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 Greeley 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: 6801 W. 29th Street, Greeley, CO 80634
Hospital Executive Name: Steve Schwartz
Hospital Executive Title: Chief Financial Officer
Hospital Executive Address: 2315 E Harmony Rd
Fort Collins, CO 80528-8620
Hospital Executive Phone number: 970-237-7003
Hospital Executive Email Address: Steve.Schwartz@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>United Way of Weld County</td>
<td>Jeannine Truswell/Christi Smith</td>
<td>Consumer Advocates/Advocacy Organizations</td>
<td>Consultation</td>
<td>All</td>
</tr>
<tr>
<td>United Way of Weld County</td>
<td>Lorena Ruiz</td>
<td>Consumer Advocates/Advocacy Organizations</td>
<td>Consultation</td>
<td>Spanish-speaking women of child bearing age in Greeley area</td>
</tr>
<tr>
<td>Northern Colorado Health Alliance</td>
<td>Dr. Mark Wallace</td>
<td>Health Alliance</td>
<td>Partnership</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>RAE2</td>
<td>Dr. Mark Wallace</td>
<td>RAE</td>
<td>Partnership</td>
<td>All</td>
</tr>
<tr>
<td>RETAC</td>
<td>Kerry Borrego</td>
<td>RETACs</td>
<td>Partnership</td>
<td>All</td>
</tr>
<tr>
<td>Co-SLAW working with NCO EDs</td>
<td>Leslie Brooks</td>
<td>Health Alliance</td>
<td>Involvement</td>
<td>Behavioral Health/Vulnerable Populations</td>
</tr>
<tr>
<td>RETAC</td>
<td>Jeff Schanels</td>
<td>RETACs</td>
<td>Partnership</td>
<td>High Risk/Trauma/Chronic Disease/Pediatrics</td>
</tr>
<tr>
<td>Colorado Prevention Alliance</td>
<td>Lauren Ambrozin</td>
<td>Health Alliance</td>
<td>Involvement</td>
<td>Vulnerable Populations (Social Determinants of Health)</td>
</tr>
<tr>
<td>No CO Health Planners &amp; Analysts</td>
<td>Annette Alfano</td>
<td>LPHA</td>
<td>Partnership</td>
<td>Community Health Assessments/Improvement Plans/Behavioral Health/SUD services/Vulnerable Populations (Pregnant Women, WIC eligible)</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>
<tr>
<td>-------------------</td>
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</tr>
<tr>
<td>NCHA</td>
<td>Leslie Brooks</td>
<td>Health Alliance</td>
<td>Involvement</td>
<td>SUD</td>
</tr>
<tr>
<td>Crisis Services NE Colorado</td>
<td>Dean Vincent</td>
<td>Mental Health Center</td>
<td>Partnership</td>
<td>All</td>
</tr>
<tr>
<td>Colorado Health Literacy Coalition</td>
<td>Dana Abbey, Angela Brega</td>
<td>Community organization addressing social determinants of health</td>
<td>Partnership</td>
<td>Social Determinants of Health</td>
</tr>
<tr>
<td>Northern Colorado Health Planners</td>
<td>Cindy Kronauge</td>
<td>Community organization addressing social determinants of health</td>
<td>Consultation</td>
<td>Vulnerable Populations</td>
</tr>
<tr>
<td>Sunrise Community Health Center Leadership Huddle</td>
<td>Dr. Leslie Brooks</td>
<td>FQHC</td>
<td>Partnership</td>
<td>All</td>
</tr>
<tr>
<td>Weld County Department of Public Health and Environment</td>
<td>Cindy Kronauge</td>
<td>LPHA</td>
<td>Involvement</td>
<td>Vulnerable Populations</td>
</tr>
<tr>
<td>Colorado Health &amp; Human Services, Refugee Department</td>
<td>Carol Tumaylle</td>
<td>Community organization addressing social determinants of health</td>
<td>Partnership</td>
<td>Refugee Population</td>
</tr>
<tr>
<td>Northern County Health Alliance</td>
<td>Mark Wallace</td>
<td>Health Alliance</td>
<td>Involvement</td>
<td>SUD/Maternal Health</td>
</tr>
<tr>
<td>Banner Health</td>
<td>Kathryn Perkins, MD</td>
<td>PCMP</td>
<td>Consultation</td>
<td>Behavioral Health</td>
</tr>
</tbody>
</table>

**Agency/Organization Acronyms:** Regional Accountable Entity (RAE); Local Public Health Agency (LPHA); Primary Care Medical Home (PCMH); Community Mental Health Center (CMHC); Social Determinants of Health (SDOH); Emergency Services Transport (EMT); Department of Health and Human Services (DHHS); Colorado Department of Public Health Environment (CDPHE); Regional Health Connector (RHC); Office of Behavioral Health (OBH); Colorado Hospital Association (CHA); Area Agency on Aging (AAA); Adult
The Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) is a government-owned business within the Department of Health Care Policy and Financing.

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 Medicaid challenges and benefits related to transitions from hospitals to nursing homes. Discussed vulnerable populations and cross collaborations. RAE involvement in SNF care. Potential partnerships.</td>
</tr>
<tr>
<td>Consultation</td>
<td>In person</td>
<td>x1</td>
<td>United Way of Weld County</td>
<td>E-mail</td>
<td>Discussed HTP and UWWC focus on new moms, seniors, immigrants, homelessness, and access to services 2-1-1 for vulnerable populations. Discussed specific programs and collaborations that the UWWC has been focused on for community needs.</td>
</tr>
<tr>
<td>Consultation</td>
<td>Phone</td>
<td>x1</td>
<td>United Way of Weld County</td>
<td>E-mail</td>
<td>Discussed community program (PASO Institute - Providers Advancing School Outcomes) supporting Spanish speaking moms and children 0-5 with education based around early childhood development, nutrition, first aid and many other areas.</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>
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</tr>
<tr>
<td>Partnership</td>
<td>In person</td>
<td>x1</td>
<td>Sunrise, United Way, Weld DHS, Banner, Northern Colorado Health Alliance</td>
<td>E-mail</td>
<td>Connected to our pediatric clinic in Greeley for potential referral, introduced Lorena to Dr J. Ryan.</td>
</tr>
<tr>
<td>Involvement</td>
<td>In person</td>
<td>x1</td>
<td>Several stakeholders</td>
<td>Public Announcement</td>
<td>Discuss ED MAT program, discussed HTP, made connections with community organizations and obtained key contacts from OBH.</td>
</tr>
<tr>
<td>Partnership</td>
<td>In person</td>
<td>Monthly</td>
<td>Salud, Sunrise, Northern Colorado Health Partners, Beacon, North Range BH</td>
<td>E-mail</td>
<td>Framing and forming yearly kick off meeting, HTP, RAEP coverage area, Chronic Over Utilization Program (COUP), key indicators for NHP measure accountabilities</td>
</tr>
<tr>
<td>Partnership</td>
<td>Phone</td>
<td>x1</td>
<td>RETAC-UCHealth</td>
<td>E-mail</td>
<td>Discussed HTP and potential RETAC NE roles/projects. Julie will present in person to the RETAC committee on HTP and related documents.</td>
</tr>
<tr>
<td>Involvement</td>
<td>In person</td>
<td>x1</td>
<td>multi-stake holder, RAE, fqhc, ED, health district</td>
<td>E-mail</td>
<td>Education about MAT in EDs and northern Colorado.</td>
</tr>
<tr>
<td>Partnership</td>
<td>In person</td>
<td>Monthly</td>
<td>Larimer, Weld, Washington City present, other members of NERETAC</td>
<td>E-mail</td>
<td>Presented information related to HTP and provided some education related to survey - to be sent via email</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>
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</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; discussed SDOH.</td>
</tr>
<tr>
<td>Partnership</td>
<td>PVH/In person</td>
<td>bimonthly</td>
<td>HDNLC, LCPH, WCPH</td>
<td>E-mail</td>
<td>Discuss shared community priorities and status of county-led health improvement plans.</td>
</tr>
<tr>
<td>Involvement</td>
<td>In person</td>
<td>Quarterly</td>
<td>FMC, NCAP, Jails, FRC,</td>
<td>E-mail</td>
<td>Discuss opatientions for coordinating care in region and with hospital system</td>
</tr>
<tr>
<td>Partnership</td>
<td>Phone</td>
<td>x1</td>
<td>Crisis services and UCHealth</td>
<td>E-mail</td>
<td>Discussed crisis services in NE CO. Presented resources and materials and recommended use of public dashboard.</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>Consultation</td>
<td>Phone</td>
<td>bimonthly</td>
<td>Colorado State university, Health District of Larimer and Weld City, United Way, Poudre Fire Authority, Northern Colorado Health Alliance</td>
<td>E-mail</td>
<td>CHORDS, HTP, Colorado's 2018 Public and Environmental Assessment Survey, Aligning CHA/CHNA efforts, determine how SDH are being documented across all the different agencies- is work being duplicated and how is this information being used?</td>
</tr>
<tr>
<td>Partnership</td>
<td>In person</td>
<td>x1</td>
<td>Sunrise staff - CMO, CEO, CFO</td>
<td>E-mail</td>
<td>Overview of patient populations, how to connect patients with Sunrise resources, components of FQHC, CHNA, and collaboration with HTP/UCHealth</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>
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<td>------------------------------------------------------</td>
</tr>
<tr>
<td>Involvement</td>
<td>Phone</td>
<td>x1</td>
<td>Larimer County, Health District, Kaiser Permanente, NCHD, North Range, Colorado State, Unite Way-Weld, Poudre-Fire, The Family Center-FC, UCHealth</td>
<td>E-mail</td>
<td>CHORDs and HTP discussion</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>Discussed Refugee care and HTP alignment.</td>
</tr>
<tr>
<td>Involvement</td>
<td>In person</td>
<td>x1</td>
<td>UCHhealth, Banner Health, Salud Clinic, North Range, Beacon Health</td>
<td>E-mail</td>
<td>We will continue our work in PAC, HTP, COUP, and other quality improvement activities.</td>
</tr>
<tr>
<td>Consultation</td>
<td>In person</td>
<td>x1</td>
<td>UCHHealth, Banner Health, Greeley P.D., Greeley Schools, Salud Clinic, Greeley Government, North Range</td>
<td>E-mail</td>
<td>Colorado Hospital Transformation Program (CHTP) Focus Group - Weld County</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 Greeley Hospital is not open yet. It will be located in Greeley and likely serve mostly Weld County residents. We worked with many groups in the Weld County area. Since the hospital is not open yet, conversations were fact-finding. Our community partners felt talks about working together and partnerships would be more fruitful once the hospital opens mid-2019.

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)

UCHealth Greeley Hospital is not yet open. It was hard to engage with partners and not have hospital operations and local staff in place. The biggest issue to carrying out the action plan activities was related to the timing 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. However, since several community groups meet every quarter and hospitals were given 3 months to do the Midpoint report activities, this was a challenge.

The second challenge was related to the hospital not being opened. Community stakeholders felt that it would be more productive and provide stronger collaborations to wait until it opened. This way, local leaders who had been to the hospital and community, could come to meetings and engage in partnership-type activities. We have made many contacts with local groups and are ready to make introductions for when the hospital becomes fully staffed and open.

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)

As stated in the Action Plan, UCH ealth Greeley Hospital is not yet open. We wrote an Action Plan to search for community groups that serve residents in the hospital service area. We have been able to meet and develop new relationships with many partners.

We used community partnerships and ongoing community meetings. Also, we met one on one with many stakeholders to ask about the Midpoint report questions.
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. Also, hospital representatives met with many community stakeholders who provided input into how we defined the hospital community service area. We do not have data for UCHealth Greeley Hospital, but suspect that almost all of its users will be Weld County residents. As such, we have focused this report on Weld County characteristics.

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.

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:

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.

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 found many data gaps linked to people with Medicaid. Most public and community organization datasets are holistic and not set apart by payor source. We do not have any data for UCHealth Greeley Hospital, since it is not open. The state gave us data for the entire RAE region 2. But this is not a true picture of data use of the hospital.

There are still major gaps in data gathering because UCHealth Greeley Ranch Hospital is not yet open. We have gotten data about the quality of items (qualitative data) from our community partners. This is a second choice for data that can be counted (quantitative data).

Even with getting data from the Health Care Policy and Financing team and the RAE, neither group was able to give us with demographic data for Medicaid clients and Medicaid high utilizer clients such as:

- income
- employment status
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:

According to the Robert Wood Johnson County Health Rankings 2019 Dataset:

Population

Weld County

- 304,633 residents, comprising 5.4% of overall Colorado's population [1]
- 62,449 rural residents (20.5%)
- 49.6% females
- 50.4% males
- Non-Hispanic White (66.0%)
- African Americans (1.1%)
- Hispanic (29.3%)
- Asian (1.7%)
- Native Hawaiian/Other Pacific Island Native (0.2%)
Weld County [1]

- 80,423 (26.4%) below 18 years of age
- 187,959 (61.7%) between ages 18 and 64 years of age
- 36,251 (11.9%) were 65 years of age and older

Race and Ethnicity

Weld County

- White (66.0%)
- Hispanic (29.3%)
- African Americans (1.1%)
- Asian (1.7%)
- Native Hawaiian/Other Pacific Island Native (0.2%)

Income and Employment Status

State of Colorado [1]

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

Weld County [1]

- 15.5% individuals living at or below the Federal Poverty Level
- unemployment rate (2.7%)
- median household income $68,700
- homeownership rates (72%)

Disability Status

Weld County

- North Weld County had lower rates of individuals with a disability (9.4%-11.6%) when compared to South Weld County (11.7%-14.8%) [1].
According to the Migration Policy Institute [3]:

Immigration Status

Weld County

- 16,900 foreign-born immigrants were living in Weld County
- 173 refugees arrived in Weld County in 2017
- refugee settlement areas included Greeley (13%)

Housing

Weld County

- homeownership rates (72%)

Education and Health Literacy Status

State of Colorado

- high school graduation rates in the state of Colorado (79%)

Weld County

- high school graduation rates (82%)
  - The northeast Weld County health literacy rate was within the second highest state quartile, while the remainder of Weld County was within the two lowest state quartiles.
- In 2019, there were 4% of residents with an English proficiency deficiency [1]

Primary Languages Spoken

Weld County

- In 2019, there were 4% of residents with an English proficiency

Unique characteristics that impact the health of Weld County residents:

- Most common ways to enable a healthier place to live, work and play as said by people of Weld County:
  - Transportation (329 responses; 25.3%)
need more bike lanes and sidewalks for people walking

Roads, trails and sidewalk needed:

- maintenance
- improvements
- construction

Government Services and Community Programming (196 responses; 15.1%)

Environment (129 responses; 9.9%)

Parks, Recreation and Open Spaces (105 responses; 8.1%)

need more parks and recreation services

better access

keeping Open Spaces

Nearly half of Weld County residents (42.3%) do not feel they have access at all to:

- parks
- trails
- recreation centers

Healthcare (101 responses; 7.8%)

There are 3 regions of Weld County:

- North
- Southwest
- Southeast

These roughly match to the political lines of the county elected officials.

The fourth region agrees with the city lines of Greeley and Evans [5]

According to the Weld County Community Health Survey Data Book:

- 74% of Weld County residents chose Weld County as the preferred location of their regular health care provider
- 72.7% of Weld County residents did not delay or go without care in the past year [5]
Medicaid Population:

According to HCPF’s Weld County Fact Sheet, in 2017:

- 70,240 Health First Colorado Members
  - 18,698 (26.6%) were Affordable Care Act (ACA) expansion adults
  - 33,972 (48.4) were children [6]

UCHealth Greeley Hospital is not yet open to the public. These facts reflect the Hospital Transformation Profile Regional Accountable Entity (RAE) 2. Please note that this is likely not what UCHealth Greeley Hospital’s patient use profile will look like [7].

RAE 2

- 39,638 unique Medicaid citizens who were assigned to RAE 2 and used a hospital in the past year [7].

Age

- 13,034 (32.9%) were below 18 years of age
- 24,277 (61.2%) were between 18-64 years old
- 2,327 (5.9%) were 65 years of age and older

Gender

- 60.9% female
- 39.1% male (39.1%) [7]

Race

- 13,183 (33.3%) Non-Hispanic Whites
- 14,393 (36.3%) multiple races
- 658 (1.7%) African American
- 7,351 (18.5%) Latino/Hispanic
- 35 (0.1%) Native Hawaiian/Other Pacific Islander [7]

Disabilities

- 4,458 (11.2%) had permanent disabilities
Immigration Status

- 1,984 (5.0%) Legal permanent residents [7]
- 399 (1.0%) refugees
- 752 homeless individuals

Primary Language Spoken

- less than 6.1% spoke languages other than English
- The secondary language field had 9.5% missing responses. So may have not have all the facts.

Housing

- 752 people without home covered by Medicaid [7].

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)
In the state of Colorado, 16.7% of all mothers with Medicaid had insurance 1 month before pregnancy [10].

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:
  - diabetes
  - mental health
  - substance use disorder
  - be more likely to use the emergency department

Individuals with behavioral health disorders (compared to someone with behavioral health disorders that have private insurance):

- Medicaid is the single largest payer in the U.S. for behavioral health disorders including:
  - mental health
  - substance use disorders [17]
- 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.
• have trouble getting and keeping jobs
• 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.
  • 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
• 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
  • compared to the U.S. with 23% [8]

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 [8].

When compared with those without disabilities, adults in Colorado with disabilities were also more likely to:
• have high blood pressure
• smoke
• be obese [8]
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)

<table>
<thead>
<tr>
<th>Serious Behavioral Health Disorders:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age-adjusted death rate due to suicide</td>
</tr>
<tr>
<td>Weld County</td>
</tr>
<tr>
<td>• 15.08 for each 100,000 people</td>
</tr>
<tr>
<td>State of Colorado</td>
</tr>
<tr>
<td>• 19.5 for each 100,000 people [9,10]</td>
</tr>
</tbody>
</table>

There were fewer numbers of firearm deaths in Weld County. Also, 2 deaths due to murder for each 100,000 people happened. This is compared to the state of Colorado at 4 deaths for each 100,000 people) [1].

UCHealth Greeley Hospital has not opened its doors as of this time. So there is no data about the use of the hospital to know how diseases affect use. The state provided only regional accountable entity data. We can suppose things from this dataset, but several essential disease characteristics, including serious mental health disorders, were missing from this dataset as well.

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

- Larimer County
  - 31% of alcohol-impaired driving deaths
  - 21% excessive drinking rates [1]
  - 13% rate of smoking

- Weld County
  - 30% of alcohol-impaired driving deaths
  - 21% excessive drinking rates
  - 16% rate of smoking
State of Colorado

- 34% of alcohol-impaired driving deaths [1]
- 21% excessive drinking rates
- 16% rate of smoking [3]

Weld County

- The total number of prescriptions of controlled substances dispensed increased from 374,298 in 2014 to 395,311 in 2016.
  - This was more than one prescription a year for every Weld County resident [12].
- had one of the lower rates of opioid-related ED visits across the state [12]
- 11.2 people for each 100,000 were seen and treated in an ER due to prescription opioids
- 15.2 people for each 100,000 in Colorado were seen and treated in an ER due to prescription opioids [12].
- 183 admitted to the hospital in Weld County related to prescription opioids
- 22.6 people for each 100,000 residents were admitted to the hospital for prescription opioid-related issues.
- 18.6 people for each 100,000 residents were admitted to the hospital for prescription opioid-related issues in Colorado [12].
- Weld County had the 17th highest opioid-related death rate (6 people for each 100,000) in the state of Colorado [12].
- 56.3% of Weld County residents strongly agree that treatment can help people with mental illness lead healthy lives [18].
- Surprisingly, only 13.3% of residents in Weld County strongly agree that people were generally caring and sympathetic to people with mental illness [18].

Other significant physical chronic conditions:

The leading causes of death in Weld County were:
- malignant neoplasms (147.7 for each 100,000 population)
- heart disease (131.1 for each 100,000 population)
- chronic lower respiratory disease (49.1 for each 100,000 population)
The Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) is a government-owned business within the Department of Health Care Policy and Financing.

- Unintentional injuries (44.1 for each 100,000 population)
- Cerebrovascular diseases (33.5 for each 100,000 population) [15]

In Weld County, people with high blood pressure had:
- Medicare insurance 41.0% of the time
- Medicaid 8.7% of the time
- Commercial insurance 7.0% of the time [13]

Diabetes
- Higher rates of type 1 and type 2 diabetes as compared to the State
  - Type 1 is an auto-immune condition and thought to be genetic
  - Type II diabetes is most often linked to obesity

Hemoglobin A1C
- Doctors order a blood test named Hemoglobin A1C. This is as a quality metric used for the management of diabetes.
  - 81.3% residents with diabetes get their hemoglobin A1C test on a set schedule.
  - 75.4% of people across the state of Colorado get theirs checked.
  - 80.2% of people with Medicaid residents have their A1C checked
  - 85.8% of people with commercial plans have their A1C checked [13]

Weld County
- Lower rates of breast and lung cancer compared to residents in Colorado [13]
  - 67% breast cancer screening rates for all payers
  - 79% breast cancer screening rates for the state of Colorado
  - Those with Medicaid insurance had the lowest breast cancer screening rates at 33% [13].

Weld County had lower levels of chronic respiratory diseases as the state of Colorado. These include:
  - Asthma
I.V.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 accounting for most utilization (include both physical and behavioral health chronic diseases):

**Weld County**

- 60.5% of people with 1 or more chronic diseases

**Colorado**

- 62.7% of people with 1 or more chronic diseases [10]

The 3 leading causes of years of potential life lost before age 75 in Weld County were:

- Lung disease
- Alzheimer’s dementia
- Parkinson’s dementia [11]

**Quality of Life markers**

**Weld County**

- 3 days of poor physical [1]
- 3 days of poor mental health

**The state of Colorado**

- 3.4 days of poor physical
- 3.6 days of poor mental health [3]

According to the state, those with chronic kidney disease and bone disease accounted for high hospital use rates and overall costs. Those with chronic kidney disease appeared to also have
congestive heart failure. Chronic obstructive pulmonary disease was highly linked with alcohol use disorder.

According to the state’s high utilizer dataset for RAE 2:

- 3,451 emergency department (ED) high utilizers
  - which resulted in 13,083 ED visits

A high utilizer of services is defined as 4 or more visits in a year.

The average number of ED visits by a Medicaid high utilizer for RAE 2 was 3.79 ED visits a year.

- This was a much lower as compared to 6.3 ED visits a year in the state of Colorado [7].

According to RAE region 2:

More than 90% of Client Overutilization Program (COUP) Medicaid members were linked to a Weld County primary care medical home. Many of these members were seen at Sunrise Community Center.

About 20 to 80% of COUP members were associated with a community mental health center and were receiving treatment for a behavioral health disorder.

RAE 2 shared its Potentially Avoidable Costs (PAC) with hospitals. This was to help us further understand which chronic diseases were driving these costs.

62% of all Northeast Health Partners potentially avoidable costs were related to chronic diseases.

The top PAC episodes of care were for:

- substance use disorders
  - 227 Medicaid members accounted for $1,978,848.00 in inpatient potentially avoidable costs.

- maternal-fetal care
  - 269 Medicaid members accounted for $1,772,016.00 in inpatient potentially avoidable costs.

We do not have hospital utilization data to comment on real-world reasons for health care utilization.

Physical health conditions that commonly co-occur with mental health diagnoses:

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

- 18.9% rates of depression
- 15.9% rates of anxiety

The state of Colorado
- 18.4% rates of depression
- 16.4% rates of anxiety [10]

According to the state dataset, members who were worked with community mental health centers for services and also used the hospital most often were admitted for:
- sepsis
- overdose
- pulmonary edema
- chronic obstructive pulmonary disease

Although it doesn’t happen often, being admitted to the hospital for trauma, was costly. This was also the second costliest reason for being admitted to the hospital for those with behavioral health disorders.

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

There were 4,244 total live births in Weld County [14].

According to the RAE:
- 57% of pregnant women with Medicaid had adequate prenatal care
- 31.2% of pregnant women with Medicaid had appropriate postpartum care

In the State of Colorado
- 53.4% of pregnant women with Medicaid had adequate prenatal care
- 30.6% of pregnant women with Medicaid had appropriate postpartum care

According to RAE 2, maternal-fetal care rates were the second highest in potential savings.

We were not able to review the episodes seen with costs that may have been avoided. But it seems that high rates of Cesarean sections might be the leading reason for inpatient PACs.

Colorado ranked 29th in the U.S. for maternal mortality rates.
Over 60% of all maternal death happened during the postpartum period.

- behavioral health had been named as the leading cause of maternal death [16]

Other populations of need and end of life care:

According to the state dataset, Medicaid members getting hospice services most often were in the hospital for:

- sepsis
- heart failure
- chronic obstructive pulmonary disease

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>Available Resource/Partners that can be leveraged:</td>
</tr>
<tr>
<td>Weld County has a shortage of primary care providers.</td>
</tr>
<tr>
<td>• For each 1 primary care provider, there were 2,030 residents.</td>
</tr>
<tr>
<td>• In the state of Colorado there were 1,230 residents for each 1 primary care provider.</td>
</tr>
<tr>
<td>According to Northeast Health Partners:</td>
</tr>
<tr>
<td>33 primary care practices had attributed Medicaid members in RAE region 2.</td>
</tr>
<tr>
<td>Most primary care attribution comes from Weld County, where 15 of the 33 primary care practices see Medicaid members.</td>
</tr>
<tr>
<td>As of February 2019, most Medicaid members were seen at Sunrise Community Health Clinic and was followed by Salud Clinic. Both are named as Federally Qualified Health Centers. The third largest Medicaid primary care provider in the area was North Colorado Family Center, Banner in Weld County.</td>
</tr>
<tr>
<td>Perceived gap:</td>
</tr>
<tr>
<td>It is not clear what the Medicaid resident to provider ratios entail.</td>
</tr>
<tr>
<td>There were 21,422 (24.4%) Medicaid member well visits for RAE 2 members. It is possible that this low number was due to coding practices.</td>
</tr>
<tr>
<td>Also, we do not have details on how many Medicaid members work with a primary care medical home each year for any service.</td>
</tr>
</tbody>
</table>
It is a challenge to get a visit set up for a patient leaving the hospital, either from the ED or inpatient during after-hours. Schedulers are not available for the most part.

Also, many Medicaid members do not know their primary care assigned medical home. Helping them navigate through many care coordination groups is challenging for hospital staff. These groups include:

- NHCA
- Salud
- Peak Vista

Specialty Care:

Available Resource/Partners that can be used:

Both counties have several specialists. E-consults and pilot programs using telehealth will likely help people get specialty care. Also, programs like ECHO, which promote primary care education in specialized disorders will also help decrease potentially avoidable specialty care utilization.

Perceived gap:

The community voiced needs in medical areas of:

- endocrinology
- orthopedics
- neurology specialties

Many mentioned needs related to addressing social determinants of health including:

- transportation
- food insecurity
- DME access

These are items that care coordinators could support patients with when setting up visits with specialty providers. Medicaid does not require pre-authorization or referrals for specialty care use. Often, this means patients self-refer, but specialty providers do not have anyone to communicate next steps or send items that require primary care follow up at this time.

Long Term Care:

Available Resource/Partners that can be leveraged:
<table>
<thead>
<tr>
<th>Perceived gap:</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
<tr>
<td>Some partners described long-term care services as limited and of poor quality, especially in home health. One reason quality of care might be low in long-term care services might be the low wages paid to staff may impact:</td>
</tr>
<tr>
<td>• turnover of staff</td>
</tr>
<tr>
<td>• lack of employee engagement</td>
</tr>
<tr>
<td>Also, home health agencies mentioned that several Medicaid members do not work with a primary care provider. This limits the ability for the agency to provide care to patients, given they must have the PCP’s signature on orders.</td>
</tr>
<tr>
<td>Most long-term care facilities do not accept Medicaid patients with behavioral health conditions or aggressive behavior. These patients find themselves staying in the hospital for weeks to months before finding long-term placement because there are no options nearby.</td>
</tr>
<tr>
<td>Also, patients who get LTSS may lose their benefits if they go into the hospital. Or if not, they tend not to fill out the needed renewal paperwork. This leads to our most vulnerable patients being left without much-needed services. Most RAE quality or provider team meetings do not include members of the LTSS community, yet this community cares for the most complex Medicaid patient population.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Complex Care Management and Care Coordination:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Available Resource/Partners that can be leveraged:</td>
</tr>
<tr>
<td>According to RAE region 2, 79% of all care coordination service accountability comes from the North Colorado Health Alliance (NCHA). Salud and Peak Vista clinics also provide usual and complex care coordination for its members.</td>
</tr>
<tr>
<td>Perceived gap:</td>
</tr>
<tr>
<td>There are many groups providing care coordination services to patients. It would be helpful to streamline the process and have a one-way referral system between hospitals and centralized care coordination agency.</td>
</tr>
<tr>
<td>Setting up a visit for someone after hours is hard. This is mostly true for people with Medicaid that are at the ED. The community citizens mentioned that it is best to provide service to patients at the time they are getting care. But the ED is open 24 hours a day, 7 days a week, and most clinics are open only during business hours. The data shows that when patients leave...</td>
</tr>
</tbody>
</table>
the ED or inpatient setting with a visit set up, they are more likely to show up. This is compared to when the patient has to set up the visit by themselves after discharge.

Maternal Health, perinatal and improved outcomes:

Available Resource/Partners that can be leveraged:

Home visit programs were often named as a service that could:

• promote maternal health
• improve perinatal outcomes
• improve birth outcomes

The RAE wide population health efforts in caring for pregnant women were viewed as a strong effort to get community partners to:

• develop better care coordination
• align services
• have better use of resources

Most primary care clinics are available to conduct postpartum follow up visits.

Perceived gap:

The ability to enroll pregnant women while in the hospital in Women, Infants, and Children (WIC) services along with other needed services is ideal. There are no resource lists available to inpatient care coordinators that shows which mental health providers take new Medicaid members who are in their perinatal period. It can be confusing to know if a patient needs to follow up after having the baby with the primary care provider or the OB provider.

End of Life Care:

Available Resource/Partners that can be leveraged:

Many hospitals have pathways or workflows to ask patients about end of life options. It is not clear if Medicaid members have lower rates of advance care directives compared to individuals covered by other payers. Centralized IT platforms may help share this type of document as members use many facilities.

Perceived gap:

Some patients may not have an advance care directive in place, or one that is easily viewed by EMS as the patient is being taken to the hospital. Telephone and emergency contact information is often outdated in the Medicaid demographics. So, there is a way to work with
HIE and others to share the most up-to-date contact information. They may be able to share advanced directives and desired wishes as well.

Behavioral Health:

Available Resource/Partners that can be leveraged:

According to RAE 2’s performance, 34.7% of all Medicaid members were engaged in substance use disorder treatment. The goal is for the RAE to work with at least 51.5% of Medicaid members to get substance use disorder treatment.

The RAE has a network of behavioral health providers that take new Medicaid members. Patients that come to the hospital for SUD often are vulnerable populations such as having no home. These patients do not have a phone number nor an address to provide. It is challenging to ensure good continuity of care for these patient populations.

Perceived gap:

Hospitals are not aware of the provider network list that shows who accepts new Medicaid members and specialties. Areas of need include:

- maternal health
- serious behavioral health

Also, connecting patients from the hospital to outpatient treatment is often more successful when a visit is set up before leaving the hospital. But most places do not have an open visit time within 7 days of leaving the ED or hospital. Hospitals are also not aware of all providers that can give integrated physical and behavioral health care.

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 participates in providing population health services and supports. Both the Colorado Community Health Partners and North Colorado Health Alliance provide:

- population health services
- review data
- enhance alignment of efforts for Weld County

State approved population health plans are found at:

- both RAES
• Colorado Community Health Partners and
• Northeast Health Partners

It is the role of the RAE to provide care coordination to all of its Medicaid attributed members.

Opportunities for partnerships:

HTP Priority Area: High Utilizers & Vulnerable Populations

Evidence shows that it takes an approach from many areas to help meet the needs of a high user of services. Approaches include:

• addressing social determinants of health
  • food insecurity
• improving access to primary care and care coordination
• addressing behavioral health needs

We have found ways to partner with key groups to address 2 of the 3 areas locally.

The RAE has a team of care coordinators that are responsible for providing care coordination services for Medicaid members. Working with the RAE, and the major primary care medical homes or Federally Qualified Health Centers upon the opening of the hospital will ease communications as Medicaid members move from the hospital to their communities.

The North Colorado Health Alliance team, which serves the 3 main primary care clinics in the Weld County area, could also provide a central location to allow for hospital-clinic partnerships.

HTP Priority Area: Behavioral Health & SUD

Both Mental Health Partners and the RAE want to

• partner to improve care for patients with behavioral health
• help link patients to the ambulatory care setting

The CO-SLAW team is also interested in partnering to provide transitions of care for those initiated on medication-assisted treatment.

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
Northeast Health Partners is interested in improving care for new moms with Medicaid. This needs to be done by making care better for women before and after giving birth. Rates of substance use disorder and mental in this group is high. There are chances for different groups to work together in this area.

Housing/Homelessness:

Nearly all community partners named housing as one of the major gaps in social supports for HTP priority people.

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.

Employment and job training:

No employment or job training issues were named during community stakeholder meetings. In general, the behavioral health workforce identified gaps to finding staff for residential or treatment programs in the areas of:

- licensed clinical social workers
- psychiatrists
- nurses

Legal, Medical/Legal, and Financial Services:

There are 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:

Not having a ride or a way to get to care is a big issue in Weld County. People are not able to get to health care visits or social benefits. Rides to health visits are paid for by Medicaid. But these must be set up ahead of time. Non-emergency transportation services are often late or don’t come at all. Patients that have a need to be seen right away but don’t have a way to get to the visit often end up in the emergency room. 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.
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>Laboratory</td>
<td>UCH Health Breast Diagnostic Center - Greeley</td>
<td>1900 16th Street Greeley, CO 80631</td>
<td>Imaging, Mammography</td>
</tr>
<tr>
<td>Outpatient Clinic</td>
<td>UCH Health Heart and Vascular Clinic - Greeley</td>
<td>1900 16th Street Greeley, CO 80631</td>
<td>Cardiology, Heart and Vascular</td>
</tr>
<tr>
<td>Outpatient Clinic</td>
<td>UCH Health Diabetes and Medical Nutrition Therapy - Greeley</td>
<td>1900 16th Street Greeley, CO 80631</td>
<td>Diabetes, Endocrinology</td>
</tr>
<tr>
<td>Outpatient Clinic</td>
<td>UCH Health Diabetes and Endocrinology Clinic - Greeley</td>
<td>1900 16th Street Greeley, CO 80631</td>
<td>Diabetes, Endocrinology</td>
</tr>
<tr>
<td>Laboratory</td>
<td>UCH Health Laboratory - Greeley</td>
<td>1900 16th Street Greeley, CO 80631</td>
<td>Laboratory, Pathology</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>UCH Health Urgent Care - Greeley</td>
<td>1900 16th Street Greeley, CO 80631</td>
<td>Urgent Care</td>
</tr>
<tr>
<td>Outpatient Clinic</td>
<td>UCH Health Occupational Medicine Clinic - Greeley</td>
<td>1900 16th Street Greeley, CO 80631</td>
<td>Occupational Medicine</td>
</tr>
<tr>
<td>Outpatient Clinic</td>
<td>UCH Health Audiology Clinic - Greeley</td>
<td>5881 West 16th Street Greeley, CO 80634</td>
<td>Audiology</td>
</tr>
<tr>
<td>Outpatient Clinic</td>
<td>UCH Health Heart and Vascular Clinic - Sterling</td>
<td>620 Iris Drive Sterling, CO 80751</td>
<td>Cardiology, Heart and Vascular</td>
</tr>
<tr>
<td>Outpatient Clinic</td>
<td>UCH Health Dermatology Clinic - Greeley</td>
<td>5881 W. 16th Street Greeley, CO 80634</td>
<td>Dermatology</td>
</tr>
<tr>
<td>Outpatient Clinic</td>
<td>UCH Health Ear, Nose and Throat Clinic - Greeley</td>
<td>5881 West 16th Street Greeley, CO 80634</td>
<td>Ear Nose and Throat</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>UCH Health Greeley Emergency and Surgery Center</td>
<td>6906 10th Street Greeley, CO 80634</td>
<td>Emergency Room, Imaging, Laboratory, Surgery</td>
</tr>
<tr>
<td>Outpatient Clinic</td>
<td>UCH Health Orthopedics Clinic - Greeley</td>
<td>5881 W. 16th Street Greeley, CO 80634</td>
<td>Orthopedics, Sports Medicine</td>
</tr>
<tr>
<td>Outpatient Clinic</td>
<td>UCH Health Physical Therapy and Rehabilitation Clinic - West Greeley</td>
<td>5881 W. 16th Street Greeley, CO 80634</td>
<td>Physical Therapy, Rehabilitation</td>
</tr>
<tr>
<td>Outpatient Clinic</td>
<td>UCH Health Physical Therapy and Rehabilitation Clinic - Windsor</td>
<td>1870 Marina Drive Windsor, CO 80550</td>
<td>Physical Therapy, Rehabilitation</td>
</tr>
<tr>
<td>Outpatient Clinic</td>
<td>UCH Health Pediatric Care Clinic - Greeley</td>
<td>5881 W. 16th Street Greeley, CO 80634</td>
<td>Flu Shot, Pediatrics</td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>Facility Type</th>
<th>Facility Name</th>
<th>Facility Address</th>
<th>Services Offered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td>UHealth Medical Fitness - Windsor</td>
<td>1870 Marina Drive Windsor, CO 80550</td>
<td>Gym</td>
</tr>
<tr>
<td>Outpatient Clinic</td>
<td>UHealth Urology Clinic - Greeley</td>
<td>5881 W. 16th Street Greeley, CO 80634</td>
<td>Kidney and Bladder,Urology</td>
</tr>
<tr>
<td>Outpatient Clinic</td>
<td>UHealth Family Medicine Clinic - Windsor</td>
<td>1455 Main Street Windsor, CO 80550</td>
<td>Family Medicine, Flu Shot, Primary Care</td>
</tr>
<tr>
<td>Outpatient Clinic</td>
<td>UHealth Women’s Care Clinic - Greeley</td>
<td>1715 61st Avenue Greeley, CO 80634</td>
<td>Obstetrics/Gynecology, Pregnancy Care, Women’s Health</td>
</tr>
<tr>
<td>Outpatient Clinic</td>
<td>UHealth Cancer Care and Hematology Clinic - Greeley</td>
<td>1675 18th Avenue Greeley, CO 80631</td>
<td>Blood Disorders, Cancer Treatment, Hematology, Oncology</td>
</tr>
<tr>
<td>Surgical Clinic</td>
<td>UHealth Surgical Clinic - Greeley</td>
<td>1900 16th Street Greeley, CO 80631</td>
<td>Surgery</td>
</tr>
<tr>
<td>Outpatient Clinic</td>
<td>UHealth Nephrology Clinic - Greeley</td>
<td>1900 16th Street Greeley, CO 80631</td>
<td>Kidney and Bladder</td>
</tr>
<tr>
<td>Outpatient Clinic</td>
<td>UHealth Neurology Clinic - Greeley</td>
<td>1900 16th Street Greeley, CO 80631</td>
<td>Imaging, Neurology</td>
</tr>
<tr>
<td>Outpatient Clinic</td>
<td>UHealth Family Medicine Clinic - Greeley</td>
<td>5881 W. 16th Street Greeley, CO 80634</td>
<td>Family Medicine, Flu Shot, Pediatrics, Primary Care, Seniors’ Health</td>
</tr>
<tr>
<td>Outpatient Clinic</td>
<td>UHealth Rheumatology Clinic - Greeley</td>
<td>1675 18th Avenue Greeley, CO 80631</td>
<td>Rheumatology</td>
</tr>
<tr>
<td>Radiology</td>
<td>UHealth Radiology - Greeley</td>
<td>1900 16th Street Greeley, CO 80631</td>
<td>Imaging, Radiology</td>
</tr>
<tr>
<td>Radiology</td>
<td>UHealth Radiology - Windsor</td>
<td>1455 Main Street Windsor, CO 80550</td>
<td>Imaging, Radiology</td>
</tr>
<tr>
<td>Outpatient Clinic</td>
<td>UHealth Internal Medicine Clinic - Greeley</td>
<td>1900 16th Street Greeley, CO 80631</td>
<td>Flu Shot, Primary Care</td>
</tr>
<tr>
<td>Laboratory</td>
<td>UHealth Laboratory - Windsor</td>
<td>1455 Main Street Windsor, CO 80550</td>
<td>Laboratory, Pathology</td>
</tr>
<tr>
<td>Laboratory</td>
<td>UHealth Laboratory - West Greeley</td>
<td>5881 W. 16th Street Greeley, CO 80634</td>
<td>Laboratory, Pathology</td>
</tr>
<tr>
<td>Outpatient Clinic</td>
<td>UHealth Pulmonology Clinic - Greeley</td>
<td>1900 16th Street Greeley, CO 80631</td>
<td>Pulmonology, Respiratory</td>
</tr>
<tr>
<td>Hospital</td>
<td>UHealth Greeley Hospital</td>
<td>6767 W. 29th Street Greeley, CO 80634</td>
<td>Hospital</td>
</tr>
<tr>
<td>Outpatient Clinic</td>
<td>UHealth Women’s Care Clinic - Windsor</td>
<td>1455 Main Street Windsor, CO 80550</td>
<td>Obstetrics/Gynecology, Women’s Health</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.
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)

There were no other major topics known other than the ones talked about in the application.
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)

We do not have 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>
<tbody>
<tr>
<td>Community health centers, federally qualified health centers</td>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Accountable care organization with care management or transition care</td>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Medicaid managed care organizations</td>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Program of All-inclusive Care for the Elder (PACE), Senior Care Options (SCO), Duals Demonstration providers</td>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Medicaid health homes</td>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Multiservice behavioral health centers, including behavioral health homes</td>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Behavioral health providers</td>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Substance use disorder treatment providers</td>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Heart failure, chronic obstructive pulmonary disease (COPD), HIV, dialysis, or cancer center clinics</td>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Pain management or palliative care</td>
<td></td>
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<td>☐</td>
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<tr>
<td>Physician/provider home visit service</td>
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<tr>
<td>Skilled nursing facilities</td>
<td></td>
<td>☐</td>
<td>☐</td>
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</table>

---

<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>Home health agencies</td>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Hospice</td>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Adult day health</td>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Public health nurses</td>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Pharmacies</td>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<p>| Social Services                     |                                      |     |    |</p>
<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>
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<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Area Agency on Aging (AAA)</td>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Aging and Disability Resource Centers</td>
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<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Assisted living facilities</td>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Housing with services</td>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Housing authority or agencies</td>
<td></td>
<td>☐</td>
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</tr>
<tr>
<td>Legal aid</td>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Faith-based organizations</td>
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<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Transportation</td>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Community corrections system</td>
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<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
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, hospital is not open yet</td>
</tr>
<tr>
<td>Executive/board-level support and champion</td>
<td>None, hospital is not open yet</td>
</tr>
<tr>
<td>Readmission data analysis (internally derived or externally provided)</td>
<td>None, hospital is not open yet</td>
</tr>
<tr>
<td>Monthly readmission rate tracking (internally derived or externally provided)</td>
<td>None, hospital is not open yet</td>
</tr>
<tr>
<td>Periodic readmission case reviews and root cause analysis</td>
<td>None, hospital is not open yet</td>
</tr>
<tr>
<td>Readmission activity implementation measurement and feedback (PDSA, audits, etc.)</td>
<td>None, hospital is not open yet</td>
</tr>
<tr>
<td>Provider or unit performance measurement with feedback (audit, bonus, feedback, data, etc.)</td>
<td>None, hospital is not open yet</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>None, hospital is not open yet</td>
</tr>
<tr>
<td>Automated ID of patients with readmission risk factors/high risk of readmission</td>
<td>None, hospital is not open yet</td>
</tr>
<tr>
<td>Automated consults for patients with high-risk features (social work, palliative care, etc.)</td>
<td>None, hospital is not open yet</td>
</tr>
<tr>
<td>Automated notification of admission sent to primary care provider</td>
<td>None, hospital is not open yet</td>
</tr>
<tr>
<td>Electronic workflow prompts to support multistep transitional care processes over time</td>
<td>None, hospital is not open yet</td>
</tr>
</tbody>
</table>

---

### HEALTH INFORMATION TECHNOLOGY ASSETS

<table>
<thead>
<tr>
<th>For Which Patients?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Automated appointment reminders (via phone, email, text, portal, or mail)</td>
</tr>
<tr>
<td>None, hospital is not open yet</td>
</tr>
<tr>
<td>☐ Other:</td>
</tr>
<tr>
<td>N/A</td>
</tr>
</tbody>
</table>

### TRANSITIONAL CARE DELIVERY IMPROVEMENTS

<table>
<thead>
<tr>
<th>For Which Patients?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Assess “whole-person” or other clinical readmission risk</td>
</tr>
<tr>
<td>None, hospital is not open yet</td>
</tr>
<tr>
<td>☐ Identify the “learner” or care plan partner to include in education and discharge planning</td>
</tr>
<tr>
<td>None, hospital is not open yet</td>
</tr>
<tr>
<td>☐ Use clinical pharmacists to enhance medication optimization, education, reconciliation</td>
</tr>
<tr>
<td>None, hospital is not open yet</td>
</tr>
<tr>
<td>☐ Use “teach-back” to improve patient/caregiver understanding of information</td>
</tr>
<tr>
<td>None, hospital is not open yet</td>
</tr>
<tr>
<td>☐ Schedule follow-up appointments prior to discharge</td>
</tr>
<tr>
<td>None, hospital is not open yet</td>
</tr>
<tr>
<td>☐ Conduct warm handoffs to post-acute and/or community “receivers”</td>
</tr>
<tr>
<td>None, hospital is not open yet</td>
</tr>
<tr>
<td>☐ Conduct post discharge follow-up calls (for patient satisfaction or follow-up purposes)</td>
</tr>
<tr>
<td>None, hospital is not open yet</td>
</tr>
<tr>
<td>☐ Other:</td>
</tr>
<tr>
<td>N/A</td>
</tr>
</tbody>
</table>

### CARE MANAGEMENT ASSETS

<table>
<thead>
<tr>
<th>For Which Patients?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Accountable care organization or other risk-based contract care management</td>
</tr>
<tr>
<td>None, hospital is not open yet</td>
</tr>
<tr>
<td>☐ Bundled payment episode management</td>
</tr>
<tr>
<td>None, hospital is not open yet</td>
</tr>
<tr>
<td>☐ Disease-specific enhanced navigation or care management (heart failure, cancer, HIV, etc.)</td>
</tr>
<tr>
<td>None, hospital is not open yet</td>
</tr>
<tr>
<td>☐ High-risk transitional care management (30-day transitional care services)</td>
</tr>
<tr>
<td>None, hospital is not open yet</td>
</tr>
<tr>
<td>☐ Other:</td>
</tr>
<tr>
<td>N/A</td>
</tr>
</tbody>
</table>

### CROSS-CONTINUUM PROCESS IMPROVEMENT COLLABORATIONS WITH:

<table>
<thead>
<tr>
<th>FOR WHICH PATIENTS?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Skilled nursing facilities</td>
</tr>
<tr>
<td>None, hospital is not open yet</td>
</tr>
<tr>
<td>☐ Medicaid managed care plans</td>
</tr>
<tr>
<td>None, hospital is not open yet</td>
</tr>
</tbody>
</table>
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<table>
<thead>
<tr>
<th>CROSS-CONTINUUM PROCESS IMPROVEMENT COLLABORATIONS WITH:</th>
<th>FOR WHICH PATIENTS?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Community support service agencies</td>
<td>None, hospital is not open yet</td>
</tr>
<tr>
<td>☐ Behavioral health providers</td>
<td>None, hospital is not open yet</td>
</tr>
<tr>
<td>☐ Other:</td>
<td>N/A</td>
</tr>
</tbody>
</table>