

# Community Health Improvement Plan | 2022



Our mission is you.

# Table of Contents

<b>Letter from the President</b>	<b>2</b>
<b>Introduction</b>	<b>3</b>
Community Health Improvement Plans (CHIP):	3
<b>About Us</b>	<b>4</b>
Background and Purpose	4
Service Area	4
Project Oversight	5
<b>Data Collection Methodology</b>	<b>6</b>
Secondary Data Collection	6
Primary Data Collection and Community Surveys	7
Resources to Address Significant Health Needs	7
Public Comment	7
<b>Identification and Prioritization of Significant Health Needs</b>	<b>8</b>
Priority Health Needs	9
Community Meeting to Prioritize Significant Needs	9
Prioritized Needs	9
Acknowledging Our Community Partners	9
Needs Not Prioritized	9
<b>Community Health Improvement Plan</b>	<b>10</b>
<b>Priority: Mental Health</b>	<b>10</b>
<b>Priority: Economic Stability</b>	<b>12</b>
<b>Priority: Health Equity</b>	<b>13</b>
<b>Areas of Continued Work Improvement</b>	<b>15</b>
<b>Appendix 1. Community Resources</b>	<b>17</b>
<b>Appendix 2. CHNA Prioritization Meeting Participants</b>	<b>18</b>

# Letter from the President

December 1, 2021

Dear Community Member,

Thank you for your interest in the health status of our community! Saint Joseph Hospital continues its 148-year commitment to improving the health of the people who call Denver home.

An important part of this work is our Community Health Needs Assessment. Through this process we engage our partners, community members, and new organizations in coming together to understand the health needs most pressing to the residents of Denver. This has not been an easy task during a pandemic often requiring physical distance, but we managed thanks to the flexibility and commitment of our partners.

Beginning in January 2022, we used all that we learned throughout the assessment process to develop our implementation plan. We used data to inform our direction and more importantly, the story behind the data-community voices-to fill in the gaps. Alongside our partners, we will continue our pursuit of a community where everyone can experience good health.

We are excited about this process, and we know that we do not do this work alone. We are grateful to be a partner in this important work of health and healing in the heart of Denver.

Sincerely,

A handwritten signature in black ink, appearing to read "Jameson Smith". The signature is fluid and cursive, with a large loop at the end of the last name.

Jameson Smith  
President, Saint Joseph Hospital

# Introduction

The Saint Joseph Hospital Community Health Needs Assessment (CHNA) was completed in 2021 and approved by the Front Range Board of Directors on October 25th, 2021. The CHNA presents 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 was 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 Colorado Health Institute, National Jewish Health, 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 Denver, Saint Joseph Hospital (SJH) has prioritized three health improvement areas for programming beginning in 2022 through 2024:

- Mental Health
- Community Wealth Building (Economic Stability)
- Health Equity

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. The 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

Saint Joseph Hospital (SHJ) was founded in Denver in 1873 by the Sisters of Charity of Leavenworth. In time, it became the first private teaching hospital in Colorado and today remains one of the largest private, multi-disciplinary teaching hospitals in the Rocky Mountain West. SJH's new state-of-the-art building opened in December of 2014. The hospital provides a tradition of health care that includes compassionate caregivers, stellar clinical expertise, and active clinical partnerships with Kaiser Permanente, National Jewish Health, and community physicians. SJH is part of SCL Health, Inc., a nonprofit faith-based health system with eight hospitals, more than 150 physician clinics, and home health, hospice, mental health and safety-net services primarily in Colorado and Montana.

In 2014, SJH and National Jewish Health formed a joint operating agreement to provide inpatient and outpatient pulmonary and related care together in Colorado. This collaborative care model brings together two leading health care organizations with complementary cultures, missions and dedication to excellence to focus on providing the best care possible. The strong outpatient approach and specialty expertise of National Jewish Health combines with SJH's focused inpatient expertise to increase both organizations' abilities to manage patients along a full continuum of care.

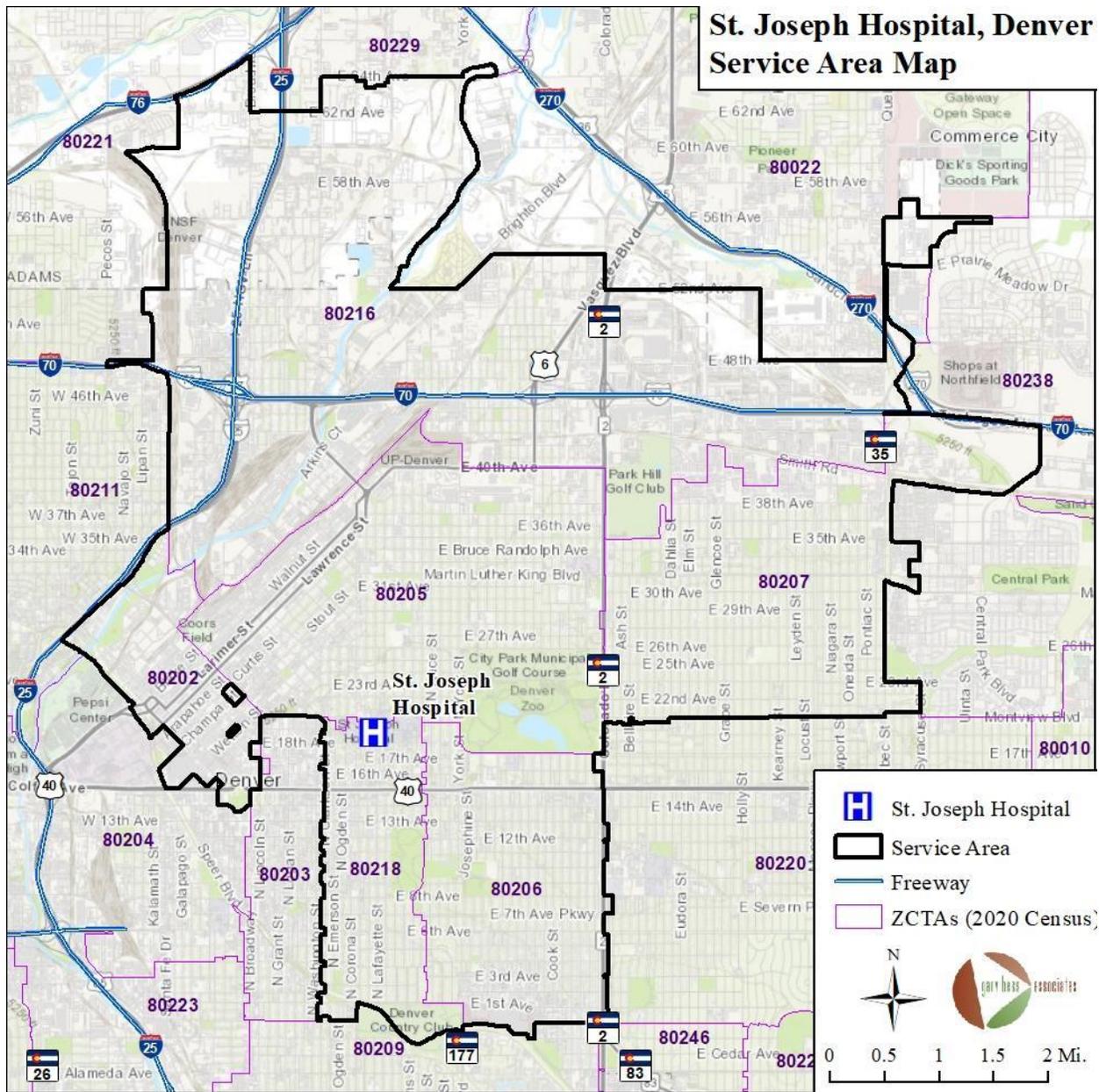
The passage of the Patient Protection and Affordable Care Act (ACA) requires tax-exempt hospitals to conduct Community Health Needs Assessments (CHNA) every three years, and to adopt Community Health Improvement Plan (CHIP) Implementation Strategies to meet the priority health needs identified through the assessment. The CHIP report provides a summary of the planned programs and activities that will be directed toward the selected priorities.

## Service Area

Saint Joseph Hospital is located at 1375 E 19th Ave, Denver, Colorado 80218. The primary service area includes six ZIP codes in Denver County, Colorado. Most patient admissions at SJH originate from these ZIP codes.

### Saint Joseph Hospital Service Area

City	ZIP Code	County
Denver	80202, 80205, 80206,80207, 80216, 80218	Denver



## 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 SJH 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

Two surveys of community members were conducted in 2021 to gather information about community perception of health needs. First, SJH surveyed community members at COVID-19 vaccine events to prioritize community health needs. One of the largest community events was held in February 2021 at the National Western Complex and surveyed 1,389 people. Of the survey respondents, 64% were female and 32% were male, 4% preferred not to report their gender. Five percent of the respondents were Spanish-speakers.

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, 2021, 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, 24 were residents of Denver County.

The results of these community surveys are reported in the [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 helps to inform potential collaborative strategies and efficiencies. It also recognizes the importance of leveraging existing expertise and trusted community leaders whether individual or organizational. 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/saint-joseph-hospital/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, public health officials and leaders from the community met on September 23, 2021, to discuss and prioritize the significant needs. A list of the meeting participants and their organizational affiliations can be found in [Appendix 2](#). The meeting was convened virtually and 21 community stakeholders attended. The group received a presentation of current secondary health data by Chuck Ault, Regional Director of Community Health, and Sister Jennifer Gordon, SCL, Vice President of Mission Integration. Primary data findings were presented through sharing the results of the 2021 COVID-19 Vaccine Clinic Spot Survey and the 2021 SCL Health Community Survey.

After completing a review and discussion of these data sources, the group prioritized the health issues that SJH is best positioned to impact in partnership with community organizations and community members. Final prioritization was voted on through a Zoom poll.

## Prioritized Needs

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

1. Mental Health
2. Community Wealth Building (Economic Stability)
3. Health Equity

## 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 SJH 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. 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](#)

## CHIP Priority: Mental Health

**Vision:** Improve the mental health of the residents of Denver with an emphasis on health equity.

### Outcome Goal(s):

- Increase access to mental health support services and preventative training and education
- Normalize mental health treatment

### Need Indicator(s):

- 16.5 % of Denver residents reported a time there was a need for mental health counseling but did not get it in past 12 months (CHNA 2021)
- 41.4% did not get needed mental health care due to stigma in past 12 months (CHNA, 2021)

### Objective:

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

### Community Partners:

- Rocky Mountain Crisis Partners
- Center for African American Health
- SJH Charity Care Clinics

Tactic(s)	Community Partner(s)	Metric	Status
<b>Partner with the Center for African American Health to deliver mental health education and prevention sessions in low-income, older adult living communities in northeast Denver.</b>	Center for African American Health	<ul style="list-style-type: none"> <li>• # of sessions delivered</li> <li>• Pre/post survey data</li> </ul>	Begins Q2
<b>Continue suicide follow-up program in SJH ED.</b>	Rocky Mountain Crisis Partners	# of referrals	Ongoing
<b>Continue Bloom program to address perinatal mood and anxiety disorders.</b>	SJH Charity Care Clinics	# of referrals	Ongoing

# Priority: Economic Stability

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.”<sup>1</sup> 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, SJH has prioritized SDoH areas in food access, access to care, education and economic stability.

<b>CHIP Priority: Economic Stability</b>	
<b>Vision:</b> Influence economic conditions in northeast Denver to enable an economy that works for everyone.	
<b>Outcome Goal(s):</b> <ul style="list-style-type: none"> <li>• Create conditions that enables opportunities for individuals to prosper</li> <li>• Invest in approaches that create opportunity for low-income residents</li> </ul>	<b>Need Indicator(s):</b> <ul style="list-style-type: none"> <li>• 13.3% of individuals are living at 100% of FPL in the SJH service area (CHNA 2021)</li> <li>• 26.4% of community members in the SJH service area are considered low income (CHNA 2021)</li> </ul>
<b>Objective:</b> Use the SJH economic engine of purchasing power and employment opportunities to create opportunities for low income residents	<b>Community Partners:</b> <ul style="list-style-type: none"> <li>• Center for Community Wealth Building (CCWB)</li> <li>• Cross Purpose</li> <li>• Denver Public Schools (DPS) Career Connect</li> </ul>

<sup>1</sup> <https://www.cdc.gov/socialdeterminants/faqs/index.htm>

## CHIP Priority: Economic Stability

Tactic(s)	Community Partner(s)	Metric	Status
Increase purchasing from locally-owned Black, Indigenous, and Persons of Color (BIPOC) catering businesses.	Center for Community Wealth Building (CCWB)	# of dollars redirected locally	Ongoing
Work with Cross Purpose to offer externship opportunities to MA and CNA program participants.	Cross Purpose	Externship-to-Hire conversion rate	Q2
Create learning and employment opportunities for Denver Public Schools (DPS) students with health care interests.	DPS Career Connect	# of students served	Ongoing

## Priority: Health Equity

According to the Robert Wood Johnson Foundation, health equity is achieved when everyone can attain their full health potential and no one is disadvantaged from achieving this potential because of social position or any other socially defined circumstance.

Without health equity, there are endless social, health, and economic consequences that negatively impact patients, communities, and organizations. The U.S. ranks last on measures of health equity compared to other industrialized countries. At SJH we know that addressing health equity is intertwined with all aspects of our healthcare delivery including clinical and community health improvement. We see the opportunity to make improvements through building stronger linkages between patient outcomes and the root causes that structurally impede overall community wellness. These causes are often referred to as structural and social determinants of health.

## CHIP Priority: Health Equity

**Vision:** To ensure that every community member, regardless of social location, has the opportunity to realize their full health potential.

### Outcome Goal(s):

Provide services and programming, focused on populations with poor health outcomes due to conditions of inequity

### Need Indicator(s):

- In the service area, average lifespan differs as much as 11 years between zip codes (CHNA 2021)
- 20,000 Colorado residents with Intellectual/Developmental Disabilities (I/DD) live with a caregiver over the age of 60 (Inclusive Housing Coalition 2020)
- The average total monthly income of residents with I/DD is \$900 (Inclusive Housing Coalition 2020)

### Objective:

Work with CHAFA to invest in place-based services for those with intellectual and developmental disabilities

### Community Partners:

- Colorado Housing and Finance Authority (CHFA)
- Coalition for Inclusive Housing

Tactic(s)	Community Partner(s)	Metric	Status
Explore funding services for I/DD community members at The Stella, an affordable, neuro-inclusive housing project in Globeville with the goal of improving opportunities for health	<ul style="list-style-type: none"> <li>• Colorado Housing and Finance Authority (CHFA)</li> <li>• Coalition for Inclusive Housing</li> </ul>	Implementing services	Q2

## Areas of Continued Work Improvement

Some CHNA priorities from previous cycles and responses to needs that emerged in our communities outside of the assessment period continue to be supported even though the work is not specifically named in the CHIP. Examples of this work include the SJH commitment to food access for our neighbors. We continue to provide fresh food production in four different spaces on our campus including a year-round, hydroponic Freight Farm. We also use the Freight Farm as a learning opportunity for students and community members. Our partnership with Metro Caring provides our clinic patients with a ready supply of food when they screen positive for food insecurity and have an immediate need.

# Appendices



## Appendix 1. Community Resources

SJH 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
Access to health care	Center for African American Health, Clinica Tepeyac, Colorado Access Medicaid, Colorado Coalition for the Homeless, Connect for Colorado, Denver Public Health, Eastside Health Clinic, Inner City Health Center, Local RAE, Mile Hi Health Alliance, Rescue Mission, Saint Joseph Hospital Clinics, Stout Street Clinic, STRIDE Community Health, The Action Center, Urban Peak
Chronic conditions	American Diabetes Association, Clinica Colorado, Clinical Tepeyac, CREA Results, Denver Public Health, Health Fairs, Inner City Health, Saint Joseph Hospital, Saint Joseph Hospital Clinics, Salud, Ventanilia de Salud with CAHEP
Food insecurity	Metro Caring, Saint Francis Center, So All May Eat, The Action Center, Denver Public Schools Backpack Program, Denver Rescue Mission, Harvest Share, Denver Urban Gardens

## Appendix 2. CHNA Prioritization Meeting Participants

### Community Health Needs Assessment Prioritization Meeting September 23, 2021

Attendee	Title	Organization
Andrew Rewold	Program Coordinator	Denver Public Schools
Benzel Jimmerson	Principal	Metro DEEP
Carl Cark	President and CEO	Mental Health Center of Denver
Chuck Ault	Regional Director, Community Health	Saint Joseph Hospital
Danelle Hubbard	Director of Health Systems	Alzheimer's Association
Denise de Percin	Executive Director	Mile Hi Health Alliance
Eric Moore	Policy and Research Manager	Center for African American Health
Gaye Woods	System Director, Community Benefit	SCL Health
Haley Todd	Director	Colorado Vincentian Volunteers
Huy Ly	Family Practice Residency Coordinator	Saint Joseph Hospital
Jean Finegan	Executive Director	Dominican Home Health
Jennifer Gordon	VP Mission Integration	Saint Joseph Hospital
Jocelyn Miller	Executive Director	RAMERC
Jodi Hardin	Director	Civic Canopy
Linda Osterlund	Academic Dean	Regis University
Maryflorencia Cox	ED Coordinator	Saint Joseph Hospital
Mattie Brister	Program Manager	Mile Hi Health Alliance
Stephanie Echer	Program Manager	Urban Peak
Tash Mitchell	Senior Management, Community Development	Metro Caring
Treloar Bower	Manager, Program Development	Museum of Nature and Science
Wendy Smittick	Food Connector	Denver Public Health and Environment
Yessica Holguin	Executive Director	Ctr. for Community Wealth Building