Community Health Improvement Plan

Platte Valley Medical Center

2019

Platte Valley SCL HEALTH

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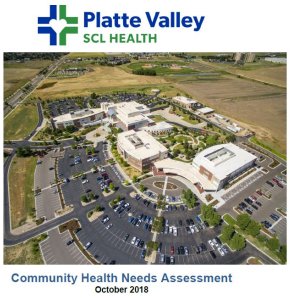


The Community Health Needs Assessment (CHNA) is a systematic approach to determining the health status, behaviors and needs of people living in our area. The full report is available on our website at https://www.sclhealth.org/-/media/files/care-sites/platte-valley/about/chnapvmc2018.pdf?la=en

Following the needs assessment, we selected health priorities to impact community health through direct and/or collaborative efforts. The Community Health Improvement Plan (CHIP) is the strategic document that outlines the hospital's plans, actions, and anticipated impact on the identified health needs.

Summary:

- The CHNA was conducted in collaboration with Biel Consulting, Inc. Oversight was provided by Peggy Jarrett, MPH, BSN, RN, Regional Director of Community Health Improvement.
- The geographic focus area for the CHNA included six communities in Adams and Weld Counties.
- Thirteen Areas of Opportunity were identified in the CHNA based on secondary data collection. Community and hospital leaders met on June 18, 2018 to narrow the list to six issues: access to health care, cancer, cardiovascular disease, diabetes, mental health/substance use, and unintentional injuries.
- Community key informant phone interviews were conducted in July and September 2018 to prioritize and give feedback on community perceptions.
- The Senior Leadership Team (SLT) at Platte Valley Medical Center (PVMC) approved the CHNA on October 10, 2018 and submitted the CHNA for Board approval. PVMC's CHNA was formally adopted by the Platte Valley Board of Directors on October 24, 2018. The CHNA was published and available on the PVMC website on December 18, 2018.
- For our Community Health Improvement Plan (CHIP), the PVMC Senior Leadership Team selected the top two health priorities of **Mental Health/Substance Use** and **Cardiovascular Disease (Heart Disease and Stroke)** based on these factors: Community Priorities, Strategic Direction/Assets and Expertise, and Current Efforts.

Letter from our CEO

At Platte Valley Medical Center we take pride in providing the healthcare services you need to live your healthiest life. We've been committed to serving you for nearly 60 years.

We collaborate with community leaders, public health officials, and other community members to conduct a Community Health Needs Assessment (CHNA) every three years. This assessment reveals the health issues that specifically impact our local population; helping us to create the services our community wants and needs today and in the future. After the assessment is completed, we use this information to implement our Community Health Improvement Plan.

As we all know, healthcare is a rapidly changing industry – affected by everything from new technology to federal and state policy. We do our best to stay ahead of these changes so that your access to care is never interrupted.

Good health requires regular check-ups with a primary care physician, that's why we continue to expand access to primary care providers across our service area. In addition, we know healthcare is expensive and we are always bringing new opportunities to provide you with affordable options for immediate, non-emergent care. This includes video visits with our providers via MyChart, Doctor on Demand – a video access tool accessible on your smartphone or mobile device – and through our Walk-In Care clinic in Fort Lupton.

Access to mental health and substance abuse support is also a rapidly growing need across the State of Colorado and our country. We are exploring new ways to help you get the resources you need to improve your mental health and, for those who need help, recover from substance abuse.

Finally, in order to improve access to high-level emergency care, Platte Valley is a Level III Trauma Center, Primary Stroke Center, and Chest Pain Center. We continue to highlight the importance of early heart attack care and stroke warning symptoms, host monthly support groups for both stroke survivors and their caregivers, and ensure our Emergency Medical Service professionals retain the latest credentials and training in stroke and heart attack medicine.

We are pleased to present this Community Health Improvement Plan to you.

With gratitude and blessings,

John Hicks
President/CEO

About Us

Platte Valley Medical Center in Brighton, Colorado became the first private general medical-surgical hospital in Adams and Southern Weld Counties in 1960. Today, Platte Valley is a 98-bed community hospital with outpatient medical plazas in Brighton, Fort Lupton, and the Reunion area of Commerce City. Platte Valley is a secular hospital within the SCL Health System and is a recognized leader in patient-centered care. High-level services include a Primary Stroke Center, a Level III Trauma Center, an Accredited Chest Pain Center, a Level II Special Care Nursery, and an Advanced Wound Center with Hyperbarics.

Our Mission

The mission of Platte Valley Medical Center is *"to foster optimal health for all."*

Our Vision

- We will be distinguished as the trusted person-centered partner to those who engage with us in their physical, mental and spiritual health decisions.
- We will share accountability with our clinicians, associates and affiliated stakeholders to deliver exceptional care that is well-coordinated, accessible, affordable, safe, and results in optimal outcomes for individuals and populations.
- We will grow as community-based health networks in partnership with others who share our vision and values and align with us to be an essential provider to those we serve.

Our Values

Caring Spirit – We honor the sacred dignity of each person.

Excellence – We set and surpass high standards.

Good Humor – We create joyful and welcoming environments.

Integrity – We do the right thing with openness and pride.

Safety – We deliver care that seeks to eliminate all harm for patients and associates.

Stewardship – We are accountable for the resources entrusted to us.

Community Health Needs Assessment

Community Health Needs Assessment (CHNA) Methodology and Process

Platte Valley Medical Center is located at 1600 Prairie Center Parkway, Brighton, CO 80601. The primary service area includes six communities in two counties. A majority of patient admissions at Platte Valley Medical Center originate from these cities.

Biel Consulting, Inc. completed the Community Health Needs Assessment. Biel Consulting, Inc. has over 20 years of experience conducting hospital Community Health Needs Assessments.

The 2018 CHNA incorporated: 1) secondary quantitative data (existing public health, census and behavioral survey data) and 2) primary qualitative data (16 key informant phone surveys).

1) Secondary Quantitative Data: Secondary data was collected from a variety of local, county, and state sources to present a community profile, social determinants of health, health access, birth indicators, leading causes of death, health behaviors, preventive practices, chronic and communicable diseases, mental health, and substance abuse. For the purposes of the Community Health Needs Assessment, when examining data by Health Statistics Region (HSR), ZIP Code level data were totaled. When available, data sets were presented in the context of the service area counties and Colorado to help frame the scope of an issue as it related to the broader community.

2) Primary Qualitative Data: PVMC conducted targeted interviews to gather information and opinions from persons who represented the broad interests of the community served by the Medical Center. 16 interviews were completed in July 2018. For the interviews, community stakeholders identified by PVMC were contacted and asked to participate in the needs assessment. Interviewees included community leaders and/or representatives of medically underserved, low-income, and minority populations, local health, and other departments or agencies that have "current data or other information relevant to the health needs of the community served by the medical center." Input was obtained from area public health departments.

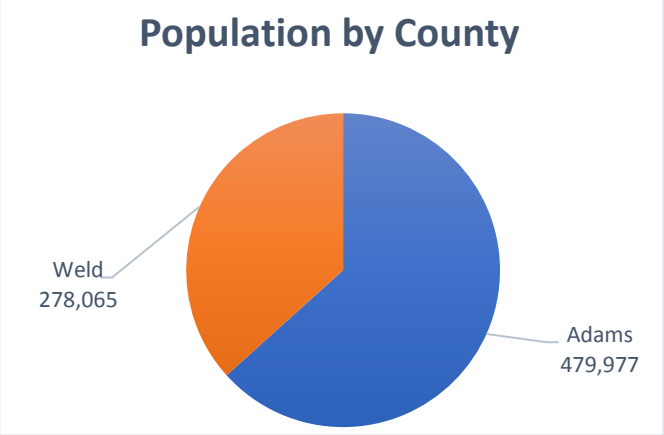
Key Survey Results

Significant health needs were identified from secondary data using the size of the problem (relative portion of population afflicted 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 2020 objectives. Indicators related to the health needs that performed poorly against one or more of these benchmarks met this criterion to be considered a health need.

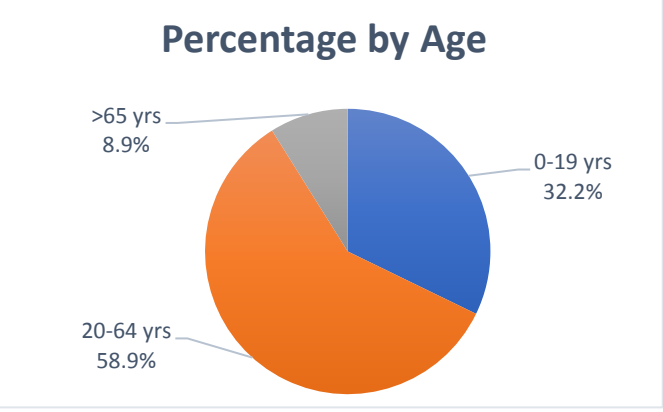
Thirteen Areas of Opportunity were identified in the 2018 CHNA:

- *Access to Healthcare Services*
- *Arthritis*
- *Cancer*
- *Dental Care*
- *Diabetes*
- *Heart Disease & Stroke*
- *Housing*
- *Lung Disease*
- *Mental Health*
- *Overweight and Obesity*
- *Stroke*
- *Substance Abuse*
- *Unintentional Injuries*

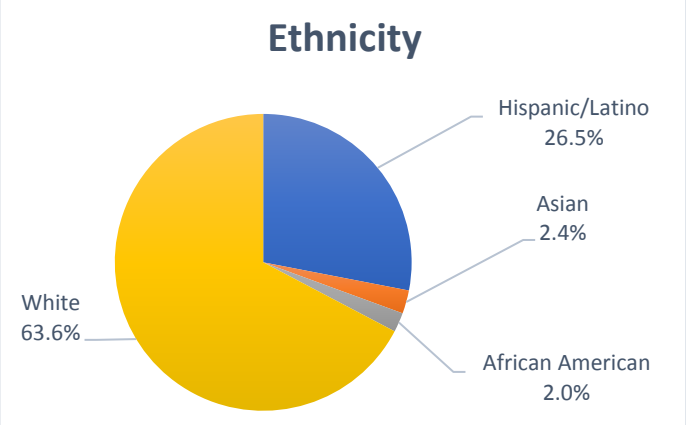
- The population of the PVMC service area was 116,630, Adams County had a population of 479,977 and Weld County's population was 279,065.



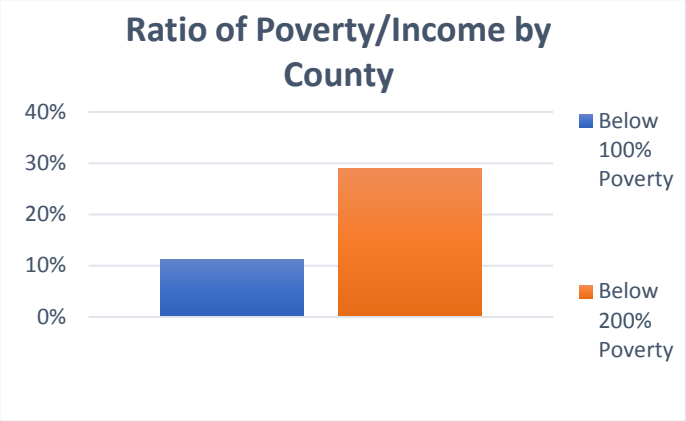
- Children and youth, ages 0-19, comprised 32.2% of the population in the service area. 58.9% of the population were 20 to 64 years old and 8.9% of the population were 65 years and older.



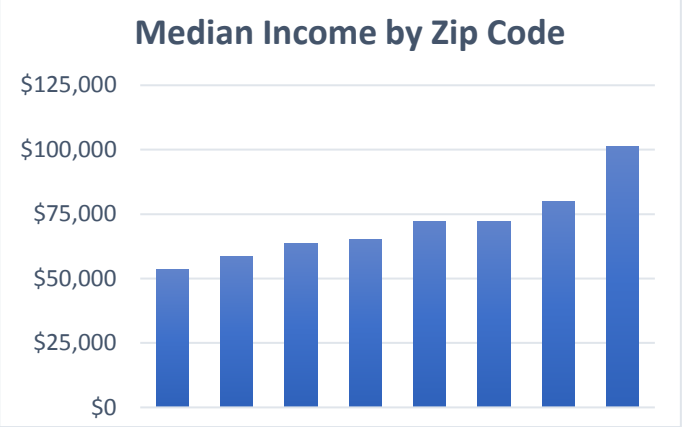
- In the service area, 63.6% of the residents were White, 26.5% were Hispanic/Latino, 2.4% were Asian, and 2% were Black/African American.



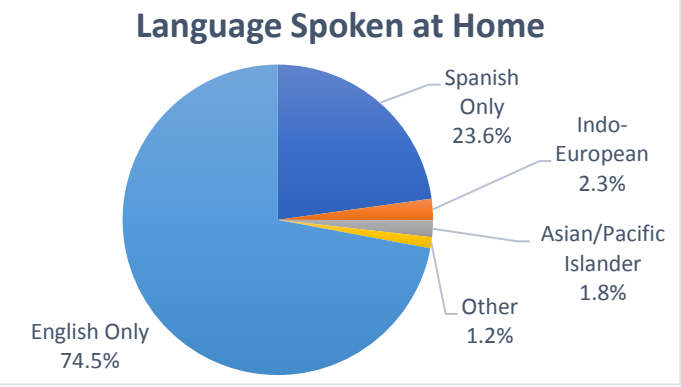
- In the service area, over 11.3% of residents were living at or below 100% of the Federal Poverty Level (FPL), and 28.9% were considered low-income (living at or below 200% FPL).



- The median household income for the service area ranged from $53,633 in Ft. Lupton to $101,105 in Brighton (80602).



- Almost three-quarters of the population (74.5%) in the PVMC service area speak English only in home; 23.6% of the population speaks Spanish in the home, 2.3% speaks an Indo-European language, and 1.8% speaks an Asian/Pacific Islander language in the home.



Community Stakeholder Involvement

Community stakeholders were convened on June 18, 2018. Twenty-one hospital and community stakeholders attended this meeting with the purpose of narrowing down the original thirteen Areas of Opportunity. The CHNA data for the original thirteen Areas of Opportunity was presented to the group. The data included trend lines as well as point in time data for each of the areas. Stakeholders were asked to rank the thirteen issues during a formalized individual ranking exercise.

Each of the thirteen Areas of Opportunity were scored based on two criteria: scope and severity, and ability to impact. Participants were asked to rank each item from 1-10, with 1 being a low score and 10 being the highest score. A statistical mean of the scores was calculated following the ranking activity. The prioritization yielded seven top priorities.

16 Key Stakeholder phone interviews were conducted. Interviewees were asked to rank the seven top priorities and to provide verbal comments about the issues that had been identified. Below you will find the rankings for the in-person meeting and the phone interviews.

Rankings for in-person meeting vs phone survey

Rank	Hospital and Community In-person Prioritization	Key Informant Phone Interview Prioritization
1	Mental Health/ Substance Abuse	Mental Health/ Substance Abuse
2	Cardiovascular Disease	Cardiovascular Disease
3	Access to Health Care	Access to Health Care
4	Cancer	Diabetes
5	Diabetes	Cancer
6	Unintentional Injuries	Unintentional Injuries

Adoption and Publication of the CHNA

The CHNA was adopted by the Board of Directors on October 24, 2018, and published on the hospital website on December 18, 2018. In the CHNA report, the entire process and methodology is outlined. As well, detailed information on the community and the prioritized list of health needs is outlined in the CHNA: https://www.sclhealth.org/-/media/files/care-sites/platte-valley/about/chnapvmc2018.pdf?la=en.

Public comments on the CHNA are welcome. Comments may be submitted online at: https://www.sclhealth.org/locations/platte-valley-medical-center/about/community-benefit/.

Community Health Improvement Plan Priorities

Platte Valley's Senior Leadership Team met in September, 2018 to review the results of the CHNA prior to submission to the Platte Valley Medical Center Board of Directors. The decision of the Senior Leadership Team was to recommend two priority focus areas: 1**) Mental Health/Substance Use** and **2) Cardiovascular Disease (Heart Disease and Stroke)**. The CHNA was approved by the Platte Valley Medical Center Board of Directors on October 24th, 2018.

The CHIP work began in December of 2018 and the resulting document was presented to the PVMC Senior Leadership Team on April 10, 2019. Feedback from the Team has been incorporated into the final Community Health Improvement Plan.

Platte Valley's Community Health Improvement Plan will be formally submitted to the Platte Valley Board of Directors on April 24, 2019.

Community Health Improvement Plan

There are five Community Health Improvement core strategies that support program development:

- 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 and inclusion initiatives.

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

Goals and Actions

Priority: Mental Health/Substance Use

Vision: By 2030, decrease the suicide rate by 4% in Adams and Weld counties and decrease drug induced deaths by 4% in Adams and Weld.
Goal 1: Improve access to mental health and substance abuse treatment options.
Goal 2: Improve opioid prescription safety.
Goal 3: Increase knowledge of signs and symptoms, treatment and resources for mental health and substance use.

Current State	Action / Tactics	Partners	Progress Update
Demonstrate the prevalence and/or significance of this need	*What steps will we take to impact this need*	*Community stakeholders who are essential to all improvement efforts*	*Key measures of success and milestones*
Mental health hospitalization rates per 100,000 (2013-2015) • Adams County: 3189.4 • Weld County: 3254.1 • Colorado: 2833.8 Age Adjusted death rate for Suicides per 100,000 (2016) • Adams: 17.6 • Weld County: 19.5 • Colorado: 19.1 Healthy People 2020 Goal: 10.2 Ratio of Population to Mental Health Providers (2015) • Adams County: 422:1 • Weld County: 616:1 • Colorado: 392:1 Adults reporting binge drinking (2013-2014) • Adams County: 9.7% • Weld County: 17.7% • Colorado: 18.1% Age-adjusted rate of drug induced deaths per 100,000 • Adams County: 18.6 • Weld County: 13.6 • Colorado: 16.6 Healthy People 2020 Goal: 11.3 Chief **Mental Health/Substance Use** concerns: • Stigma	**Goal 1: Improve timely access to mental health and substance abuse treatment options.** 1. Provide telemedicine psychiatric consults (Denver Health) to assess, treat and appropriately refer acute behavioral health patients presenting in the Emergency Department and on Inpatient Units. 2. Research the formation of a partnership with Pennock Center for Counseling to provide **S**creening **B**rief **I**ntervention and **R**eferral to **T**reatment (SBIRT) Program starting in the Emergency Department. Patients who are identified, through an admission question, as drinking any amount of alcohol will receive a visit from a licensed counselor during their Emergency Department visit to assess for substance use, depression, anxiety, and comorbid sub-pathological behavior health issues. 3. Participate in CHoSEN QIC (**C**olorado **Ho**spitals **S**ubstance **E**xposed **N**ewborns- **Q**uality **I**mprovement **C**ollaborative). Implement the *Eat, Sleep, Console* routine for substance-exposed newborns and their primary care givers to improve outcomes for the infant post-withdrawal. 4. Develop a process to partner with community OB/GYN	BAART Programs Brighton CHoSEN Collaborative Colorado ALTO Project Colorado Hospital Association Community Reach Center Denver Health Pennock Center for Counseling Tri-County Health Department	**Goal 1 outcomes:** 1. 70% of patients presenting in the ED with behavioral health problems are appropriately identified and referred. 2. Initiate SBIRT Program by 3rd Quarter 2020. 3. Maintain length of stay of **SEN** patients (**S**ubstance **E**xposed **N**ewborns-exposure to Methamphetamines or Opioids) to an annual average of <6 days per infant.

Current State	Action / Tactics	Partners	Progress Update
Demonstrate the prevalence and/or significance of this need	*What steps will we take to impact this need*	*Community stakeholders who are essential to all improvement efforts*	*Key measures of success and milestones*
• Refusal of care • Cost • Access- limited number of treatment facilities and providers.	practices and to provide a formal testing of at-risk Moms prior to delivery. 5. Communicate available mental health crisis resources via the PVMC/SCL website. Colorado Crisis Services number-1/844-493-8255. **Goal 2: Improve Opioid prescription safety.** 1. Participate in the Colorado ALTO (**AL**ternatives **T**o **O**pioids) Project to lower new opioid prescriptions and increase e-Prescribing house-wide. 2. Develop outreach efforts to Brighton community physicians to share the success of the ALTO Project, lessons learned and ways that they can incorporate. **Goal 3: Increase knowledge of mental health and substance abuse signs and symptoms, treatment and resources.** 1. Provide 4 free evidence-based trainings to the community and PVMC associates (Mental Health First Aid). This program supports individual skill development in the recognition of depression, stress, anxiety and potential thought disorders and identifies lower level interventions for those individuals presenting with the above listed conditions. 2. Provide educational opportunities to the community to learn about mental health and substance use issues at community events: a. 9Health Fair b. Aging Mastery Program c. Girls Night Out 3. Provide a two-day training (ASIST-**A**pplied **S**uicide **I**ntervention **S**kills **T**raining) annually for the community. ASIST is designed for all		**Goal 2 outcomes:** 1. Less than 8% of new Opioid prescriptions that are given to discharging patients annually will exceed 7 days in duration. 2. The annual percentage of controlled substance prescriptions that are ePrescribed for discharging patients will be greater than 30%. 3. Decrease the annual percentage by 10% of prescriptions that exceed a Morphine Equivalent Daily Dose (MEDD) of >90 based on the 2018 baseline. 4. At least 80% of opioid overdose patients or patients with a high MEDD will be discharged with a prescription for naloxone. **Goal 3 outcomes:** 1. Increase annual attendance at the Mental Health First Aid program by 10%. 2. Following completion of the course, participants in the ASIST Training will show a 10% improvement in knowledge concerning suicide and will state an improved competence in responding to individuals at risk.

Current State	Action / Tactics	Partners	Progress Update
Demonstrate the prevalence and/or significance of this need	*What steps will we take to impact this need*	*Community stakeholders who are essential to all improvement efforts*	*Key measures of success and milestones*
	audiences and teaches participants how to recognize someone who may be considering suicide. The class also teaches participants how to work with them and create a plan to assure their immediate safety. 4. Participate in the Tri-County Overdose Prevention Partnership. 5. Participate in the Weld County Improvement Plan program, "Thriving Weld". Subcommittees for this initiative work on reducing resident's risk for chronic disease and improving social and emotional wellness for Weld County Residents.		

Priority aligns with **Healthy People 2020** – improvement guidelines

Priority aligns with **Social Determinants of Health** (Health and Health Care) – *Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning, and quality of life outcomes and risks.* ~CDC

Priority 2: Cardiovascular Disease (Heart Disease/Stroke)

Vision: By 2030, decrease mortality related to heart disease by 4% and mortality related to stroke to 34.8 deaths per 100,000 (Healthy People 2020 goal) within the PVMC primary service area.

Goal 1: Increase knowledge around cardiovascular disease in the community.

Goal 2: Provide support for caregivers and stroke survivors.

Goal 3: Improve workforce capacity and competence to provide the best care possible for cardiac event and stroke patients.

Current State	Actions/Tactics	Partners	Last Update
Demonstrate the prevalence and/or significance of this need.	*What steps will we take to impact this need?*	*Community stakeholders who are essential to improvement efforts*	
Heart Disease ranks as the second highest age-adjusted cause of death per 100,000 (2017) • Adams County: 136.5 • Weld County: 131.1 • Colorado: 126.3 Healthy People 2020 Goal: 103.4 Stroke death rates (age adjusted per 100,000) and where it ranks among top ten causes of death (2017) • Adams County (5th): 40.2 • Weld County (6th): 33.5 • Colorado (5th): 35.1 Healthy People 2020 Goal: 34.8 Elevated cholesterol (2016) • Adams County 31.1% • Weld County 32.5% • Colorado 33.6% Elevated blood pressure (2016) • Adams County 26.4% • Weld County 23.1% • Colorado 25.8% Chief **Cardiovascular** concerns: • Access to care • Obesity • Aging populations • High Blood Pressure • High Cholesterol • Diabetes • Sedentary Lifestyles	**Goal 1: Increase knowledge of signs and symptoms of stroke and heart attack.** 1. Organize educational annual run/walk. 2. Provide stroke education for at least two local festivals/fairs each year and at the Hearts 4 Hearts Run/Walk. 3. Provide 6-week food and nutrition course to encourage and promote heart healthy eating. 4. Provide cardiac screenings for youth athletes annually. 5. Provide cardiovascular screening and education at the 9Health Fair: i. Blood pressure checks, ii. Cardiac risk assessment, iii. Low-cost blood tests for cholesterol and glucose. 6. Provide free community seminars related to cardiovascular disease. **Goal 2: Provide support for caregivers of stroke and cardiac event survivors** 1. Provide funding and scholarships for an annual Stroke Camp. Provide survivors and caregivers an opportunity to meet other stroke survivors/caregivers, attend educational seminars, participate in therapeutic activities, receive support and relax.	Brighton Community Emergency Physicians Brighton Fire Department Ft. Lupton Fire Department Platte Valley Ambulance SE Weld Fire Department SW Adams County Fire Department Northglenn Ambulance SCL Health Heart and Vascular Institute-Brighton	**Goal 1 Outcomes:** Increase attendance at annual cardiac screenings for youth athletes 5%. **Goal 2 Outcomes:** Decrease recurring cardiac events and strokes as evidenced by a 5% increase in the number of participants in the stroke and cardiac support groups. Community members purchasing the $25 monthly post cardiac event wellness program will attend 75% of the purchased visits.

• Smoking • Cost	2. Host monthly stroke support groups for survivors and caregivers. 3. Post Cardiac Event Wellness Program- Low cost exercise program for 1.5 hour 3 days a week. Anyone in the community who has experienced a cardiac event are able to use the cardiac rehab gym at a monthly fee of $25 while being supervised by cardiac rehab nurses. **Goal 3: Improve workforce capacity and competence to provide the best care possible for cardiac event and stroke patients.** 1. Provide ongoing training and recertification classes for local EMS professionals. i. CPR ii. PALS iii. ACLS 2. Educate internal staff and meet best practice standards for cardiovascular disease at PVMC. i. Participate in the Metro Denver Stroke Coordinator meeting, to include all health systems. ii. Participate in SCL Health specific Stroke and Chest Pain meetings. iii. Maintain Primary Stroke Center certification. iv. Maintain Chest Pain Certification. 3. Organize and host EMS Summit for area EMS providers related to stroke and chest pain. 4. Provide clinical and shadowing rotations for students: medical, nursing, EMT/Paramedic, medical imaging.		**Goal 3 outcomes:** Increase attendance at the EMS Summit by 5%. Following the EMS Summit, at least 80% of the participants will respond positively to questions related to the training being relevant and having been useful Chest Pain Recertification in June 2021 Stroke Center Recertification in August 2019 and 2021

Other Significant Needs Not Prioritized

Each of the health needs identified in the CHNA are important and numerous partners throughout the community are addressing these needs through various innovative programs and initiatives. PVMC will not directly address: Access to Health Care, Cancer, Diabetes and Unintentional Injuries. The PVMC CHIP will address **Cardiovascular Disease** and **Mental Health/Substance Use** in order to maximize resources, expertise and time to achieve successful impact. We will continue to look for community partners with whom to collaborate in order to work on issues not addressed in this CHIP.

Areas of Opportunity	
Access to Care	Adams County Health Department Adams County Human Services Advance Urgent Care Almost Home Alzheimer's Association Arthritis Association Boys & Girls Clubs Brighton Housing Authority Brighton Shares the Harvest Call-n-Ride Colorado Access Colorado University School of Medicine Community Reach Center Cultivate Boulder Denver Regional Mobility and Access Council (DRMAC) Eagle View Adult Center Elk Club GoGoGrandparent Greeley Guadalupe Respite Center Health First Colorado Medicaid Enrollment Program Kids First Health Care School-Based Center Lyft Meals on Wheels North Colorado Health Alliance North Range Behavioral Health Parkinson's Association Pennock Center for Counseling Project Angel Heart Regional Care Collaborative for Medicaid Population Regional Transportation District (RTD) Public Transportation Salud Family Health Center FQHC Senior Hub Sunrise Community Health FQHC Tri County Health Department Tri County Human Services Uber Veyo Medicaid Transportation Via Mobility

	Von Miller Vision Weld County Health Department Weld County Human Services Women Infant and Children Food and Nutrition Service (WIC) zTrip
Diabetes	Adams County Human Services Angel Heart Meals Boys & Girls Club Brighton Shares the Harvest Colorado Access Cultivate Boulder Denver Broncos Eagle View Adult Center Fuel Up to Play 60 (NFL and National Dairy Council) Health First Colorado Medicaid Enrollment Program Meals on Wheels North Colorado Health Alliance Regional Care Collaborative for Medicaid Population
Cancer	American Cancer Society Colorado Access Eagle View Adult Senior Center Meals on Wheels Project Angel Heart Rocky Mountain Cancer Centers Rocky Mountain Leukemia and Lymphoma Association Salud Family Health Center FQHC Senior Hub Sunrise Community Health FQHC Tobacco Free Coalition of Weld County University of Colorado Health
Unintentional Injuries	Advance Urgent Care and Occupational Medicine Aging and Disability Resources for Colorado (ADRC) Ambulance Slip Trip and Fall Education Area Agency on Aging (DRCOG) Boys & Girls Clubs Denver Broncos Drive Smart Coalition Eagle View Adult Center First Responders: Police Departments, Fire departments

Continuing the Work

The CHIP provides community health improvement direction for Platte Valley Medical Center (PVMC), its partners, community organizations and residents of Adams and Weld counties. The progress of our work will be evaluated on an on-going basis. Strategies and actions that do not yield the intended outcomes will be revised.

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Community Partners

Sincere thanks and appreciation for our community partners:

27J School District
Access Housing
Almost Home, Inc
BAART Programs Brighton
Boys and Girls Club of Metro Denver
Boys and Girls Club of Weld County
Brighton Housing Authority
City of Brighton
Colorado Access
Community Reach Center
Eagle View Adult Center
Foundations Academy
Front Range Community College
Pennock Center for Counseling
Richard Lambert Foundation
Salud Family Health Center
The Senior Hub
Tri-County Health Department
Via Mobility Services
Weld County Health Department