# HOSPITAL TRANSFORMATION PROGRAM COMMUNITY AND HEALTH NEIGHBORHOOD ENGAGEMENT

## MIDPOINT REPORT

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Instructions and Timeline

Via the Midpoint Report, program participants will report on Community and Health Neighborhood Engagement (CHNE) work over the first half of the pre-waiver process. Specifically, hospitals will use this report to update the State regarding efforts to engage community partners in completing an evidence-based environmental scan to identify community needs and resources and the hospital’s plans going forward.

The State will be reviewing Midpoint Reports to ensure:

- The process has been adequately inclusive of organizations that serve and represent the broad interests of the community and that no key stakeholders are excluded;
- A diverse and regular enough range of venues, locations, times and manners for engagement are being provided to allow for a meaningful opportunity for participation;
- Needed adjustments were made to the Action Plan and any divergence from the Action Plan is justified;
- The environmental scan assessment is complete, sufficiently detailed, and evidence-based, and was informed by community input; and
- Over the remainder of the pre-waiver CHNE process, community organizations will have meaningful opportunities to inform the hospital’s planning of its Hospital Transformation Program (HTP) participation.

Please note that the word limits included are guidelines. You may exceed them as necessary to fully respond to the question or information request.

Midpoint Reports must be submitted in .pdf form with all supporting documentation included in one document via e-mail by April 19, 2019 at 5pm to the Colorado HTP email address COHTP@state.co.us. Reports received after this deadline will not be considered.

Following the submission date, the State will review the reports. The reports will not be scored; however, the State will work collaboratively with participants to seek clarifications as needed and to ensure that there is agreement between the hospital and the State as to the plan for the remainder of the process, including plans to address any needed changes to the hospital’s CHNE process based on the review of the Midpoint Report.
Contact Information

Please provide the legal name and Medicaid ID for the hospital for which this Midpoint Report is being submitted.

Hospital Name: UCHealth Broomfield Hospital
Hospital Medicaid ID Number: _____

Please provide any updates to the hospital address as well as to the names, titles, addresses and contact information for the hospital executive with signatory authority to whom official correspondence should be addressed and for the primary and secondary points of contact if that information has changed since submitting your CHNE Action Plan. If this information has not changed, this section can be left blank.

Hospital Address: 11820 Destination Dr. Broomfield CO 80021-2518
Hospital Executive Name: Barbara Carveth
Hospital Executive Title: Chief Financial Officer
Hospital Executive Address: 12401 E 17th Ave, Mail Stop F448 Aurora CO 80045-2603
Hospital Executive Phone number: 720-848-7773
Hospital Executive Email Address: Barbara.Carveth@uchealth.org

Primary Contact Name: Roberta Capp
Primary Contact Title: Medical Director Care Transitions
Primary Contact Address: 12401 E 17th Ave, Aurora CO 80045
Primary Contact Phone Number: 720-848-4398
Primary Contact Email Address: Roberta.Capp@uchealth.org

Secondary Contact Name: Kellee Beckworth
Secondary Contact Title: Sr. Project Manager
Secondary Contact Address: 12401 E 17th Ave, Aurora CO 80045
Secondary Contact Phone Number: 720-848-6525
Secondary Contact Email Address: Kellee.Beckworth@uchealth.org
## Engagement Update

III.a. Please respond to the following questions to provide us with an update of the hospital’s engagement activities. Please note that the word limits are guidelines. You may exceed them as necessary to fully respond to the question or information request.

Please use the following grid to provide a list of external organizations that the hospital has engaged, including the organizational contact, the type of organization, and the organization-specific engagement activities undertaken with this organization. Please also note any specific connection of the organization to HTP priority populations and / or project topics.

<table>
<thead>
<tr>
<th>Organization Name</th>
<th>Organizational Contact</th>
<th>Organization Type</th>
<th>Engagement Activity</th>
<th>Connection to any specific HTP priority populations and / or project topics, as applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vivage</td>
<td>Heather Terhark</td>
<td>LTSS</td>
<td>Partnership</td>
<td>All</td>
</tr>
<tr>
<td>CHI</td>
<td>Ann Loeffler</td>
<td>LPHA</td>
<td>Partnership</td>
<td>All</td>
</tr>
<tr>
<td>BCHIC</td>
<td>Morgan Rogers McMillian</td>
<td>Health Alliance</td>
<td>Involvement</td>
<td>All</td>
</tr>
<tr>
<td>CHA Opioid Summit</td>
<td>Ashley Baker</td>
<td>Consumer Advocates/Advocacy Organizations</td>
<td>Involvement</td>
<td>Behavioral Health</td>
</tr>
<tr>
<td>Berkeley Home Health Agency</td>
<td>Gary Ruvins</td>
<td>LTSS</td>
<td>Consultation</td>
<td>All</td>
</tr>
<tr>
<td>RETAC-Denver Metro</td>
<td>Shirley Terry</td>
<td>RETACs</td>
<td>Partnership</td>
<td>All</td>
</tr>
<tr>
<td>Mental Health Partners</td>
<td>Dixie Casford</td>
<td>Community Mental Health Center</td>
<td>Consultation</td>
<td>Behavioral Health</td>
</tr>
<tr>
<td>Stride</td>
<td>Heather Logan</td>
<td>FQHC</td>
<td>Partnership</td>
<td>Vulnerable Populations (Transition of Care for pregnant women)</td>
</tr>
<tr>
<td>Boulder County Opioid Advisory Group</td>
<td>Arielle Gross</td>
<td>Consumer Advocates/Advocacy Organizations</td>
<td>Involvement</td>
<td>Behavioral Health</td>
</tr>
<tr>
<td>CCHA</td>
<td>Hanna Thomas</td>
<td>RAE</td>
<td>Partnership</td>
<td>SUD/Vulnerable Populations/High Utilizers</td>
</tr>
<tr>
<td>Colorado Prevention Alliance</td>
<td>Lauren Ambrozie</td>
<td>Health Alliance</td>
<td>Involvement</td>
<td>Vulnerable Populations (Social Determinants of Health)</td>
</tr>
<tr>
<td>BCSN</td>
<td>Marianna Williamson</td>
<td>Community organization addressing SDOH</td>
<td>Involvement</td>
<td>All</td>
</tr>
<tr>
<td>Colorado Health Literacy Coalition</td>
<td>Dana Abbey, Angela Brega</td>
<td>Community organization addressing SDOH</td>
<td>Partnership</td>
<td>Social Determinants of Health</td>
</tr>
<tr>
<td>Colorado Health Institute</td>
<td>Ann Loeffler</td>
<td>Community organization addressing SDOH</td>
<td>Partnership</td>
<td>Social Determinants of Health</td>
</tr>
<tr>
<td>Colorado Health &amp; Human Services, Refugee Department</td>
<td>Carol Tumayle</td>
<td>Community organization addressing SDOH</td>
<td>Partnership</td>
<td>Refugee Population</td>
</tr>
</tbody>
</table>
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<th>Organization Type</th>
<th>Engagement Activity</th>
<th>Connection to any specific HTP priority populations and / or project topics, as applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCHN</td>
<td>Katie Jacobson</td>
<td>FQHC</td>
<td>Involvement</td>
<td>All</td>
</tr>
</tbody>
</table>

The following community outreach was done by the Colorado Health Institute:

<table>
<thead>
<tr>
<th>Organization Name</th>
<th>Organizational Contact</th>
<th>Organization Type</th>
<th>Engagement Activity</th>
<th>Connection to any specific HTP priority populations and / or project topics, as applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Organization Name</strong></td>
<td><strong>Organizational Contact</strong></td>
<td><strong>Organization Type</strong></td>
<td><strong>Engagement Activity</strong></td>
<td><strong>Connection to any specific HTP priority populations and / or project topics, as applicable</strong></td>
</tr>
<tr>
<td>Adams County Health Alliance</td>
<td>Attendee list not available</td>
<td>Health Alliance</td>
<td>Facilitated Discussion</td>
<td>Social supports, care transitions, health data infrastructure, advocacy</td>
</tr>
<tr>
<td>Douglas County Health Alliance</td>
<td>Attendee list not available</td>
<td>Health Alliance</td>
<td>Facilitated Discussion</td>
<td>Social supports, care transitions, health data infrastructure, advocacy</td>
</tr>
<tr>
<td>Jefferson County Health Alliance</td>
<td>Attendee list not available</td>
<td>Health Alliance</td>
<td>Facilitated Discussion</td>
<td>Social supports, care transitions, health data infrastructure, advocacy</td>
</tr>
<tr>
<td>Adams County Health Alliance</td>
<td>Meghan Prentiss</td>
<td>Health Alliance</td>
<td>Focus Group</td>
<td>Social supports, care transitions, health data infrastructure, advocacy</td>
</tr>
<tr>
<td>AllHealth Network</td>
<td>Cynthia Grant</td>
<td>Community Mental Health Center</td>
<td>Focus Group</td>
<td>Behavioral health, substance use</td>
</tr>
<tr>
<td>Aurora Health Alliance</td>
<td>Mandy Ashley</td>
<td>Health Alliance</td>
<td>Focus Group</td>
<td>Social supports, care transitions, health data infrastructure, advocacy</td>
</tr>
<tr>
<td>Boulder County Health Improvement Collaborative</td>
<td>Morgan McMillan</td>
<td>Health Alliance</td>
<td>Focus Group</td>
<td>Social supports, care transitions, health data infrastructure, advocacy</td>
</tr>
<tr>
<td>Broomfield FISH</td>
<td>Dayna Scott</td>
<td>Community organizations addressing social determinants of health</td>
<td>Focus Group</td>
<td>Social supports</td>
</tr>
<tr>
<td>Center for African American Health</td>
<td>Deidre Johnson</td>
<td>Community organizations addressing social determinants of health</td>
<td>Focus Group</td>
<td>Social supports</td>
</tr>
<tr>
<td>Center for Health Progress</td>
<td>Christopher Klene</td>
<td>Community organizations addressing social determinants of health</td>
<td>Focus Group</td>
<td>Social supports</td>
</tr>
<tr>
<td>City and County of Denver</td>
<td>Tristan Sanders</td>
<td>Local Public Health Agency</td>
<td>Focus Group</td>
<td>Population health, maternal child health, social determinants of health, behavioral health</td>
</tr>
<tr>
<td>Clinica Family Health</td>
<td>Simon Smith</td>
<td>Federally Qualified Health Centers</td>
<td>Focus Group</td>
<td>Access, primary care, social determinants, behavioral health, mothers and infants, care coordination</td>
</tr>
<tr>
<td>Organization Name</td>
<td>Organizational Contact</td>
<td>Organization Type</td>
<td>Engagement Activity</td>
<td>Connection to any specific HTP priority populations and / or project topics, as applicable</td>
</tr>
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</tr>
<tr>
<td>Clinica Tepeyac</td>
<td>Jim Garcia</td>
<td>Federally Qualified Health Centers</td>
<td>Focus Group</td>
<td>Access, primary care, social determinants, behavioral health, mothers and infants, care coordination</td>
</tr>
<tr>
<td>Colorado Access</td>
<td>Daniel Obarski, Molly Markert</td>
<td>RAE</td>
<td>Focus Group</td>
<td>High utilizers, total cost of care, coordination, service availability, social determinants of health, behavioral health</td>
</tr>
<tr>
<td>Colorado Community Health Alliance</td>
<td>Hanna Thomas, Jessica Rink</td>
<td>RAE</td>
<td>Focus Group</td>
<td>High utilizers, total cost of care, coordination, service availability, social determinants of health, behavioral health</td>
</tr>
<tr>
<td>Denver Health and Hospital Authority</td>
<td>Simon Hambidge</td>
<td>Federally Qualified Health Centers</td>
<td>Focus Group</td>
<td>Access, primary care, social determinants, behavioral health, mothers and infants, care coordination</td>
</tr>
<tr>
<td>Denver Public Health</td>
<td>Jessica Forsyth, Kellie Teter</td>
<td>Local Public Health Agency</td>
<td>Focus Group</td>
<td>Population health, maternal child health, social determinants of health, behavioral health</td>
</tr>
<tr>
<td>Douglas County Health Alliance</td>
<td>Wendy Nading</td>
<td>Health Alliance</td>
<td>Focus Group</td>
<td>Social supports, care transitions, health data infrastructure, advocacy</td>
</tr>
<tr>
<td>High Plains Community Health Center</td>
<td>Eric Niedermeyer</td>
<td>Federally Qualified Health Centers</td>
<td>Focus Group</td>
<td>Access, primary care, social determinants, behavioral health, mothers and infants, care coordination</td>
</tr>
<tr>
<td>Hunger Free Colorado</td>
<td>Sandy Nagler, Brett Reeder</td>
<td>Community organizations addressing social determinants of health</td>
<td>Focus Group</td>
<td>Social supports</td>
</tr>
<tr>
<td>Jefferson Center for Mental Health</td>
<td>Don Bechtold</td>
<td>Community Mental Health Center</td>
<td>Focus Group</td>
<td>Behavioral health, substance use</td>
</tr>
<tr>
<td>Jefferson County Public Health</td>
<td>Kelly Kast, Melissa Palay</td>
<td>Local Public Health Agency</td>
<td>Focus Group</td>
<td>Population health, maternal child health, social determinants of health, behavioral health</td>
</tr>
<tr>
<td>Marillac Clinic</td>
<td>Kay Ramachandran</td>
<td>Federally Qualified Health Centers</td>
<td>Focus Group</td>
<td>Access, primary care, social determinants, behavioral health, mothers and infants, care coordination</td>
</tr>
<tr>
<td>Mile High Health Alliance</td>
<td>Dede de Percin, Karen Trautman, Alyssa Harrington</td>
<td>Health Alliance</td>
<td>Focus Group</td>
<td>Social supports, care transitions, health data infrastructure, advocacy</td>
</tr>
<tr>
<td>Mountain Family Community Health Center</td>
<td>Ross Brooks</td>
<td>Federally Qualified Health Centers</td>
<td>Focus Group</td>
<td>Access, primary care, social determinants, behavioral health, mothers and infants, care coordination</td>
</tr>
<tr>
<td>Organization Name</td>
<td>Organizational Contact</td>
<td>Organization Type</td>
<td>Engagement Activity</td>
<td>Connection to any specific HTP priority populations and / or project topics, as applicable</td>
</tr>
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</tr>
<tr>
<td>Peak Vista Community Health Center</td>
<td>Pam McManus</td>
<td>Federally Qualified Health Centers</td>
<td>Focus Group</td>
<td>Access, primary care, social determinants, behavioral health, mothers and infants, care coordination</td>
</tr>
<tr>
<td>Sheridan Health Services</td>
<td>Erica Shierer</td>
<td>Federally Qualified Health Centers</td>
<td>Focus Group</td>
<td>Access, primary care, social determinants, behavioral health, mothers and infants, care coordination</td>
</tr>
<tr>
<td>Signal Behavioral Health</td>
<td>Heather Dolan</td>
<td>Managed Service Organization</td>
<td>Focus Group</td>
<td>Behavioral health, substance use</td>
</tr>
<tr>
<td>STRIDE Community Health Center</td>
<td>Ben Niederman</td>
<td>Federally Qualified Health Centers</td>
<td>Focus Group</td>
<td>Access, primary care, social determinants, behavioral health, mothers and infants, care coordination</td>
</tr>
<tr>
<td>Sunrise Community Health Center</td>
<td>Mitzi Moran</td>
<td>Federally Qualified Health Centers</td>
<td>Focus Group</td>
<td>Access, primary care, social determinants, behavioral health, mothers and infants, care coordination</td>
</tr>
<tr>
<td>Tri-County Health Department</td>
<td>Emma Goforth, Heather Baumgartner</td>
<td>Local Public Health Agency</td>
<td>Focus Group</td>
<td>Population health, maternal child health, social determinants of health, behavioral health</td>
</tr>
<tr>
<td>Colorado Coalition for the Homeless</td>
<td>Brian Hill</td>
<td>Federally Qualified Health Centers</td>
<td>Focus Group and Key Informant Interview</td>
<td>Access, primary care, social determinants, behavioral health, mothers and infants, care coordination</td>
</tr>
<tr>
<td>CORHIO</td>
<td>Morgan Honea, Kate Horle</td>
<td>Regional Health Information Exchange</td>
<td>Key Informant Interview</td>
<td>Health data exchange infrastructure</td>
</tr>
<tr>
<td>InnovAge</td>
<td>Beverley Dahan</td>
<td>Long Term Services and Supports Provider</td>
<td>Key Informant Interview</td>
<td>Older adults/end of life, care transitions, primary care</td>
</tr>
<tr>
<td>Colorado Cross-Disability Coalition</td>
<td>Julie Reiskin, Dawn Howard, Kim Jackson</td>
<td>Consumer advocate</td>
<td>Key Informant Interview</td>
<td>Consumer advocacy, long-term services and supports, access, care transitions, high utilizers</td>
</tr>
<tr>
<td>Colorado Criminal Justice Reform Coalition</td>
<td>Terri Hurst</td>
<td>Consumer advocate</td>
<td>Key Informant Interview</td>
<td>High utilizers, care transitions, behavioral health, social supports, disconnected from system</td>
</tr>
<tr>
<td>Colorado Children’s Campaign</td>
<td>Erin Miller</td>
<td>Consumer advocate</td>
<td>Key Informant Interview</td>
<td>Maternal child health, social supports</td>
</tr>
<tr>
<td>Denver Regional Council of Governments</td>
<td>Ron Papsdorf</td>
<td>Community organizations addressing social determinants of health</td>
<td>Key Informant Interview</td>
<td>Social determinants of health, long-term services and supports</td>
</tr>
<tr>
<td>Every Child Pediatrics</td>
<td>Jessica Dunbar</td>
<td>Primary Care Medical Provider</td>
<td>Key Informant Interview</td>
<td>Access, primary care, social determinants, behavioral health,</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Organization Name</th>
<th>Organizational Contact</th>
<th>Organization Type</th>
<th>Engagement Activity</th>
<th>Connection to any specific HTP priority populations and / or project topics, as applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mile High &amp; Foothills RETAC</td>
<td>Bill Clark</td>
<td>RETACs</td>
<td>Key Informant Interview</td>
<td>mothers and infants, care coordination</td>
</tr>
</tbody>
</table>

Please use the following grid to provide a list of engagement activities, (e.g. workgroups, committees, meetings, discussion groups, public forums, etc.) that the hospital has undertaken, including the locations and manners for participation (e.g. in-person, by phone, in writing, etc; please also indicate if the participants facilitated or provided data analysis), frequency of the activity, the partners included, how notice was provided, and the key deliverables for each activity (e.g. action items, high-level decisions, documents drafted / finalized, data reports, etc).

<table>
<thead>
<tr>
<th>Engagement Activity</th>
<th>Location and Manners for Participation</th>
<th>Frequency of Activity</th>
<th>Partners Included</th>
<th>How Activity Was Noticed</th>
<th>Key Deliverables</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partnership</td>
<td>In person</td>
<td>x1</td>
<td>Vivage and UCHealth</td>
<td>E-mail</td>
<td>Discussed challenges and opportunities in the post-acute care space related to Medicaid clients</td>
</tr>
<tr>
<td>Partnership</td>
<td>In person</td>
<td>Monthly and add-hoc (X5)</td>
<td>LPHA, CHI, hospitals, RAE</td>
<td>E-mail</td>
<td>Discussed collaboration between hospitals and LPHA and mid-term report needs</td>
</tr>
<tr>
<td>Involvement</td>
<td>In person</td>
<td>x1</td>
<td>Hospital, FQHC, PCMH, LPHA, DHS</td>
<td>E-mail</td>
<td>Participated in meetings related to specialty care access. Discussed opp for collaboration</td>
</tr>
<tr>
<td>Involvement</td>
<td>In person</td>
<td>x1</td>
<td>Hospitals, OBH, CMHC, PCMH, FQHC, RAE, CDPHE, CHA, advocates</td>
<td>Public Announcement</td>
<td>Discuss ED MAT program, discussed HTP, and bias in building opioid use disorder programs</td>
</tr>
<tr>
<td>Consultation</td>
<td>In person</td>
<td>X1</td>
<td>LTSS</td>
<td>Email</td>
<td>Discuss challenges and opportunities in transitions of care between hospitals and home health agencies when caring for Medicaid clients</td>
</tr>
<tr>
<td>Consultation</td>
<td>Phone</td>
<td>x1</td>
<td>RETAC-UCHealth</td>
<td>E-mail</td>
<td>Discussed HTP and understanding of RETAC.</td>
</tr>
<tr>
<td>Consultation</td>
<td>In person</td>
<td>x1</td>
<td>Mental Health Partners, UCH</td>
<td>E-mail</td>
<td>Discussed behavioral health and gaps/capacity.</td>
</tr>
<tr>
<td>Engagement Activity</td>
<td>Location and Manners for Participation</td>
<td>Frequency of Activity</td>
<td>Partners Included</td>
<td>How Activity Was Noticed</td>
<td>Key Deliverables</td>
</tr>
<tr>
<td>---------------------</td>
<td>----------------------------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
<td>--------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Partnership</td>
<td>UCH-A/In person</td>
<td>x1</td>
<td>Stride/UCH-A</td>
<td>E-mail</td>
<td>Discussed Stride's CHNA findings and opportunities for partnerships</td>
</tr>
<tr>
<td>Involvement</td>
<td>Phone</td>
<td>Quarterly</td>
<td>LPHA, BCPH, OBH, community advocates</td>
<td>E-mail</td>
<td>Discussed policy, behavioral health and substance abuse initiatives, and corrections systems grants activities.</td>
</tr>
<tr>
<td>Partnership</td>
<td>In person</td>
<td>X3</td>
<td>RAE, UCHealth</td>
<td>E-mail</td>
<td>RAE opportunities for hospital-RAE partnerships</td>
</tr>
<tr>
<td>Involvement</td>
<td>CIVHC Board Room/In person</td>
<td>x1</td>
<td>Health Systems, Payers, CDPHE, CCMU</td>
<td>E-mail</td>
<td>SDOH white paper put together by CPA; opportunities to use similar SDOH tools</td>
</tr>
<tr>
<td>Involvement</td>
<td>Phone</td>
<td>x1</td>
<td>Community resources</td>
<td>E-mail</td>
<td>Meeting records are located on Boulder County website</td>
</tr>
<tr>
<td>Involvement</td>
<td>In person</td>
<td>Monthly</td>
<td>PACE, Meals on Wheels, habitat for humanity, United Way, hospitals,</td>
<td>E-mail</td>
<td>Discuss existing resources and gaps that address health and social needs</td>
</tr>
<tr>
<td>Partnership</td>
<td>Phone</td>
<td>x1</td>
<td>Colorado Health Literacy Coalition and UCHealth</td>
<td>E-mail</td>
<td>Capture the health literacy rates by county and discussed partnership opportunities.</td>
</tr>
<tr>
<td>Partnership</td>
<td>Phone</td>
<td>x1</td>
<td>Denver Metro Hospitals &amp; CHI</td>
<td>E-mail</td>
<td>CHI acted as the convener organization in reaching out to stakeholders to gather information for mid-term HTP report</td>
</tr>
<tr>
<td>Partnership</td>
<td>Phone</td>
<td>Monthly</td>
<td>CCHA and UCHealth</td>
<td>E-mail</td>
<td>HTP: Data Request &amp; Timeline HTP: Review Midpoint Report Transitions of Care Process Data Sharing Strategy</td>
</tr>
<tr>
<td>Partnership</td>
<td>Phone</td>
<td>x1</td>
<td>Colorado Health &amp; Human Services, Refugee Department and UCHealth</td>
<td>E-mail</td>
<td>Understand refugee population needs and services provided</td>
</tr>
<tr>
<td>Involvement</td>
<td>In person</td>
<td>X1</td>
<td>CCHN, Stride, Salud, Clinica, Denver Health, Peak Vista, People’s clinic</td>
<td>E-mail</td>
<td>Discuss opportunities between hospitals and FQHCs in the context of the HTP</td>
</tr>
</tbody>
</table>
### The following community outreach was done by the Colorado Health Institute:

<table>
<thead>
<tr>
<th>Engagement Activity</th>
<th>Location and Manners for Participation</th>
<th>Frequency of Activity</th>
<th>Partners Included</th>
<th>How Activity Was Noticed</th>
<th>Key Deliverables</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation</td>
<td>Phone and in person</td>
<td>X10</td>
<td>CORHIO, Colorado Children’s Campaign, CCH, Colorado Criminal Justice Reform Coalition, Denver Regional Council of Governments, Every Child Pediatrics, Innovage, Mile High and Foothills Retac</td>
<td>Email</td>
<td>Discussion around the health care challenges, gaps, and opportunities in the metro Denver community</td>
</tr>
<tr>
<td>Consultation</td>
<td>Location: offices of the Colorado Health Institute. Attendees participated either in-person or by webinar/phone.</td>
<td>X6</td>
<td>Colorado Access, Adams County Health Alliance, AllHealth Network, Aurora Health Alliance, Boulder County Health Improvement Collaborative, Broomfield FISH, Center for African American Health, Center for Health Progress, City and County of Denver, Clinica Family Health, Clinica Tepeyac, Colorado Coalition for the Homeless, Colorado Community Health Alliance, Denver Health and Hospital Authority, Denver Public Health, Douglas County Health Alliance, High Plains Community Health Center, Hunger Free Colorado, Jefferson Center for Mental Health, Jefferson County Public Health, Marillac Clinic, Mile High Health Alliance, Mountain Family Community Health</td>
<td>Email</td>
<td>Discussion around the health care challenges, gaps, and opportunities in the metro Denver community</td>
</tr>
<tr>
<td>Engagement Activity</td>
<td>Location and Manners for Participation</td>
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<td>Partners Included</td>
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</tr>
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</tr>
<tr>
<td>Consultation</td>
<td>Online-Survey</td>
<td>Survey link was emailed once through partners' existing email distribution lists. Approximately 120 responses received as of April 11, 2019.</td>
<td>Mile High Regional Emergency Medical and Trauma Advisory Council, Jefferson County Health Alliance, Douglas County Health Alliance, Adams County Health Alliance, Aurora Health Alliance</td>
<td>Email</td>
<td>Insights around the health care challenges, gaps, and opportunities in the metro Denver community</td>
</tr>
<tr>
<td>Consultation</td>
<td>In person</td>
<td>X3</td>
<td>Adams County Health Alliance, Douglas County Health Alliance, and Jefferson County Health Alliance</td>
<td>Email</td>
<td>Discussion around the health care challenges, gaps, and opportunities in the metro Denver community</td>
</tr>
</tbody>
</table>
III.b. Please respond to the following questions to tell us about your experiences of executing your Action Plan, including the challenges you have faced and how, if at all, you have had to adjust in light of those challenges.

1. Please use the space below to describe:
   - Any organizations that you expected to engage but were unable to or that are no longer engaged and your understanding of why; and
   - How you have attempted to address these gaps in engagement

Response (Please seek to limit your response to 500 words or less)

UCHealth Broomfield Hospital is a hospital in Broomfield County. We met with many organization leaders, partnered with all Denver Metro hospitals and the Colorado Health Institute (CHI) to lead the HTP mid-term report.

We have met with all of the groups listed in the Action Plan. We were able to meet with Mental Health Partners to have more talks about HTP and behavioral health disorders.

2. Please use the space below to describe any challenges you faced in implementing planned activities as described in the Action Plan and the cause of the challenges.

Response (Please seek to limit your response to 500 words or less)

The biggest challenge with carrying out the action plan activities was linked to the amount of time between Action Plans and Midpoint Reports. The state stressed using ongoing meetings as a way to have talks about gathering data and information needed for this report.

But, since many community groups meet each quarter and hospitals were given 3 months to do the Midpoint report activities, this was a challenge. Also, hospitals did not want these groups to become tired of answering questions and coming to meetings that were all very much the same. Working with hospitals in one area to gather the same group of stakeholders was challenging.

3. Please use the space below to describe any divergences from your final Action Plan made in order to successfully conduct your Community and Health Neighborhood Engagement, including those made to address the challenges described above.

Response (Please seek to limit your response to 500 words or less)

We met with all stakeholders listed in our Action Plan. We went to larger community meetings to get feedback from many stakeholders when we could. We were part of meetings and partnerships that are in place right now between UCHealth and community groups.

Most of the challenges we had were linked to getting details needed for the Midpoint report and turning talks towards doing the needs assessment and environmental scan. The Midpoint report phase was an information gathering stage, and the Hospital Transformation Program does not have more money to pay for this phase. In spite of this, community groups often gave solutions but still asked hospitals to help pay for issues that were found.
Environmental Scan Findings

Please see Appendices I and II for checklists that may be useful in responding to these questions.

Please note that the word limits are guidelines. You may exceed them as necessary to fully respond to the question or information request.

IV.a. Please use the space below to describe how the hospital has defined the community (based on input received).

Response (Please seek to limit your response to 500 words or less)

The hospital defined the community based on its setting and the zip code of citizens that use the hospital system. UCHealth Broomfield Hospital takes care of people from all Denver Metro areas. The 2 surrounding counties are Jefferson and Broomfield. The regions are served by these regional accountable entities (RAE):

- Colorado Access
- Colorado Community Health Alliance

The Colorado Health Institute set up meetings for hospital partners that are part of the Metro Denver Partnership for Health’s (MDPH) Public Health-Health Systems Collaboration Work Group. MDPH is a joint effort led by the 6 local public health agencies that serve the 7-county Denver Metro area, including:

- Adams
- Arapahoe
- Boulder
- Broomfield
- Denver
- Douglas
- Jefferson

This environmental scan lined up the data collection and community partner outreach across the metro Denver region for these partner hospitals:

- Centura Health
- Children’s Hospital Colorado
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- Denver Health
- Health One
- National Jewish Hospital
- SCL Health
- UCHealth (UCHealth Broomfield Hospital
- UCHealth Highlands Ranch Hospital
- UCHealth University of Colorado Anschutz Medical Campus Hospital
- UCHealth Longs Peak Hospital

Colorado Department of Health Care Policy and Financing (HCPF) data are reported at the Regional Accountable Entity level:

RAE 3:
- Adams
- Arapahoe
- Douglas
- Elbert

RAE 5:
- Denver

RAE 6:
- Boulder
- Broomfield
- Clear Creek
- Gilpin
- Jefferson
IV.b. Please use the space below to identify the sources and information used to identify community health needs and service levels available including specific to the HTP priority populations and project topics.

Response (Please seek to limit your response to 500 words or less)

We did many surveys and interviews with community groups. By being part of ongoing community meetings we could ask for needed facts. We also reviewed public records that contained points about the broad population of the area. We want to thank all of our partners for setting up groups of community stakeholders and sharing data with us.

Also, we built an internal UCHealth data workgroup to check our internal electronic health record data. Lastly, we teamed up with the Regional Accountable Entity (RAE) and got data linked to the Medicaid population. The Health Policy and Finance (HCPF) Center also gave hospitals data on Medicaid members that used the hospital identified in this application. All data had any proof of who the members were taken off.

References:

[4] https://data-cdphe.opendata.arcgis.com/datasets/5878e60d6a714c5395fd934ec7f864e9_2
[9] Health Care Policy and Financing Data, July 2017-June 2018
IV.c. Please use the space below to describe any data gaps encountered while conducting the environmental scan, and how these were accounted for.

Response (Please seek to limit your response to 500 words or less)

We did many surveys and interviews with community groups. By being part of ongoing community meetings we could ask for needed information. We also reviewed public records that contained details about the broad population of the area.

What we learned from this data has some limits linked to it and how it was done. This includes:

- Data telling us about Medicaid enrollees that use the hospital services may not be the same as to the Medicaid population as a whole in that area.

- Knowing how much a person uses the hospital can’t be known for sure since data about a person was only used once, not for each time they used the hospital for care.

- The data we have may not show the true amount that people on Medicaid use a service at the hospital. Because people may have Medicaid only for part of year, we miss the details of what services they need and use when not on Medicaid.

We were not able to study many data points by county and payer (Medicaid/public) because there was no data to be found. County values are for the whole population unless stated.

Quantitative data (things that can be counted) telling the unique health needs of the groups of people that are our main concern are limited. These groups of people include:

- prenatal or pregnant women
- those with behavioral health and substance use concerns
- non-English speakers
- refugees

[16] https://www.colorado.gov/pacific/cdphe/colorado-health-indicators
[17] https://www.coloradohealthinstitute.org/research/colorado-health-access-survey
• people with developmental disabilities

Data on these populations were gathered through qualitative (observing to gather data that is not a number) methods. However, there is little quantitative data to prove these important, personal accounts further.

This scan includes insights from community partners and stakeholders representing the people that we are focused on for the HTP and listed in the CHNE Guidebook. Many providers in the metro area were asked to take part in the scan. Still, some were not be part of interviews or focus groups, due to issues with their schedules. Also the tight timeframe we had to finish the environmental scan made it hard for others. An online survey was sent to all community partners who were engaged in this process but not able to give feedback through an in-person talk.

IV.d.i. Please use the space below to provide an overview of the hospital’s service area, including providing basic information about the demographics of the general population and the Medicaid population, including related to:

• Race;
• Ethnicity;
• Age;
• Income and employment status;
• Disability status;
• Immigration status;
• Housing status;
• Education and health literacy levels;
• Primary languages spoken; and
• Other unique characteristics of the community that contribute to health status.

Response (Please seek to limit your response to 750 words or less)

General Population:

The metro Denver population differs across counties, communities, and neighborhoods.

As a region, residents are mainly white with a large Hispanic population.

They face:

• large income disparities
• high costs of housing
• a growing population with more than 367,000 people moving to the area from 2010 until 2017

Race and Ethnicity
Denver County
- Most of the metro Denver region is White (82.1%)
- Hispanic (22.3%)

Adams County
- almost 2 of 5 (39.3%) identify as Hispanic

Douglas County
- 8.3% are Hispanic

Arapahoe
- 10.5% are African American

Boulder
- less than 1% (0.9%) are African American [1]

Population
Broomfield County
- 68,341 residents, comprising 1.22% of overall Colorado's population
- 410 rural residents (0.6%)
- 52,580 (76.9%)
- 891 (1.3%) African American
- 8,476 (12.4%) Latino/Hispanic
- 4,510 (6.6%) Asian
- 93 (0.1%) Native Hawaiian/Other Pacific Island Native [1].

Jefferson County
The Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) is a government-owned business within the Department of Health Care Policy and Financing, www.colorado.gov/hcpf

- 574,613 residents, comprising 10.25% of overall Colorado's population [1].
- 39,648 rural residents (6.9%)
- 450,122 (78.3%) Non-Hispanic Whites
- 6,293 (1.1%) African American
- 88,334 (15.4%) Latino/Hispanic
- 16,988 (3.0%) Asian
- 697 (0.1%) Native Hawaiian/Other Pacific Island Native

Age

Broomfield County
- 16,128 (23.6%) below 18 years of age
- 43,192 (63.2%) between ages 18 and 64 years of age
- 9,021 (13.2%) 65 years of age and older

Jefferson County
- 114,923 (20.0%) below 18 years of age
- 367,178 (63.9%) between ages 18 and 64 years of age
- 92,512 (16.1%) were 65 years of age and older

Income and Employment Status

State of Colorado
- state of Colorado at 12.7% [4] at FPL
- (2.8%) unemployment rate

Denver Metro
- average household income in the Denver metro region was $97,285
- about a third of the Denver metro population live under 200% of the FPL [2,3]

Adams County
The Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) is a government-owned business within the Department of Health Care Policy and Financing, www.colorado.gov/hcpf

- 2 in 5 people living below 200% of the Federal Poverty Level (FPL)

Denver County
- 38.5% living below 200% of the Federal Poverty Level (FPL)

Douglas County
- 15.0% living below 200% of the Federal Poverty Level (FPL)

Broomfield County
- 6.75% of people living at or below the Federal Poverty Level
- unemployment rate (2.6%)
- median household income $92,000

Jefferson County
- 7.6% people living at or below the Federal Poverty Level
- unemployment rate (2.6%)
- median household income $80,600

Disability Status

Broomfield County
- West Broomfield County had higher rates of people with a disability (9.4%-45.8%) when compared to East Broomfield County (0% to 9.3%) [4].

Jefferson County
- West Jefferson County had lower rates of people with a disability (0.0%-9.3%) when compared to East Jefferson County (9.4%-45.8%) [4].

Immigration Status

Broomfield County
- As stated by the Migration Policy Institute, no foreign-born immigrants
- no refugee data on hand publicly
- 116 refugees came in 2017

Jefferson County
The Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) is a government-owned business within the Department of Health Care Policy and Financing, www.colorado.gov/hcpf

- 10,300 foreign-born immigrants were living in Jefferson County [5]
- refugee settlement area in Denver Metro (80%)

Weld County
- refugee settlement areas included Greeley at 13%

El Paso County
- refugee settlement areas in Colorado Springs at 7% [6]

Housing

Broomfield County
- homeownership rate is 60 to 70%

Jefferson County
- homeownership rate is 60 to 70%

Education and Health Literacy Status

State of Colorado
- high school graduation rates in the state of Colorado is 79%

Broomfield
- no data on high school graduation rates [1]
- As stated on the Health Literacy Data Map, northeast Broomfield County health literacy rate was in the lowest state quartile, while the rest of Broomfield County was mostly within the 2 highest state quartiles made up of Quartile 3 and 4.
- In 2019, there were 2% of people with an English proficiency deficiency.

Jefferson County
- high school graduation rates (83%)
- The northeast Jefferson County health literacy rate was in the first and second lowest state quartiles made up of Quartile 1 and 2. While the rest of Jefferson County was within the 2 highest state quartiles made up of Quartile 3 and 4 [7].
- In 2019, there were 2% of people with an English proficiency deficiency [1].
Primary Languages Spoken

Broomfield County
- In 2019, there were 2% of residents with an English proficiency

Jefferson County
- In 2019, there were 2% of residents with an English proficiency

Unique characteristics that impact the health of UCHealth Broomfield Hospital Service Area:

UCHealth Broomfield Hospital serves the whole Denver Metro area residents, and as such, serves a varied community of residents. Patients that use UCHealth Broomfield Hospital live in diverse places. This highlights the need to know what resources are throughout the whole Denver Metro region and to work closely with two different regional accountable entities.

There are unique needs linked to:
- transportation challenges
- needs linked to mental health and substance use disorders treatment
- caring for very complex patients who need to be discharged to a nursing home or with home health services

Medicaid Population:

Broomfield County
- 7,071 Health First Colorado Members enrolled each month [8]

Jefferson County
- 96,720 Health First Colorado Members enrolled each month [8]
- UCHealth Broomfield Hospital evaluated 243 unique Medicaid citizens who used the hospital over a period of 12 months.

Age:
- 48 (19.8%) were below 18 years of age
- 194 (73.3%) were between 18-64 years old
- 1 (7.0%) were 65 years of age and older

Gender
- 54.3% females
- 45.7% males

Race/Ethnicity
- 105 (43.2%) Non-Hispanic Whites
- 100 (41.2%) Multiple Races
- 9 (3.7%) African American
- 17 (7.0%) Latino/Hispanic
- 0 (0.0%) Native Hawaiian/Other Pacific Islander

Disability
- 31 (12.8%) Medicaid enrollees had permanent disabilities

Refugee
- 4 (1.6%) Medicaid enrollees were legal permanent residents and no refugees

Primary Language
- There were less than 0.8% of Medicaid enrollees who spoke languages other than English. But, the secondary language field had 17.7% missing responses. So, we may not have all of the facts [9].

We were not able to get details from the state or the RAE on these items:
- income
- employment status
- education
- health literacy levels

IV.d.ii. Please also provide information about the HTP populations of focus within the hospital’s service area, including:
- Individuals with significant health issues, co-occurring conditions, and / or high health care utilizers;
- Vulnerable populations including related to maternal health, perinatal, and improved birth outcomes as well as end of life care;
- Individuals with behavioral health and substance use disorders; and
- Other populations of need as identified by your landscape assessment. Please consider those at-risk of being high utilizers to whom interventions could be targeted. This should include populations that may not currently receive care in the hospital but are known to community organizations and reflected in the response to IV.d.i.
Response (Please seek to limit your response to 750 words or less)

People with major health issues, co-occurring conditions, and high health care utilizers:

UCHealth Broomfield Hospital evaluated 63 unique Medicaid high utilizer citizen enrollees who used the hospital over a period of 12 months. [9].

Age

- 5 (7.9%) are below 18 years of age
- 54 (85.7%) are between 18 to 64 years old
- 4 (6.3%) are 65 years of age and older

Gender

- 44.4% females
- 55.6% males

Race/Ethnicity

- 26 (41.3%) Non-Hispanic Whites
- 3 (4.8%) African American
- 4 (6.3%) Latino/Hispanic
- 0 (0.0%) Native Hawaiian/Other Pacific Islander

Disability

- 26 (41.3%) had permanent disabilities

Refugee

- 3 Medicaid enrollees (4.8%) were legal permanent residents
- no refugees

- 7 Medicaid homeless high utilizers

Primary Language

- less than 1.6% of Medicaid enrollees who spoke languages other than English [9]

We were not able to get details from the state or the RAE on these items:
• income
• employment status
• education
• health literacy levels

Vulnerable Populations including related to maternal health, perinatal, and including outcomes of birth and end of life care:

Compared to women covered by private insurance, Medicaid covered pregnant women tend to:

• be between ages 20 to 34 years
• be adolescents
• be single mothers
• have fewer years of education
• be obese
• have a diagnosis of:
  o diabetes
  o mental health
  o substance use disorder
• be more likely to use the emergency department

Individuals with behavioral health disorders:

• single largest payer in the U.S. for behavioral health disorders including:
  o mental health
  o substance use disorders [10]
• most common mental health disorder is major depressive disorder
• females are more likely to have a mental health disorder than male enrollees
• African Americans and Latino/Hispanics with Medicaid are more likely to have a mental health disorder, compared to Whites.
• Members with disabilities are more likely to also have a mental health disorder or
substance use disorder.

• About 1 in 4 Medicaid members diagnosed with a mental health disorder also have some
other issues such as substance use disorder.

• More likely to be divorced or separated compared to people with mental health disorders
that have private insurance.

• Less likely to work full time compared to a person with behavioral health disorders that
have private insurance.

• are mostly young, between ages 18 and 55 years of age

• Chronic physical health and behavioral health issues in this group is like the broad
population.

o But the costs linked with a Medicaid member having another physical and behavioral
health problem is 3 times more than a Medicaid member with only a physical chronic disease.

Other populations of need:

Refugee groups:

• have complex social situations

• often have faced early life trauma

o many have mental health diagnosis

• less likely to look for mental health care or take medicines due to contrasts of culture

• language barriers and health care system navigation add to the challenge of caring for
this group

People with disabilities

• have complex health care and social needs

• In Colorado, there were 17% of people who lived with some disability

o compared to the U.S. with 23% [11]

As stated by Medicaid claims, a large part of Medicaid health care costs came from people with
disabilities.

About 32.7% of adults in Colorado with disabilities were more likely to be inactive compared to
16.3% of those without disabilities [11].
Compared with those without disabilities, adults in Colorado with disabilities were also more likely to:

- have high blood pressure
- smoke
- be obese [11]

IV.e.i. Please use the space below to describe the prevalence of significant behavioral and physical health needs generally in your service area, specifically citing the service area’s top behavioral health, substance use, and chronic disease burdens for both the Medicaid and the general population. Include rates for:

- Serious Behavioral Health Disorders;
- Substance Use Disorders including alcohol, tobacco and opiate abuse; and
- Significant physical chronic conditions.

Response (Please seek to limit your response to 750 words or less)

Serious Behavioral Health Disorders:

The age-adjusted death rate due to suicide is:

- 17.2 out of 100,000 in Broomfield County
- 18.4 out of 100,000 Jefferson County
- 19.5 out of 100,000 in the State of Colorado [12]

Denver Metro Area’s percent of high school students who seriously thought about attempting suicide during the past 12 months is 16.0%.

- The rate in Broomfield is 15.6%
- The rate in Jefferson is 15.9% [2]

According to the state dataset, there were no emergency department (ED) visits to UCHealth Broomfield Hospital for serious behavioral health disorders for those who are emergency department high utilizers. This is defined as 4 or more ED visits in 12 months [9]. Also, when reviewing the statewide Medicaid dataset, there were no ED visits for primary serious mental health diagnosis [9]. This finding may be linked to the fact that the State Medicaid dataset only includes physical health data and not behavioral health data.

According to SAMHSA, 4.2% of adults in Colorado live with serious mental health conditions such as:

- schizophrenia
- bipolar disorder
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www.colorado.gov/hcpf

- major depression [13]

Only 0.4% of all hospital visits for people with one or more mental health issues was for a serious mental health condition, such as:

- schizophrenia
- psychotic disorders

Of all patients who used UCHealth Broomfield Hospital, those with Medicaid insurance were 3.4 times more likely to use the hospital for schizophrenia and psychotic disorder treatment. This is compared to patients that had commercial insurance.

In total, 1.32% of all visits for people with 1 or more mental health disorders were for suicide ideation or attempt. Of all patients who used UCHealth Broomfield Hospital, those with Medicaid were 10.3 times more likely to use the hospital for suicidal ideation or attempt, when compared to patients with commercial insurance.

When looking at the UCHealth electronic health record data, we noted that people in Broomfield with a mental health diagnosis made up 4.0% of all IP and ED visits. People from Jefferson County made up 15%. This rate was slightly higher for Medicaid Jefferson residents (14.6%), but not for Broomfield residents (3.3%) who used an UCHealth hospital.

Substance use Disorders including alcohol, tobacco, and opiate abuse:

The percent of adults aged 18 years and older who said they had been binge drinking in the past 30 days was:

- 19.4% for the Denver Metro
- 22.3% for Broomfield County
- 17.9% Jefferson County [14]

Alcohol abuse and dependence was a common cause of hospital admissions for many Medicaid members with chronic conditions. Colorado Community Health Alliance highest expense was linked to alcohol abuse and dependence diagnosis. No other substance use disorder codes were noted as a common diagnosis in the state Medicaid dataset [9].

The Colorado Health Observation Regional Data Service (CHORDS) shows that adult tobacco use:

- is 9.3% in Broomfield County
- is 16.1% in Denver Metro area
- is 16.4% in Jefferson County [14]

Opioid Use Disorder is:
The Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) is a government-owned business within the Department of Health Care Policy and Financing.

- 0.7% in the Denver Metro Area
- 0.7% in Jefferson County
- 0.3% in Broomfield County

Adult depression is:
- 11.1% in the Denver Metro Area
- 12.1% in Broomfield County
- 14.4% in Jefferson County [2]

Other significant physical chronic conditions:

High blood pressure is the most often diagnosed chronic disease in the state of Colorado (12%) [15].

The leading causes of death in Broomfield County are:
- cancer (malignant neoplasms) (148.6 per 100,000 population)
- heart disease (118.1 per 100,000 population)
- chronic lower respiratory disease (42.7 per 100,000 population)
- unintentional injuries (37.5 per 100,000 population)
- stroke (cerebrovascular diseases) (30.2 per 100,000 population) [16]

The leading causes of death in Jefferson County are:
- cancer (malignant neoplasms) (133.7 per 100,000 population)
- heart disease (132.5 per 100,000 population)
- chronic lower respiratory disease (49.9 per 100,000 population)
- unintentional injuries (49.2 per 100,000 population)
- Alzheimer’s disease (35.7 per 100,000 population) [16]

In general, adult high blood pressure rates are:
- 15.5% in Denver Metro Area
- 18.6% in Broomfield County
16.2% in Jefferson County [14]

Adult diabetes rates are:

- 7.9% in Broomfield County
- 7.3% in the Denver Metro Area
- 7.0% in Jefferson County

Rates for diabetes in the Medicaid population:

- 9.3% for Broomfield County
- 9.8% for Jefferson County

Compared to the rest of the state, Jefferson County had higher levels of chronic respiratory diseases such as:

- asthma
- chronic obstructive pulmonary disease

Compared to the rest of the state, Broomfield County had lower levels of chronic respiratory diseases such as:

- asthma
- chronic obstructive pulmonary disease [16]

As stated by the Department of Public Health and Environment, there were many rates that were affected by someone’s age in Broomfield and Jefferson counties that added to other major physical chronic conditions.

Looking at only certain age groups together (the age-adjusted rate) for being in the hospital for congestive heart failure in:

- Denver Metro Area was 701 out of 100,000 people
- Broomfield was 514 out of 100,000 people
- Jefferson was 597 out of 100,000 people [2,14]

Looking at only certain age groups together (the age-adjusted rate) for being in the hospital for heart disease in:

- Broomfield County was 1,836 out of 100,000 people
- Jefferson County was 1,977 out of 100,000 people
• Denver Metro Area was 2,266 out of 100,000 people [2]

Looking at only certain age groups together (the age-adjusted rate) for being in the hospital for stroke in:

• Broomfield County was 219 out of 100,000 people
• Jefferson County was 242 out of 100,000 people
• Denver Metro Area was 248 out of 100,000 people [2]

Looking at only certain age groups together (the age-adjusted rate) for being in the hospital for a heart attack in:

• Broomfield County was 117 out of 100,000 people
• Jefferson County was 140 out of 100,000 people
• Denver Metro Area was 151 out of 100,000 people [2]

IV.e.ii. Please also specifically address other significant behavioral and physical health needs in your service area that align with the populations and project topics of focus within the HTP, such as:

• Top chronic conditions accounting for most utilization (include both physical and behavioral health chronic diseases);
• Physical health conditions that commonly co-occur with mental health diagnoses;
• Related to maternal health, perinatal, and improved birth outcomes; and
• Related to end of life care.

Response (Please seek to limit your response to 750 words or less)

Top chronic conditions that result in the most use of services:

The most common reason for hospital admission at UCH health Broomfield Hospital was for either vaginal delivery or Cesarean section.

For diagnosis that have a physical health chronic disease section, the most common cause of being in the hospital was congestive heart failure.

For Medicaid enrollees admitted to UCH health Broomfield Hospital, the most common reasons in order were:

• vaginal delivery
• septicemia (blood poisoning)
• gastrointestinal disorders
According to the state record set showing people that use services more often than others (high utilizer dataset), 57 people came to the emergency department (ED) 75 times.

The average number of ED visits by each Medicaid high utilizer for UCHealth Broomfield Hospital was 1.3 ED visits each year.

In the state of Colorado, there were 6.3 ED visits each year by high utilizers [9].

The two most common reasons for Medicaid high utilizers to the emergency department at UCHealth Broomfield Hospital were:

- upper respiratory infections
- abdominal pain

Of all Medicaid ED high utilizers:

- 16% had one or more mental health disorders
- 1% had alcohol use disorder
- 5.1% had opioid use disorder

Being seen by a provider after leaving the hospital is linked to lower return rates to the hospital. Medicaid’s RAE region 6 has 51.4% of people coming for a visit to a provider 30 days after leaving the hospital.

The baseline rates in Colorado for Medicaid patients is 53.4%.

Working closely with a primary care provider is vital to not having to be admitted to the hospital. Medicaid’s RAE region 6 ambulatory well visit rates were 29.0%. This is compared to the Medicaid state of Colorado of 29.2%.

As stated by the state, during the state fiscal year of 2018, 15 Medicaid clients who used UCHealth Broomfield Hospital had no home. 7 or 46.6% of those patients were high utilizers.

In evaluating UCHealth Broomfield Hospital’s electronic health record it was found that:

- 70.6% of all homeless hospital users had Medicaid
- 10.6% had Medicare
- 3.7% have commercial insurance

The two most common reasons for hospital admission for people without a home were:

- diabetes complications
- infections
The two most common reasons for emergency department use for people without a home were:

- alcohol-related disorders
- suicide ideation or attempt

Maternal Health, perinatal and improved birth outcomes:

UCHealth Broomfield Hospital does not have a birthing center unit. There were no deliveries performed at UCHC health Broomfield Hospital during the state fiscal year of 2018.

In RAE region 6:

- 57.0% of pregnant women with Medicaid received adequate prenatal care
- 32.5% of pregnant women with Medicaid received appropriate postpartum care

In RAE region 3:

- 58.2% of pregnant women with Medicaid received adequate prenatal care
- 31.2% of pregnant women with Medicaid received appropriate postpartum care

In Colorado:

- 53.4% of pregnant women with Medicaid received adequate prenatal care
- 30.6% of pregnant women with Medicaid received appropriate postpartum care

The most common reason of emergency department use by pregnant women with Medicaid in our hospital service area was:

- a medical visit indicator
- antepartum diagnoses
- threatened abortion [9]

In reviewing our health records for UCHhealth Broomfield Emergency Department, we noted that the most common reason for a pregnancy-related emergency department visit:

- vaginal bleeding in the first trimester
- other complications of pregnancy

Most Medicaid pregnant women who used UCHHealth Broomfield Emergency Department lived in either:

- Arapahoe
• Adams
• Denver
• Jefferson counties

End of Life Care:

Health Statistics Region 16 had 35.8% of their residents that had an advance care directive. In the state of Colorado, the rate is 35.7% of people having an advance care directive [17].

As stated by the state dataset, there were no inpatient hospital visits linked to people on Medicaid getting hospice care.

IV.f.i. Please use the following response space to describe the delivery system’s service capacity within the region and any identified gaps in direct or supporting care services. Assessments should address the state of capacity generally in the community, including community-based social services beyond medical services (i.e. housing and legal assistance, nutrition programs, employment services), as well as information specific to the HTP priority populations and project topics (including services for high utilizers, maternal health and end-of-life services and services for other vulnerable populations, those with behavioral health and substance use disorders, and population health interventions), and should specifically address:

(a) Service availability, access, and perceived gaps generally as well as related to HTP priority populations and project topics, including related to:
   i. Primary care;
   ii. Specialty care;
   iii. Long term care;
   iv. Complex care management;
   v. Care coordination via primary care or other providers;
   vi. Maternal health, perinatal, and improved birth outcomes;
   vii. End of life care;
   viii. Behavioral health;
   ix. Other outpatient services;
   x. Population screenings, outreach, and other population health supports and services; and
   xi. Any other areas of significant capacity gaps.

(b) Qualified staff recruitment and retention concerns, particularly related to the services listed in (a).

(c) Resources and gaps related to care transitions among specific populations or across major service delivery systems, including:

- Available resources and partners that can be leveraged; and
- Perceived gaps.
(d) Social supports related to social factors impacting health outcomes specific to HTP priority populations:

- Available resources and partners that can be leveraged; and
- Perceived gaps.

Take into consideration the following community-based social services-resources:

i. Housing;
ii. Homelessness;
iii. Legal, medical-legal, financial;
iv. Nutrition;
v. Employment and job training; and
vi. Transportation.

Response (Please seek to limit your response to 2,000 words or less)

<table>
<thead>
<tr>
<th>Primary Care:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The resident to primary care ratio is highest in Denver County at 2,340 residents to every 1 doctor.</td>
</tr>
<tr>
<td>• The resident to primary care ratio is lowest in Broomfield County at 980 residents to every 1 doctor.</td>
</tr>
<tr>
<td>• The resident to primary care provider ratio in Colorado is 1 primary care provider for every 1,230 residents.</td>
</tr>
<tr>
<td>• It is not clear what access for Medicaid members is like, since not all practices accept Medicaid members.</td>
</tr>
</tbody>
</table>

For the past year, the top 2 primary care medical homes for UCHealth Broomfield Hospital Medicaid users were:

- Clinica
- Family Medicine Associates Depot Hill Clinics

Partners named gaps in primary care that can serve as medical homes for high-need patients, along with disease management services. Access to primary care was thought of as uneven across the metro area. Care is simpler to find in the cities and less in the outlying areas. Partners mentioned prenatal care as specifically hard to get during non-traditional hours. This creates barriers for many pregnant women that have lower incomes. Midwifery was also listed as a needed service that was limited right now.

Community health centers were found as a great place to get health services for:

- medical needs
- oral care

The Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) is a government-owned business within the Department of Health Care Policy and Financing, www.colorado.gov/hcpf
The Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) is a government-owned business within the Department of Health Care Policy and Financing.

- behavioral needs

Care given there is known as:
- integrated
- culturally appropriate

Specialty Care:

The metro Denver area has limited access to specialty care providers for all people, according to some community partners. However, Medicaid enrollees are especially underserved given the high demand for services. Unique specialty needs include:

- orthopedics
- neurology
- gastroenterology
- dermatology
- oncology
- any surgical care

Geriatric care specialists were also identified as limited in the region.

E-consultations or office visits that take place using the computer, were mentioned as a solution for opening access to specialty care. Partners felt there was a need for Medicaid to cover e-consultations to increase the incentives for providers to offer this service.

Long Term Care:

- 1 Medicaid client that lived in a nursing home used UCHealth Broomfield Hospital for services [9].
- 7 Medicaid clients that get long term care services used UCHealth Broomfield Hospital [9].

Assisted living was described as “available” for Medicaid enrollees. But partners did talk about the challenges in timing for getting patients approved for long term care through Medicaid. There is a 3 to 5 day stay minimum. Also, not all people that have both Medicare-Medicaid are screened for or referred to the long-term services and supports (including PACE) for which they may be eligible. There is a view of limited home health care and nursing home options for Medicaid clients. Also, there is lack of Medicaid care coordination services available to the post-acute care network.

Complex Care Management and Care Coordination via Primary Care or Other Providers:

The Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) is a government-owned business within the Department of Health Care Policy and Financing.
All Medicaid members can get care coordination. This is to include basic and complex care coordination services through the regional accountable entities (RAEs). The RAE may either:

- give direct care coordination services
- subcontract care coordination services to centralized teams or primary care medical homes

Most community partners named gaps in the current complex care management and care coordination services. One partner shared that “poor communication with and among health care organizations” was one of the major issues in the metro region.

Transitions between different sites of care were discussed in general. Members often focused on hospital discharge transitions.

Maternal Health, perinatal and improved outcomes:

UCHealth Broomfield Hospital does not have a birthing center. Because of this they do not have any admissions for pregnancy-related problems. Pregnant patients do use the emergency department, often during the first trimester. There are many OB providers in the Denver Metro area.

Home visitation programs were listed as a service that could:

- promote maternal health
- improve perinatal health
- improve birth outcomes

Many public health agencies and community partners provide these services, but partners felt the supply was limited. The local public health agencies also connect women with Women Infants and Children (WIC) services. Still, connecting pregnant women or new mothers to these services from the hospital can be a challenge. This is related to getting intake forms filled out and passing the details of the new mothers to the community agency.

Partners stated that more emergency training for maternal health care is needed for emergency department providers. They also talked about a need for more robust community-based or outpatient lactation services to support new parents. These services are needed to supplement and continue the support that new parents get during the delivery stay.

End of Life Care:

Partners focused on the role of advance care directives as a way to get end of life care. Just over 1 of 3 residents (35.9%) in the metro area have an advance care directive. Douglas County residents are most likely to have an advance care directive (48.3%) and Denver County residents least likely (28.4%) [17].
Partners shared that hospitals were “doing a good job” of asking patients about having an advance care directive. But they suggested that other providers, including primary care doctors need to stress these messages. Just 40% of people in the metro area report ever having had a serious talk about their advance directive with a health care provider.

Behavioral Health:

Most partners shared that behavioral health services are limited. Still one partner shared that even when more open slots added, they are quickly filled. This suggests there may never be enough services to meet needs.

In averaging the number of people to mental health providers, the Denver Metro area, there were 447 residents per provider.

- Douglas County has the highest number of mental health providers per resident (1000:1).
- Boulder County has the lowest number of mental health providers per resident (150:1).
- In the state of Colorado for every mental health provider there are 300 residents [1].

Still, it is not clear how many behavioral health providers take new patients with Medicaid. More and more practices in the Denver Metro area can provide behavioral and physical health services. This is improving access to behavioral health services.

Many partners talked about workforce gaps for medication-assisted treatment (MAT). According to the SAMSHA, there are over 100 medical providers able to prescribe buprenorphine in the Denver Metro area. This is a medicine used to treat opioid use disorder [19].

Still, it is not clear how many of those providers are actively prescribing this medicine and taking new Medicaid members. Such as, one partner talked about a need for providers who can work with a patient throughout this process, starting with withdrawal. There are not established mentor systems offered right now in the region that connect comfortable, experienced providers with ones new to the process.

Residential and outpatient substance use treatment services were identified as especially limited. This is even more so for:

- people with both behavioral health (mental health and substance use) and physical health concerns
- people who also have developmental or intellectual disabilities

Most partners felt positive about the availability and capacity of the peer workforce.

Other Outpatient Services:

Partners did not specifically name other outpatient services needed that have not already been addressed in other areas.
Population screenings, outreach, and other population health supports and services:

The UCHealth Medical Group takes part in providing population health services and supports. The RAEs also have population health plans that are state approved. The RAE is charged with for giving care coordination to all of its Medicaid members. Gaps include connecting these services and data across many groups. The goal is to not copy services and offer and to make sure there is no break in the care for patients.

Opportunities for partnerships:

HTP Priority Area: High Utilizers & Vulnerable Populations

Data shows that helping those who use services more than others (over-utilizers) use services less takes many methods to make it happen. This includes:

- looking into the social determinants of health, such as food insecurity
- improving access to primary care and care coordination
- looking into behavioral health needs

We have found chances for partnership with key partners looking into 2 of the 3 areas. The RAE has a team of care coordinators that have the job of providing Medicaid member care coordination services. Partnering will help set up talks between the hospital and community services as Medicaid members are discharged. This includes:

- the RAE
- major primary care medical homes
- Federally Qualified Health Centers

HTP Priority Area: Behavioral Health

Both Mental Health Partners and the RAE have interests in joining forces to improve care for patients with behavioral health. There is a need to help join patients with the ambulatory care setting. Several community-wide opioid advocacy groups have talked about interventions and resources in this area.

HTP Priority Area: Social Determinants of Health

Many agencies speak to the social determinants of health, but their resources are limited. There is a wish to know how large the issue of the social determinants of health in a community is and share referral data across different settings.

HTP Priority Area: Maternal Health
Both Obstetricians and the RAE have interests in partnering to make maternal health better. Most, if not all, local public health agencies also have programs that aim for the care of women after giving birth.

Specific resources and gaps are described below.

General resources, gaps, and concerns:

Having social service providers in health system settings was identified as a best practice that could be made larger. People may be “captive audiences” in a hospital emergency department or inpatient bed. While providers may not have all the needed forms to fill out for programs like SNAP or WIC, they can make vital steps in connecting people with services such as:

- meeting someone face-to-face to talk about a program
- getting the right contact information
- starting the process

Also, some people may be worried about having to visit a county office to sign up. One partner felt that hospital social workers are giving patients lists of services, but not necessarily making connections. Some community-based groups and safety net providers also offer services that meet the needs of someone’s culture and first language. Placing these providers into hospital settings is a chance to make sure the patient feels comfortable with the next step of care.

Population-specific resources, gaps, and concerns:

1. Maternal care transitions are vital for parent and child health. Hospitals were named as trusted providers with unique connections and time with parents during the delivery stay. Hospitals can talk straight to new parents during a very sensitive time such as the delivery and hospital stay. This is a chance to:
   a. increase awareness of depression in new mothers
   b. screen for:
      i. depression in new mothers
      ii. substance use
      iii. other social services (such as WIC or SNAP)
   c. behavioral health concerns
   d. promote and support new parents with breastfeeding
   e. talk about:
      i. immunizations
ii. oral health

iii. healthy eating strategies for new parents

2. People that do not have a home were often named as being hard to set up transitions for. This is mainly due to the basic need for housing. Some cases to use may include the Jefferson County Regional Homeless Navigator model. This helps connections across many cares and social needs in the county’s cities. To help people without a home when they are admitted or discharged from a hospital, the Colorado Coalition for the Homeless has also developed partnerships with area hospitals including:

- Denver Health
- SCL
- St. Joseph Hospital
- UCHealth Anschutz

5. Setting up a way for doctors to talk to each other before a patient is moved from hospital to long term care or is admitted from long term care, was named as very important to community partners.

Challenges or Concerns:

Many partners felt that a transition is only a success if services exist when a person is ready to use them. Also, the best case is to have a face-to-face meeting between a patient and a community or external provider or group that is in charge of giving or setting up their care. This should be done before that patient is released from the hospital to make sure there is a successful transition.

Many partners shared that it was a challenge to find a patient that they did not meet while they were in the hospital. They felt that the chance that the patient would get the care and supports needed were low if no meeting took place. The need for going to the emergency room or having to come back to the hospital was higher when they could not connect with the patient early on.

Housing and Homelessness:

Most all community partners listed housing as one of the major gaps in social supports for HTP priority populations. This ranged from safe housing settings, mostly for older adults or the frail elderly as well as children with special health care needs. Permanent supportive housing that includes “wrap-around” services to address people’s needs for:

- medical care
- behavioral health care
- social issues
These supports are also lacking in supply for people with behavioral health and physical health concerns. Some partners mentioned the sober living homes open for use in the metro area and cited a need to grow these services.

The total lack of housing that can be afforded in the metro area, including limited apartment capacity, was named as a dire need for low-income Medicaid enrollees. Partners see people often moving around, which impacts whether and how they access care. This involuntary displacement may also negatively impact behavioral health. People with low-incomes facing lifelong and complex health conditions may have less assets to use for other basics like food and housing as they struggle to cover health care costs.

Those dealing with lack of housing face a tough time when moving from the hospital to back to the community. There are also fears about public health diseases outbreaks such as tuberculosis, hepatitis, and so on.

Medical homeless respite is a funded resource by Medicaid in other states. It has strong proof that it lowers readmissions and inpatient length of stay. In Colorado, this is not a service that is paid for and one that is hard to find in the community.

Legal, Medical/Legal, and Financial Services

The metro area has had many pilot programs for services related to help with:

- legal needs
- medical-legal needs
- financial services

These have been valuable for streamlining care and making health better. These may be especially relevant for people with serious behavioral health conditions or people with dementia. They often don’t have a chosen power of attorney or caregivers who can or are willing to do this when care decisions are needed.

Nutrition

There are some community resources and services available to meet patients’ nutritional needs. This may include groups like Hunger Free Colorado that can enroll patients in SNAP or WIC. Others also mentioned home-delivered meals that may be offered through non-profit groups such as Project Angel Heart or Meals-on-Wheels.

These services are in high demand. They also have limited on what they can do to help. This is true most often for Meals-on-Wheels. Having a way to get healthy, nutritious food is a known need among people dealing with having nowhere to live.

Transportation

One community partner described the Non-Emergency Medical Transportation (NEMT) program as a challenge to use. Such as, a patient may miss an outpatient visit with a specialist due to a
late or missed NEMT pick-up. They are then barred from getting future visits set up and then have to visit an ER. This may be due to either due to worsening conditions or an idea that the only way to get specialty care is through an ER.

Like concerns were cited for people who count on public transportation. It is hard to get to care visits on time. Many partners talked about how few people with low-incomes own cars and the challenges this makes for getting places. Partners talked about the need to support the Regional Transportation District’s fare reductions for low-income households.

Pilot programs that connect people to ride-sharing programs such as Uber or Lyft were mentioned by a few partners. This may be another promising plan, especially for less-mobile groups of people.

Job/Training:

Gaps in the behavioral health workforce to staff residential or treatment programs were mostly identified as:

- licensed clinical social workers
- psychiatrists
- nurses

There are challenges to hire and keep people in the metro Denver area. This is largely from competition from non-profit groups that can offer higher salaries. Some people mentioned that home health employees caring for people with Medicaid might also be enrolled in Medicaid themselves.
IV.f.ii. Please use the table below to identify the hospital’s facilities and services available in the community as the hospital has defined them.

<table>
<thead>
<tr>
<th>Facility Type</th>
<th>Facility Name</th>
<th>Facility Address</th>
<th>Services Offered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Clinic</td>
<td>UCHealth Family Medicine Clinic - Westminster</td>
<td>7403 Church Ranch Boulevard, Suite 107 Westminster, CO 80021</td>
<td>Family Medicine, Flu Shot, Pediatrics, Primary Care</td>
</tr>
<tr>
<td>Hospital</td>
<td>UCHealth Broomfield Hospital</td>
<td>11820 Destination Drive Broomfield, CO 80021</td>
<td>Hospital</td>
</tr>
<tr>
<td>Free-standing</td>
<td>UCHealth Emergency Room - Littleton (Freestanding)</td>
<td>13351 W. Bowles Avenue Littleton, CO 80127</td>
<td>Emergency Room</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>UCHealth Emergency Room - Arvada (Freestanding)</td>
<td>9505 Ralston Road Arvada, CO 80002</td>
<td>Emergency Room</td>
</tr>
<tr>
<td>Emergency</td>
<td>UCHealth Emergency Room - Arvada West</td>
<td>15240 W. 64th Avenue Arvada, CO 80007</td>
<td>Emergency Room</td>
</tr>
<tr>
<td>Outpatient Clinic</td>
<td>UCHealth Primary Care - Broomfield</td>
<td>340 E. First Avenue, Suite 101 Broomfield, CO 80020</td>
<td>Family Medicine, Flu Shot, Primary Care</td>
</tr>
<tr>
<td>Outpatient Clinic</td>
<td>UCHealth Broomfield Medical Center</td>
<td>875 W. 136th Avenue Broomfield, CO 80023</td>
<td>Orthopedics</td>
</tr>
<tr>
<td>Emergency</td>
<td>UCHealth Emergency Care - Broomfield Hospital</td>
<td>11820 Destination Drive Broomfield, CO 80021</td>
<td>Emergency Room</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>UCHealth Urgent Care - Arvada West</td>
<td>15240 W. 64th Avenue Arvada, CO 80007</td>
<td>Urgent Care</td>
</tr>
<tr>
<td>Facility Type</td>
<td>Facility Name</td>
<td>Facility Address</td>
<td>Services Offered</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------------------------------</td>
<td>-----------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Outpatient</td>
<td>UCHealth Primary Care - Arvada West</td>
<td>15240 W. 64th Avenue Arvada, CO 80007</td>
<td>Family Medicine, Primary Care</td>
</tr>
<tr>
<td>Clinic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td>UCHealth Greeley Medical Center</td>
<td>1900 16th Street Greeley, CO 80631</td>
<td>Allergy, Cardiology, Diabetes, Imaging, Primary Care, Pulmonology, Rehabilitation, Surgery</td>
</tr>
<tr>
<td>Clinic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laboratory</td>
<td>UCHealth Laboratory - Broomfield</td>
<td>11820 Destination Drive Broomfield, CO 80021</td>
<td>Laboratory</td>
</tr>
<tr>
<td>Hospital</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

IV.g. Please use the space below to describe the current state of protected health data exchange infrastructure and use inside the defined service area (available RHIOs, participation level amongst area providers, primary data exchange capabilities) as well as an assessment of the hospital's current capabilities regarding data exchanges across network providers, external partners and with RHIOs or regional data exchanges. Please speak specifically to how this impacts care, including care transitions and complex care management.

Response (Please seek to limit your response to 750 words or less)

UCHealth uses EPIC© as its electronic health record platform across all hospitals and ambulatory clinics. Patient’s records are available through Care-Everywhere.

UCHealth is also part of the CORHIO (Colorado Regional Health Information Organization) by sending in electronic health record information. CORHIO has been collecting and storing data since 2009. There are more than 16,000 health information exchange (HIE) users and nearly 5.6 million unique patients in the HIE. The RAE and select primary care practices also get data from CORHIO.

UCHealth hospitals can share data with CORHIO, RAE, and primary care providers. However, CORHIO data cannot be seen in EPIC©. To see data clinicians must log in to the CORHIO website: Once on the site they can see details related to:

- admissions
- discharges
- transfers
- lab results

Current gaps include not being able to:

- see the plan of care that is in use at the current time
quickly find high utilizers without reviewing all visits in the electronic health record, and
find if patients followed up on recommended social services or health care agency referrals if it was with an external health system.
see primary care notes that are not in Care-Everywhere
share data on people with substance use disorder secondary to 42 CFR regulations

Lastly, the RAE has access to the patient’s risk scores and complex care plans for COUP patients (Client Overutilization Program). Still, at this time there is no way to share such care plans and risk stratification scores. Also, it is a challenge to find Medicaid members who get home-based community services (HCBS) as they use the hospital. This is because the care management staff does not have access to such information in a timely fashion.

IV.h. Please use the space below to provide information about any other major topics discussed with community stakeholders and input received.

Response (Please seek to limit your response to 500 words or less)

Bias in Care Delivery:

First choices may drive disparities seen among some of these populations within care delivery settings. These might include:

• limited harm reduction approaches
• lack of trauma-informed care

A much needed step to removing barriers to care involves having programs that can assess and address these barriers throughout the care delivery system, including hospitals.

Health and Social Service Literacy:

Many of the priority groups we are working with have been identified as having low health and social service literacy. This means they are not able to find or use the health services they need for basic care and prevention of illness. This raises their chance of poor health outcomes if they cannot get their needs met.

IV.i. Please use the space below to provide preliminary thinking regarding the likely focus of HTP initiatives, in particular target populations and target community needs.

Response (Please seek to limit your response to 500 words or less)

The Midpoint report shows what the needs are in the community right now. We focused on finding the resources that are in place already. Our next step is to talk about what we found with our partners. We need to find how we can work together in areas that are already in place between hospitals and community based services.
We will be talking about the HTP initiatives focus with our community partners in this next phase of the HTP pre-waiver period.

From the needs assessment and scan of the area, we found that the main items groups ask for as their most important needs are in behavioral health (including mental health and substance abuse) and care transitions.

Resources that will help the Medicaid population to have the structure needed for transitions of care are available. These are found through:

- the RAE
- local public health agencies
- other community agencies

During this process, we found that we have partnership projects now underway with many community organizations. We also found that our hospital care management team works with many of the resources in the community already.

As we set up any screening or transitions programs for this patient group, we will make sure we can find resources in the area as well.
**Planned Future Engagement Activities**

V.a. Please use the space below to outline planned future activities for engaging community organizations and processes that will be completed to inform and develop the hospital’s HTP application. Please describe how organizations that serve and represent the broad interests of the community will continue to be engaged in the planning and development of the hospital’s application, including:

- Prioritizing community needs;
- Selection of target populations;
- Selection of initiatives; and
- Completion of an HTP application that reflects feedback received.

Please note that the word limit is a guideline and you may exceed it as necessary.

Response (Please seek to limit your response to 750 words or less)

| We will keep on working with groups so we can blend activities and make sure outcomes for people are helped. We will see these results in the data collected for the HTP. The community health needs process let us to find the areas we needed to focus on first. These will likely change and grow as we work closely with the state, RAE, and community partners over the next 5 years. The community health needs engagement process showed the areas that people felt were the most important to work on first. We will choose groups of people to focus on and make sure our plans line up with the HTP priorities and areas to be measured. Over the next few months as we pick projects for the Hospital Transformation Program, we will think over:

| stakeholder input |
| feasibility |
| sustainability |
| cost |

Throughout the HTP pre-waiver phase, we have shared our reports for the state with stakeholders and asked for feedback from our partners. We know this record will be made public by the Health Care Policy and Financing Department. We welcome any feedback that you may feel will add value to the final HTP report. The UCHealth contact names and email address are found on the first page of this form. |
Additional Information (Optional)

You may use the space below to provide any additional information about your CHNE process.

Please note that the word limit is a guideline and you may exceed it as necessary.

Response (Please seek to limit your response to 250 words or less)

There is no additional information.
## Appendix I: Community Inventory Tool

Use this tool to inventory clinical, behavioral, and social service resources in the community that could provide timely post-hospital follow-up, monitoring, and assistance. Use this inventory to identify which resources your hospital regularly uses. Also use this inventory as an implicit gap analysis to stimulate a consideration of providers or agencies you may want to more regularly use.

### Clinical and Behavioral Health Providers

<table>
<thead>
<tr>
<th>Provider or Agency</th>
<th>Transitional Care Services [Examples]</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>
| Community health centers, federally qualified health centers | • Mental Health Partners 303-443-8500  
• ARC  
• Centennial Peaks Hospital  
• West Pines  
• ClearView Behavioral Health - Johnstown               | ☒  | ☐ |
| Accountable care organization with care management or transition care | • CCHA  
• Colorado Access                                       | ☒  | ☐ |
| Medicaid managed care organizations                    | • Denver Health Managed Medicaid  
• Rocky Mountain Managed Medicaid                         | ☒  | ☐ |
| Program of All-inclusive Care for the Elder (PACE), Senior Care Options (SCO), Duals Demonstration providers | • PACE: None  
• SCO: None  
• DDP: None                                                | ☐  | ☒ |
| Medicaid health homes                                  | • UCHHealth-CU Medicine Primary Care Clinics:  
  o South Pointe HealthCare  
  o Clinica Westminster                                      | ☒  | ☐ |
| Multiservice behavioral health centers, including behavioral health homes | • Centennial Peaks  
• Mental Health Partners  
• West Pines  
• ClearView Behavioral Health - Johnstown                  | ☒  | ☐ |
| Behavioral health providers                            | • Centennial Peaks  
• Mental Health Partners  
• West Pines  
• ClearView Behavioral Health - Johnstown                  | ☒  | ☐ |
| Substance use disorder treatment providers             | • CEDAR - Boulder  
• Centennial Peaks  
• Mental Health Partners  
• West Pines  
• ClearView Behavioral Health - Johnstown                   | ☒  | ☐ |

---

## Provider or Agency

<table>
<thead>
<tr>
<th>Provider or Agency</th>
<th>Transitional Care Services [Examples]</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>
| Heart failure, chronic obstructive pulmonary disease (COPD), HIV, dialysis, or cancer center clinics | Heart Failure:  
- UCH Health Heart and Vascular - Longmont  
Dialysis Center Clinics:  
- Davita  
- Fresenius  
- Thornton Kidney Center  
- Kidney Center of Lafayette  
Cancer Center Clinics:  
- Rocky Mountain Cancer Center | ☒ | ☐ |
| Pain management or palliative care | TRU Community  
- Halcyon  
- Berkley | ☒ | ☐ |
| Physician/provider home visit service | None | ☐ | ☒ |
| Skilled nursing facilities | Vivage | ☒ | ☐ |
| Home health agencies | Berkley Home Health | ☒ | ☐ |
| Hospice | Tru Community  
- Halcyon | ☒ | ☐ |
| Adult day health | FlatIrongs Adult Day Care | ☒ | ☐ |
| Public health nurses | None | ☐ | ☒ |
| Pharmacies | Walgreens  
- Costco  
- King Soopers | ☒ | ☐ |
| Durable medical equipment | Home Medical Supplies | ☒ | ☐ |
| Other | | ☐ | ☐ |

### Social Services

<table>
<thead>
<tr>
<th>Provider or Agency</th>
<th>Transitional Care Services [Examples]</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult protective services</td>
<td>Broomfield County APS 1-844-264-5437</td>
<td>☒</td>
<td>☐</td>
</tr>
<tr>
<td>Area Agency on Aging (AAA)</td>
<td>Boulder County Agency on Aging: 303-441-3570</td>
<td>☒</td>
<td>☐</td>
</tr>
<tr>
<td>Aging and Disability Resource Centers</td>
<td>Senior Services: 303-464-5526</td>
<td>☒</td>
<td>☐</td>
</tr>
<tr>
<td>Assisted living facilities</td>
<td>Sunrise</td>
<td>☒</td>
<td>☐</td>
</tr>
<tr>
<td>Provider or Agency</td>
<td>Transitional Care Services [Examples]</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>---------------------------------------</td>
<td>-----</td>
<td>----</td>
</tr>
</tbody>
</table>
| Housing with services                    | • Broomfield Housing Authority 303-438-6396  
   • Services:  
     o Broomfield Housing need assessment  
     o Rehab and mobile home repair  
     o Urgent home repair program  
     o Homeownership counseling  
     o Tenant Based Rental Assistance program  
     o Down Payment Assistance | ☒ | ☐ |
| Housing authority or agencies            | • Broomfield Housing Authority 303-438-6396  
   • Services:  
     o Broomfield Housing need assessment  
     o Rehab and mobile home repair  
     o Urgent home repair program  
     o Homeownership counseling  
     o Tenant Based Rental Assistance program  
     o Down Payment Assistance | ☒ | ☐ |
| Legal aid                                | • Colorado Legal Services 970-353-7554 | ☐ | ☒ |
| Faith-based organizations                | • Catholic Charities Hispanic Elderly 303-857-0521  
   • Catholic Charities 970-353-6433 | ☒ | ☐ |
| Transportation                           | • Veyo authorizes transport for Medicaid  
   • Broomfield Easy Ride 303-464-5534  
   • Access-A-Ride - 303-299-6560  
   • Call-n-Ride Broomfield - 303.434.8989  
   • Community Wheels - 303.235.6972  
   • First Transit-Colorado - 855.264.6368  
   • Red Cross - 303.722.7474 | ☒ | ☐ |
| Community corrections system             | • None | ☐ | ☒ |
| Other                                    | | ☐ | ☐ |
**Appendix II: Hospital Care Transitions Activities Inventory Tool**

An inventory of readmission reduction efforts will reveal the administrative, clinical, health information technology, and other organizational assets already in place. Once you know what efforts and assets already exist, you can consider whether they are optimally aligned and coordinated. The inventory will also serve as an implicit gap-analysis of activities or assets not currently in place. You may identify the need to implement new practices as part of this process.

### Readmission Activities/Assets

<table>
<thead>
<tr>
<th>ADMINISTRATIVE ACTIVITIES/ASSETS</th>
<th>For Which Patients?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Specified readmission reduction aim</td>
<td>None</td>
</tr>
<tr>
<td>☒ Executive/board-level support and champion</td>
<td>All patients</td>
</tr>
<tr>
<td>☒ Readmission data analysis (internally derived or externally provided)</td>
<td>All patients</td>
</tr>
<tr>
<td>☒ Monthly readmission rate tracking (internally derived or externally provided)</td>
<td>All patients</td>
</tr>
<tr>
<td>☒ Periodic readmission case reviews and root cause analysis</td>
<td>All patients</td>
</tr>
<tr>
<td>☐ Readmission activity implementation measurement and feedback (PDSA, audits, etc.)</td>
<td>None</td>
</tr>
<tr>
<td>☐ Provider or unit performance measurement with feedback (audit, bonus, feedback, data, etc.)</td>
<td>None</td>
</tr>
<tr>
<td>☐ Other:</td>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HEALTH INFORMATION TECHNOLOGY ASSETS</th>
<th>For Which Patients?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☒ Readmission flag</td>
<td>All Patients</td>
</tr>
<tr>
<td>☒ Automated ID of patients with readmission risk factors/high risk of readmission</td>
<td>All Patients, CHF Patients</td>
</tr>
<tr>
<td>☐ Automated consults for patients with high-risk features (social work, palliative care, etc.)</td>
<td>None</td>
</tr>
<tr>
<td>☒ Automated notification of admission sent to primary care provider</td>
<td>All Patients</td>
</tr>
<tr>
<td>☒ Electronic workflow prompts to support multistep transitional care processes over time</td>
<td>All Patients</td>
</tr>
<tr>
<td>☒ Automated appointment reminders (via phone, email, text, portal, or mail)</td>
<td>All Patients</td>
</tr>
<tr>
<td>☐ Other:</td>
<td>N/A</td>
</tr>
</tbody>
</table>

---

### TRANSITIONAL CARE DELIVERY IMPROVEMENTS

<table>
<thead>
<tr>
<th>Improvement</th>
<th>For Which Patients?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☒ Assess “whole-person” or other clinical readmission risk</td>
<td>All Patients</td>
</tr>
<tr>
<td>☒ Identify the “learner” or care plan partner to include in education and discharge planning</td>
<td>All Patients</td>
</tr>
<tr>
<td>☒ Use clinical pharmacists to enhance medication optimization, education, reconciliation</td>
<td>All Patients</td>
</tr>
<tr>
<td>☒ Use “teach-back” to improve patient/caregiver understanding of information</td>
<td>All Patients</td>
</tr>
<tr>
<td>☒ Schedule follow-up appointments prior to discharge</td>
<td>All Patients</td>
</tr>
<tr>
<td>☒ Conduct warm handoffs to post-acute and/or community “receivers”</td>
<td>All Patients</td>
</tr>
<tr>
<td>☒ Conduct post discharge follow-up calls (for patient satisfaction or follow-up purposes)</td>
<td>All Patients</td>
</tr>
<tr>
<td>☐ Other:</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### CARE MANAGEMENT ASSETS

<table>
<thead>
<tr>
<th>Asset</th>
<th>For Which Patients?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☒ Accountable care organization or other risk-based contract care management</td>
<td>All payors</td>
</tr>
<tr>
<td>☐ Bundled payment episode management</td>
<td>None</td>
</tr>
<tr>
<td>☐ Disease-specific enhanced navigation or care management (heart failure, cancer, HIV, etc.)</td>
<td>None</td>
</tr>
<tr>
<td>☒ High-risk transitional care management (30-day transitional care services)</td>
<td>All Patients</td>
</tr>
<tr>
<td>☐ Other:</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### CROSS-CONTINUUM PROCESS IMPROVEMENT COLLABORATIONS WITH:

<table>
<thead>
<tr>
<th>Collaboration</th>
<th>For Which Patients?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☒ Skilled nursing facilities</td>
<td>All Patients</td>
</tr>
<tr>
<td>☒ Medicaid managed care plans</td>
<td>All Patients</td>
</tr>
<tr>
<td>☒ Community support service agencies</td>
<td>Skilled Nursing Facilities, Home Health Agencies</td>
</tr>
<tr>
<td>☐ Behavioral health providers</td>
<td>None</td>
</tr>
<tr>
<td>☐ Other:</td>
<td>N/A</td>
</tr>
</tbody>
</table>