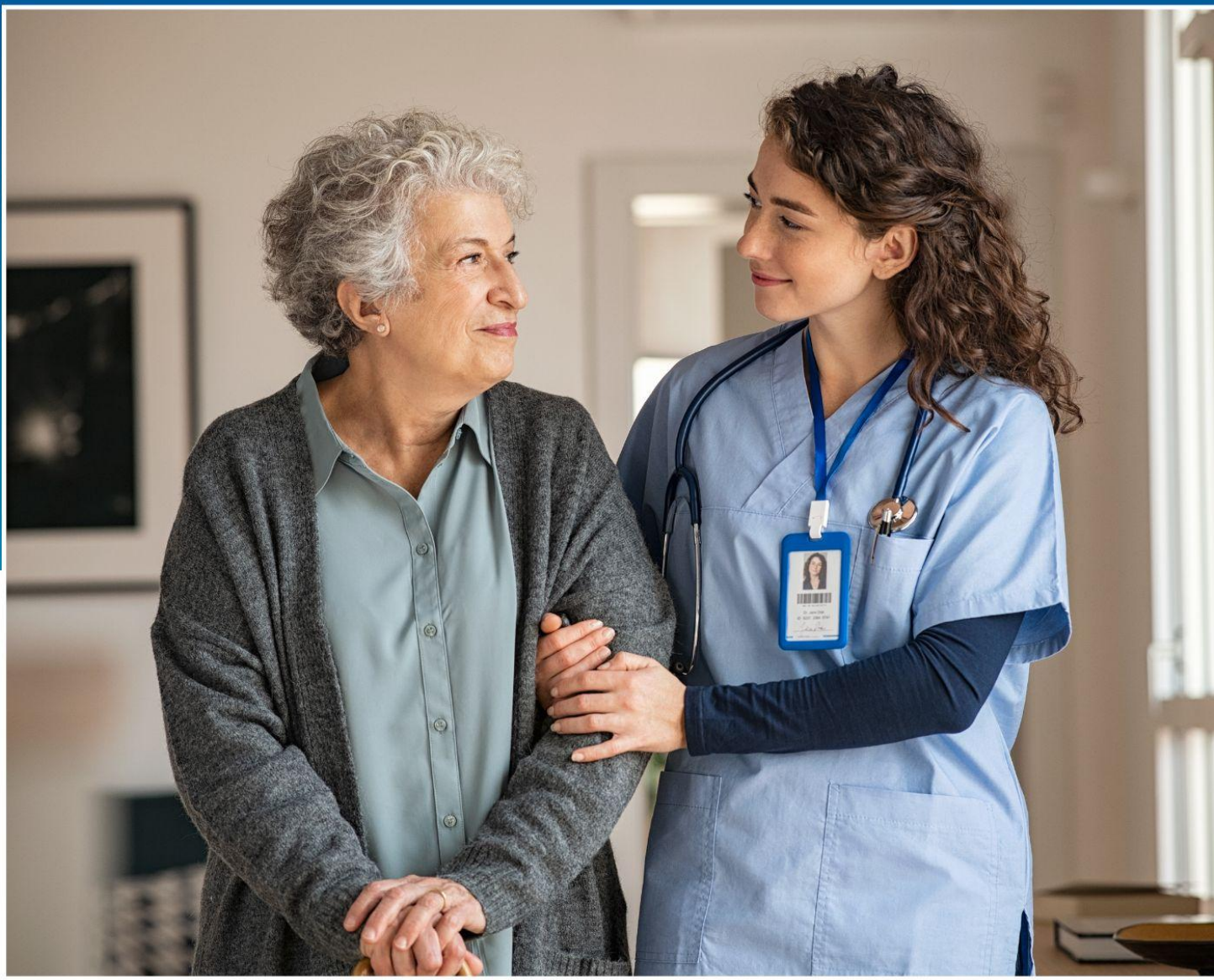
Community Health Improvement Plan | 2022



SCL Health
LUTHERAN

Our mission is you.

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Letter from the President

December 15, 2021

Dear Community Member,

Thank you for your interest in the health status of our community! Since 1905, Lutheran Medical Center has been committed to improving the health of the people and communities we serve.

Our triannual Community Health Needs Assessment represents Jefferson County. In 2021, Lutheran Medical Center, Saint Anthony Hospital, and the Jefferson County Public Health Department combined efforts, partnering to assess the health needs of the community. By working together, we make good use of our local resources and avoid overburdening our community members and partners. This is good stewardship of what is most precious.

In addressing the second step in the assessment process, we developed this Community Health Implementation Plan (CHIP) alongside community members and organizations. This CHIP will become our map for the next three years of community impact.

We look forward to working in partnership to elevate health in Jefferson County.

Sincerely,

Grant Wicklund

President & CEO, Lutheran Medical Center

Regional President, SCL Health Western Colorado

Introduction

The 2021 Lutheran 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. LMC's CHNA was approved by the Front Range Board of Directors on October 25th, 2021.

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 Jefferson County Public Health, Centura St. Anthony Hospital, 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 Jefferson County, Lutheran Medical Center (LMC) has completed its 2021 CHNA and identified three priority areas for health improvement programming from 2022 through 2024:

- Mental health and substance use
- Food insecurity
- Housing

The complete CHNA Reports are available here.

Community Health Improvement Plans (CHIP):

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

About Us

Background and Purpose

Lutheran Medical Center (LMC) is a community-based, acute care hospital in Wheat Ridge, Colorado. LMC began in 1905 as the Evangelical Lutheran Sanitarium, a tent colony for tuberculosis patients. By 1961, the sanitarium evolved into a community hospital. Today, LMC is a member of the SCL Health System, Inc., a faith-based, nonprofit healthcare organization. The hospital's mission 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."

LMC includes Lutheran Hospital Center and Lutheran Spine Center at Denver West. It offers a five-star birthing center, Heart and Neurovascular Center, robotic surgery, Primary Stroke Center, Comprehensive Cancer Center, orthopedics, a Level III Trauma Center, and emergency services, including the first Senior Emergency Department in Colorado.

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

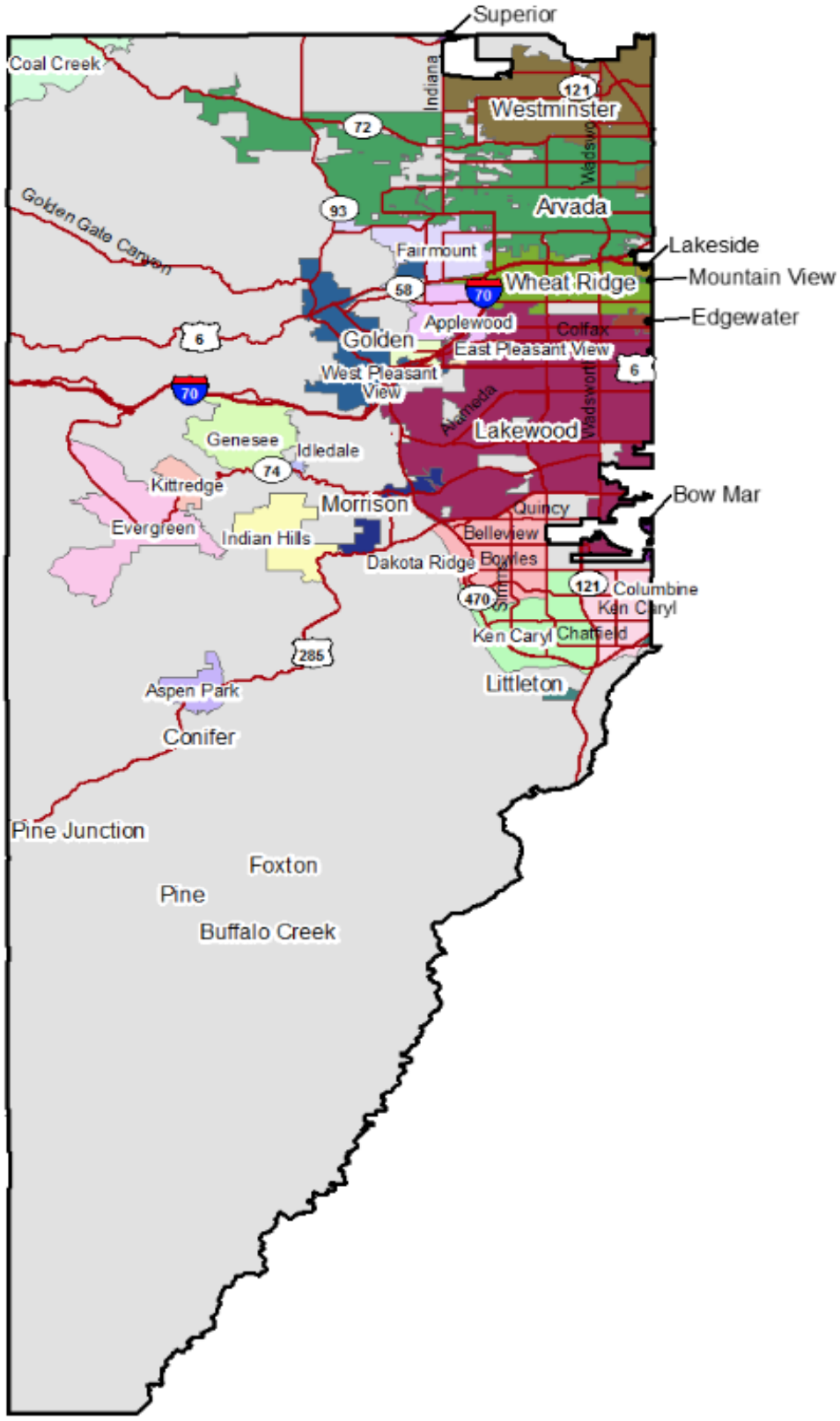
Service Area

Lutheran Medical Center is located at 8300 West 38th Avenue, Wheat Ridge, Colorado 80033. The service area includes 14 communities and 26 ZIP Codes. While LMC serves the Denver Metro area, for purposes of this CHNA, LMC's primary service area is Jefferson County.

Lutheran Medical Center Service Area

City	ZIP Code
Arvada	80002, 80003, 80004, 80005, 80007
Broomfield	80021
Buffalo Creek	80425
Conifer	80433
Denver	80215, 80221, 80227, 80228, 80232, 80235
Evergreen	80439
Golden	80401, 80403
Idledale	80453
Indian Hills	80454
Kittredge	80457
Littleton	80123, 80127, 80128
Morrison	80465
Pine	80470
Wheat Ridge	80033

See map of the service area with these zip codes on the following page.


Superior
Coal Creek
Indiana
121
Westminster
72
Wadsworth
Golden Gate Canyon
93
Arvada
Fairmount
Lakeside
Mountain View
58
70
Wheat Ridge
Edgewater
Applewood
Colfax
6
Golden
East Pleasant View
West Pleasant View
6
70
Alameda
Wadsworth
Lakewood
Genesee
Idledale
74
Kittredge
Morrison
Bow Mar
Quincy
Evergreen
Indian Hills
Belleview
Dakota Ridge
Bowles
Simms
121
Columbine
Ken Caryl
470
Ken Caryl
Chatfield
285
Littleton
Aspen Park
Conifer
Pine Junction
Foxton
Pine
Buffalo Creek

Project Oversight

The CHIP process was overseen by:

Chuck Ault
Regional Director, Community Health Improvement
SCL Health, Saint Joseph Hospital and Lutheran Medical Center

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

Data Collection Methodology

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

Secondary Data Collection

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

Secondary data for the service area were collected and documented in data tables with narrative explanation. The tables present the data indicator, the geographic area represented, the data measurement (e.g., rate, number, or percent), county and state comparisons (when available), the data source and data year. The report includes benchmark comparison data that measures LMC 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

LMC undertook a community survey to gather information and opinions from community residents. The 2021 Public Health Partnership Community Health and Wellbeing survey gathered the opinions of residents in Jefferson, Clear Creek and Gilpin Counties. Developing the questionnaire was a collaborative effort between Polco staff and stakeholders from Jefferson County Public Health (JCPH), with input from Mountain Youth Network, Clear Creek County Public and Environmental Health, Gilpin County Public Health, and other health stakeholders within Jefferson County.

This survey was implemented in May through July 2021. A total of 8,400 households were randomly selected to receive mailed invitations to complete an online survey and/or to complete and mail back a paper survey. Households were selected randomly from a USPS list of households in the three counties and stratified by major cities within the counties. USPS lists are best for ensuring all households in a given area are included in the sampling frame and therefore have an equal chance of being selected to participate. The surveys and mailed invitations were also translated into Spanish. The JCPH and partners were provided a separate URL to share an invitation to an "open participation" survey, where all residents who received notice through social media or other communication channels could complete the survey. A total of 486 individuals completed the random sample survey (1 in Spanish) for a response rate of 7% and an overall margin of error of ±5%. Additionally, 503 completed the open participation survey (3 in Spanish). The results from these two efforts were statistically compared and the two data sets were combined for analysis. The results of each effort were weighted to reflect the demographic profile of each of the sub-geographies within each county that were included in the study, and then weighted to reflect their proportion of the population in the county and the region overall. This allows for the most robust comparison at each level of interest The results of the community survey are reported in 2021 CHNA.

Resources to Address Significant Health Needs

One of the methods used to select prioritized needs was a review of the other community based organizations that are working in the need area. Identifying these additional resources informs potential collaborative strategies and efficiencies. It also recognizes the importance of leveraging existing expertise and trusted community leaders. A list of community resources potentially available to address the significant health needs are presented in Appendix 1.

Public Comment

In compliance with IRS regulations for charitable hospitals, a hospital CHNA and Community Health Improvement Plan (CHIP) Implementation Strategy are to be made widely available to the public and public comment is to be solicited. The previous CHNA and CHIP Implementation Strategy were made widely available to the public on the website https://www.sclhealth.org/locations/lutheran-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 September 14, 2021, to discuss significant changes in health indicators or challenges over the past three years since the last assessment process and to prioritize the significant needs. The meeting was convened virtually and 45 community stakeholders were in attendance. A list of the meeting participants and their organizational affiliations can be found in Appendix 2. The group received a presentation of current secondary health data offered by an epidemiologist from Jefferson County Public Health. Primary data were presented through sharing findings from the 2021 Jefferson County Community Health and Wellbeing Survey.

After completing review and discussion of these data sources, the group was asked to respond to three questions intended to understand if the current priorities are still relevant, what other issues should be considered, and the issues most likely to benefit from collective action on the part of the county's two hospitals and public health department. Priority needs emerged from the discussion.

Prioritized Needs

LMC and its community partner and CHNA participants identified the following priority community health needs to be address in the hospital's Community Health Improvement Plan (CHIP) and its Implementation Strategies:

1. Mental Health and substance use
2. Food insecurity
3. Housing

Acknowledging Our Community Partners

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

Needs Not Prioritized

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

Community Health Improvement Plan

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

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

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

Priority: Mental Health

Mental health needs continue to present as an urgent and prevalent issue in many communities. LMC and most of its sister hospitals 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, LMC uses some common definitions when talking about Mental Health.

- Behavioral Health is an umbrella term that is defined by the Substance Abuse & Mental Health Administration (a branch of the U.S. Department of Health and Human Services) as "…the promotion of mental health, resilience and wellbeing; the treatment of mental and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities." SAMHSA

- "Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community." (WHO, 2018)

- "Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home." SAMHSA

CHIP Priority: Mental Health

Vision: Improve the mental health of the residents of Jefferson County with an emphasis on vulnerable populations such as youth and the unhoused.

Outcome Goal(s):

- Reduce the percent of individuals that report needing but not receiving mental health treatment over the next three years
- Reduce the percent of individuals reporting having poor mental health

Need Indicator(s):

- 12.6% of adults in Jefferson County reported having poor mental health (CHNA 2021)
- 15.8% of Jefferson County residents reported a time there was a need for mental health counseling or treatment but ultimately did not get it in the past 12 months (CHNA 2021)

Objective:

Provide mental health programming that is easily accessible by individuals living on the margins and those with reduced access

Community Partners:

- Jefferson County Public Library
- Rocky Mountain Crisis Partners
- Jefferson Center for Mental Health
- Wheat Ridge High School

Tactic(s)	Community Partner(s)	Metric	Status
Work with Arvada Public Library to offer weekly "Coffee and Conversation" sessions with a mental health provider	Jefferson County Public Library	• 15 sessions will be offered by year end. • 7-10 community members will attend each weekly session	Sessions begin in September 2022
Question, Persuade, Refer (QPR, evidence-based suicide prevention) training for community leaders	Jefferson County Public Library	• 30 Community leaders attend QPR training • Community leaders host a at least one of their own community trainings in the first quarter 2023	Training scheduled in Q3
Begin suicide follow-up program into LMC emergency department (ED)	Rocky Mountain Crisis Partners (RMCP)	• Roll out training program for ED clinicians • Begin referrals to RMCP	• Training complete by Q2 2022 • Program in place Q3 2022
Explore support of mental health clinician at Wheat Ridge High School	• Wheat Ridge High School • Jefferson Center for Mental Health	Establish agreement with community partners to fund and support new position. Jefferson Center for Mental Health will hire and manage this position.	Position created by Q3 2022

Priority: Food Insecurity

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, LMC has prioritized SDoH areas in food access, access to care, and housing.

CHIP Priority: Food Insecurity	
Vision: **Improve healthy food access for residents of Jefferson County.**	
Outcome Goal(s): • Reduce the percentage of food insecure individuals in Jefferson count • Encourage enrollment in food assistance programs for those who qualify	**Need Indicator(s):** • The food insecurity rate in Jefferson County is 9.1% (CHNA 2021) • 54% of Jefferson County residents who are eligible for food assistance are not enrolled. (CHNA 2021)
Objective: • Make food immediately available to food insecure individuals discharging from LMC • Enroll qualifying individuals in a nutrition assistance program	**Community Partners:** • Food Bank of the Rockies • Community Table • Jeffco Action Center • Benefits in Action • STRIDE

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

Tactic(s)	Community Partner(s)	Metric	Status
Expand Healthy U program to offer a two week supply of food to food insecure community members discharging from LMC	• Food Bank of the Rockies • Jeffco Action Center • Community Table • STRIDE	• All individuals discharging from LMC are screened for food insecurity. • All patients in need are referred to food assistance organizations, including Food bank of the Rockies and Jeffco Action Center, and Community Table for a two week supply of food upon discharge. The STRIDE Navigator identifies food insecure patients who need food access as part of their care plan and follow-up.	Program in place by Q2 2022
Refer food insecure community members to Benefits in Action to receive help identifying and applying for appropriate assistance programs	• Care Management • Benefits in Action	Number of referrals	Begins Q2 2022

Priority: Housing

Housing challenges in Jefferson County range from affordability and quality issues to the complexities surrounding temporary and chronic homelessness. As LMC embarked on this emerging priority in 2018, the breadth of issues involving housing were so numerous that determining a focal point was necessary. Considering the LMC mission to serve the poor and vulnerable in our communities, the focus of LMCs' housing work has been prevention and responding to the conditions of 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 the Metro Denver area, only a sheltered homeless count was conducted in 2021. The total number of sheltered homeless at the PIT Count in 2021 was 376 in Jefferson County. Among sheltered homeless persons, 16.4% were chronically homeless and 57.1% had a disabling condition. LMCs' response continues to evolve to reflect available service delivery and infrastructure to address housing in the 2022 CHIP.

Please see following page for improvement plan details.

CHIP Priority: Housing

Vision: **Support Jefferson County residents in need of housing with access and options that align with their circumstances.**

Outcome Goal(s):

- Reduce overall homlessness in Jefferson county
- Reduce the number of individuals in unstable housing, particularly those who are medically fragile

Need Indicator(s):

- 997 individuals experienced homlessness or unstable housing in Jefferson County in 2019 (CHNA 2021)
- Of those experiencing homelessness, 33% were in an unstable housing situation (CHNA 2021)

Objective:

- Strengthen supportive services that get individuals into housing
- Support medical respite for individuals experiencing homelessness who are recovering from an illness

Community Partners:

- Jefferson County Homeless Navigators
- Recovery Works

Tactic(s)	Community Partner(s)	Metric	Status
Support a flexible fund that allows Homeless Navigators the ability to provide needed services while getting an individual housed	Jefferson County Homlessness Navigators	Supportive services provided	Q2 2022
Partner with Recovery Works to offer a medical respite option to homeless patients discharging from the hospital	Recovery Works	2-4 patients per month are referred to medical respite	Q1 2022

Areas of Continued Work Improvement

Some CHNA priorities from previous cycles and responses to new needs that emerged in our communities outside of the assessment period continue to be supported even though the work is not specifically prioritized in the CHIP. Examples of this include LMCs response to community fall prevention. In 2020, the most common reason for an individual to visit the LMC Emergency Room was due to a fall. Vulnerable elders represent the vast majority of people involved and most of these live in the community surrounding Lutheran Medical Center. This phenomenon is due to a confluence of a variety of social factors related to aging including limited access to education about preventing falls, lack of resources to make home modifications that would create a safer environment, and diminished social connections and community connectivity.

The need for high quality and innovative falls prevention programming was met by LMC, bringing a research-based program from the Netherlands to Jefferson County. The Friends Don't Let Friend Fall program engages groups of elders in a four-week series that includes agility training, obstacle course practice, and learning proper fall techniques on a crash mat. The result is a measurable increase in confidence and an important decrease in fear of falling for the individuals who participate.

Appendices

Appendix 1. Community Resources

Lutheran Medical Center identified 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
Health Equity	Clinica Tepeyac, Colorado Access Medicaid, Conectando Jefferson County, Denver Health, HCP, Inner City Health Center, Jefferson County Health Alliance, Jefferson County Public Health, Stout Street Clinic, STRIDE Community Health, The Action Center
Transportation	Jefferson Center for Mental Health, PrimeCare Colorado, RTD Access-a-Ride, Senior Resource Center, Viva Health
Workforce Development	Arvada Chamber, Business and Workforce Center Jefferson County, City of Wheat Ridge, Department of Labor, Early College of Denver, Front Range Community College, Jefferson County Workforce Development, Red Rocks Community College, Jefferson County Public Schools
Special Populations	Americorp, Asian Pacific Development Center, CENTURA Links, Clinica Tepeyac, Colorado Access, Colorado Coalition for the Homeless, Colorado Vincention Volunteers, Connect for Health Colorado, Jefferson County Public Health, Jefferson County Public Library, Jefferson County Public Schools, Mariposa, Metro Caring, Next 50, Servicios de la Raza, Silver Sneakers

Appendix 2. CHNA Prioritization Meeting Participants

Community Health Needs Assessment Prioritization Meeting September 14, 2021

Attendee	Title	Organization
Annie Dorchak	Paramedic	Evergreen Fire Department
Ashleigh Phillips	Outreach and Community Relations	Centura Health
Chuck Ault	Regional Director, Community Health	Lutheran Medical Center
Darcy Copeland	Nurse Scientist	Saint Anthony Hospital
Deanna Harrington	Battalion Chief	Arvada Fire Department
Dr. Michelle Haney	President	Red Rocks Community College
Ed Brady	Deputy Chief of Police	Arvada Police Department
Faint Kinsinger	Quality Management	Lutheran Medical Center
Glenn Most	Executive Director	West Pines Behavioral Health
Jasmin Patriquin	Injury Prevention Specialist	Lutheran Med Center
Jason Firestone	Manager, Student Engagement	Jefferson County Public Schools
Jody Ermin	Deputy Director	Jefferson County Public Health
Joel Newton	Executive Director	Edgewater Collective
Kate Watkins	Epidemiologist	Jefferson County Public Health
Katie Haas	Health Planner	Jefferson County Public Health
Keli Barker	Jefferson County Homelessness Coordinator	Jeffco Human Services
Kelly Kast	Epidemiologist/Program Coordinator	Jefferson County Public Health
Kelly Keenan	Accreditation manager	Jefferson County Public Health
Kiara Kuenzler	President and CEO	Jefferson Center for Mental Health
Laura Larson	VP Development	STRIDE Community Health
Laura Robertson	Health Educator	Mountain Youth Network
Laurie Walowitz	Director of Programs	The Action Center
Lindsay Reinert	Outreach Specialist	Lutheran Medical Center

Melissa Ryder	Community Resilience Coordinator	City of Arvada
Mollie Fitzpatrick	Managing Director	Root Policy Research
Monica Buhlig	Group Director, Community Health	Centura Health
Noah Atencio	VP Community Impact	Community First Foundation
Paola Vilaxa	Diversity and Inclusion Coordinator	Jefferson County Public Library
Patrice Ferrell-Deline	VP Mission Integration	Lutheran Medical Center
Peg Hooper	Manager Public Services	Jefferson County Public Library
Robert Hayes	Trauma Injury Prevention Specialist	Centura Health
Shannon Burk	Director, Mission and Spiritual Care	Saint Anthony Hospital
Tracy Volkman	Environmental Health Specialist	Jefferson County
Annie Dorchak	Community Health	Denver Dept. of Health and Environment