is an issue. People may be stuck in their homes, and those homes may not be age friendly and it can lead to unintentional injuries. Also, we are seeing more injuries related to substance use. Car accidents, overdoses; those injuries of carelessness or poor judgement brought on by substance use.
- Overdoses and deaths for people who are not aware they are taking drugs with fentanyl that can kill them. Also, when people get released from incarceration without a warm handoff to a treatment center or mental health facility, they are vulnerable. If they went to jail because of drugs, they have a higher likelihood of overdosing and dying because they will take the same number of drugs they took before jail and their tolerance level decreased while incarcerated, and they die. It is the most vulnerable time for a person.
- What do you do when you have an injury? Not having knowledge on the next steps and not taking proper care of it, instead living with it, and not knowing of another clear path or option other than the ED are all challenges. And the ED is cost prohibitive, so they do nothing.
- With college students there is a huge amount of unintentional injury from alcohol and drugs use. Also, that group is also trying out a lot of things and that can lead to accidents, like rock climbing, skiing, new sports.

Appendix 4. Community Resources

Good Samaritan 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 Health Alliance, Boulder Community Health, Boulder County Public Health Department, Broomfield County Public Health, Clinica Colorado, Clinica Family Health Services, Colorado Access, Colorado Community Health Alliance, Connect for Health Colorado, Foothills United Way, Healthy Boulder County, Healthy Kids Colorado, Human Service Alliance, Inner City Health Center, Kids First Health Care, Kids in Need of Dentistry (KIND), Lens Crafters Gift of Sight Program, Lions Club, Marisol Health, National League of Cities Prescription Discount Card, Nurse-Family Partnership, Regional Accountable Entity Governing Council, Rocky Mountain Youth Clinics, Salud Family Health Centers, Servicious de La Raza, Tri-County Health Department, Veterans Administration Dental Clinic, Veterans Administration Medical Center Denver, VEYO Transportation, Via Mobility Services
Housing and Homelessness	Access Housing, Action Center, Adams County Housing Authority, Almost Home, Arising Hope, Boulder Housing Partners, Boulder Shelter for the Homeless, Brighton Housing Authority, Broomfield FISH, Colorado Coalition for the Homeless, Denver Indian Family Resource Center, Empowerment Program, Family Tree Programs, Growing Home Family Resource Center, Hope House, Mile High Behavioral Healthcare, Precious Child, 180 Street Outreach & Shelter, Servicios de La Raza, Stout Street Clinic, Veteran Services Center
Mental Health	Aurora Strong Resilience Center, BeyondHome, Boulder County Task Force on Mental Health, Broomfield Public Health Behavioral Health Transformation Task Force, Colfax Community Network, Colorado Crisis Services, Colorado State University Extension Services, Community Enterprise, Community Reach Center, Communities That Care Coalition, Co-Responder/Crisis Outreach Response and Engagement (CORE), Denver Indian Family Resource Center, El Centro, Families Forward Resource Center, Family Tree Programs, Florence Crittenton Services, Interfaith Network on Mental Illness, Latino Task Force Boulder County, Law Enforcement Assisted Diversion (LEAD), Let's Talk Colorado, Mental Health Partners, Mental Health Pod at Adams County Detention Facility, Mile High Behavioral Health Care, Out Boulder County, People House, Servicios de

	La Raza, SafeCare Colorado, Safehouse Progressive Alliance for Nonviolence (SPAN), Speak Now Colorado, Suicide Prevention Coalition of Colorado, Thrive Center
Overweight/ Obesity	Community Food Share, Fit Family Challenge, Great Outdoors Colorado, Healthy Eating Active Living Coalition, Meals on Wheels, My Outdoor Colorado, Nature Kids Lafayette, Nourish Colorado, Sister Carmen Community Center, SNAP, WIC
Substance Use and Misuse	Advocates for Recovery Colorado, Arapahoe House, BAART, Boulder County Substance Use Advisory Group, Collegiate Recovery Center University of Colorado Boulder, EmbarkPCA Recovery Services, Healthy Futures Coalition, Mile High Behavioral Health, SAMHSA National Helpline, The Phoenix: National Sober Active Community, Recovery Café Longmont, Responsibility Grows Here, Rise Above Colorado, Springs Recovery Connection, West Pines Behavioral Health
Unintentional Injuries	Adams County Assistance for Minor Home Repair, Aging Mastery Program, National Council on Aging, Asian Pacific Development Center, Boulder County Area Agency on Aging, City of Thornton Neighborhood Services, Colorado Center for the Blind, Colorado Gerontological Society, Denver Regional Council of Governments, Jewish Family Services, Lutheran Family Services, A Matter of Balance Program, North Metro Fire Rescue District, Project Safeguard, Rocky Mountain Poison and Drug Center, Senior Hub, Senior Resource Center, Silver Sneakers, VA Hotline

Appendix 5. Prioritization Meeting Participants

Community Health Needs Assessment Prioritization Meeting July 6, 2021

Attendee	Title	Organization
Dana Bellomy	Senior Services Supervisor	Lafayette and Broomfield Senior Center
Emily Joo	Community Engagement Specialist	Broomfield FISH
Gaye Woods	Director System Community Benefits	SCL Health
Grace Dobbertin	Trauma Outreach Education Coordinator	GSMC
Jan Bonner	Executive Director of the Good Samaritan Foundation	GSMC
Jordan Goto	Health and Wellness Coordinator	Boulder Valley School District
Kelly MacGregor	Communications Manager	GSMC
Kristina Hyde	School Medicaid Coordinator	Boulder Valley School District
Lisa Bitzer	Director of Operations	Via Mobility
Marcy Campbell	Special Initiatives Coordinator	Boulder County Public Health
Michael McHale	President and Chief Executive Officer	Tru Community Care
Nikki Crouse	Senior Services Manager	Broomfield Senior Center
Patrice Farrell-DeLine	Regional Vice President of Mission Integration	SCL Health
Peggy Jarrett	Regional Director of Community Health Improvement	GSMC
Samantha McCrory	Diversity, Equity and Inclusion Coordinator	SCL Health
Sara Reid	Grants and Program Evaluation Manager	Mental Health Partners
Sarah Mauch	Planning and Communications Administrator	Broomfield County Public Health
Stephen Knips	Finance Manager	GSMC
Susan Wortman	Vice President of Development	Clinica Family Health Center
Suzanne Crawford	Executive Director	Sister Carmen Community Center
Suzanne Sandoval	Medical Staff Director	GSMC

Teresa DeAnni	Healthy Aging Programs Manager	Boulder County Area Agency on Aging
Todd Grivetti	Director, Care Management/Utilization Management/Behavioral Health	GSMC
Cindy Cohagen	Director, Community Relations and Philanthropy	Mental Health Partners
Emily Joo	Community Engagement Specialist	Broomfield FISH
Gaye Woods	Director System Community Benefits	SCL Health
Grace Dobbertin	Trauma Outreach Education Coordinator	GSMC
Marcy Campbell	Special Initiatives Coordinator	Boulder County Public Health
Nikki Crouse	Senior Services Manager	Broomfield Senior Center
Patrice Farrell-DeLine	Regional Vice President of Mission Integration	SCL Health
Peggy Jarrett	Regional Director of Community Health Improvement	GSMC
Samantha McCrory	Diversity, Equity and Inclusion Coordinator	SCL Health
Stephen Knips	Finance Manager	GSMC
Susan Wortman	Vice President of Development	Clinica Family Health Center
Teresa DeAnni	Healthy Aging Programs Manager	Boulder County Area Agency on Aging

Appendix 6. Review of Progress

Good Samaritan 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. GSMC addressed Unintentional Injuries and Heart Disease and Dtroke 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.

Unintentional Injuries

Goal: by 2030, decrease hospitalizations from unintentional injuries within the GSMC primary service area by 3% (the measure is the annual age-adjusted unintentional death rate per 100,000 residents).

Unintentional Injury Rate, 2017-2020 Change

	Adams County	Boulder County	Broomfield County	Jefferson County
2017	389.1	343.2	274.1	380.0
2020	416.5	274.4	266.9	346.7
Change	↑7.0%	↓20.0%	↓2.6%	↓8.8%

Report of Progress, Unintentional Injuries

Objectives	Accomplishments
Increase knowledge of injury prevention.	• Since January 2019, seven “Stop the Bleed” trainings have been offered, reaching 755 community members. This training instructs participants about the three quick actions that can be used to stop life-threatening bleeding in a severely injured person. Participants in the training receive education and 1practice what they learn. • The injury prevention department provided several classes and events to address injuries due to falls including “Matter of Balance”, “Get Up, Get Up” and “Body in Balance”. Eight classes had a total of 121 participants. • The “Aging Mastery Program” (AMP) is a 10-class course created by the National Council on Aging to help older adults make the most of their lives as they age. Fall prevention is one of the classes in AMP and it outlines ways to prevent falls and how to reduce the risk of falling. In 2020 this program was offered virtually one time with five participants.

	• Due to COVID restrictions, the annual fall prevention week activities had to be modified. The injury prevention coordinator worked with a videographer to produce three fall prevention videos. The videos featured a physical therapist instructing the viewer on the following topics: Tips on How to Avoid Falls, How to Use Assistive Devices, and Tips for Going Upstairs. The videos were shared on the BCAAA website. Additionally, a link was sent out in a newsletter that went out to all of the BCAAA clients. There were 46 views of the videos during the Fall Prevention week.
Provide screenings to prevent injuries and distribute safety equipment.	• 108 Helmets have been distributed at three events since January 2019. Children received a professional fitting for the helmets in addition to receiving the free helmet. Due to COVID restrictions, community Festivals and Fairs were canceled for the summer of 2020 and opportunities for helmet giveaways were decreased. • Good Samaritan Medical Center operated a child car seat check for the community to prevent childhood injuries from auto accidents. The seats were checked to make sure that they were installed correctly and that they were not damaged or on a recall list. Any seat that was found to be defective, recalled or otherwise a danger to the child was replaced at no cost to the family. The program is usually done in-person but in 2020, due to COVID, the program was provided virtually for part of the year. 2,693 car seats were examined from Jan 2019 through July 2021 and 5 seats needed to be replaced.

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 Death Rate, 2017-2020 Change

	Adams County	Boulder County	Broomfield County	Jefferson County
2017	128.5	100.9	93.7	134.0
2020	149.7	106.8	91.5	127.2
Change	↑16.5%	↑5.8%	↓2.2%	↓5.1%

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

Stroke Death Rate, 2017-2020 Change

	Adams County	Boulder County	Broomfield County	Jefferson County
2017	40.6	35.0	21.6	35.0
2020	43.8	37.2	23.3	31.1
Change	↑7.9%	↑6.3%	↑7.9%	↓11.1%

Report of Progress, Heart Disease and Stroke

Objectives	Accomplishments
Increase knowledge around cardiovascular disease in the community.	• Offered an annual "Wear Red" event to the community. The event as planned included a Heart-Healthy Walk and included a table in the lobby where individuals could sign up for the 2020 AHA Heart Walk and receive education on heart disease. • Good Samaritan Medical Center provided a free cardiovascular screen for school-aged athletes in cooperation with the "Play with Heart" organization. 1 in 300 children are born with a hidden cardiac condition and this screening helps to identify and address problems so that children do not suffer a Sudden Cardiac Arrest event while participating in a sporting event. 81 youth had a 12-lead EKG screening performed on them in order to identify who might be at risk of Sudden Cardiac Arrest.
Provide support for caregivers and stroke survivors.	• Good Samaritan Medical Center hosts a bi-monthly stroke support group in coordination with Rocky Mountain Stroke Center. Attendance equaled 809 from January 2019 to July 2021. Many of the meetings in 2020 switched to a virtual format due to COVID and remain virtual to date.
Improve workforce capacity and competence to provide the best care possible for cardiac event and stroke patients	• In order to prevent death from cardiac events in the community, Good Samaritan purchased an AED to donate to the Bollman Technical College and provided training on the equipment in 2020. • The Good Samaritan Medical Center EMS Outreach coordinator provided training (CPR, PALS and ACLS) at no cost to local EMS professionals. 46 certifications were completed for CPR, PALS or ACLS in 2019. The classes were not offered in 2020 due to COVID and there have not been any classes to date in 2021. • Emergency Medical Service professionals must complete continuing education hours. Our EMS Outreach Coordinator provided continuing education training at no cost for 2,851 course completions from January 2019 through July 2021 at five local fire stations. • Our EMS Outreach Coordinator provided at no cost, recertification of EMS professional licenses for 240 individuals from January 2019 through July 2021.