

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 Poudre Valley Medical Center

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: 1024 S. Lemay Ave., Fort Collins, CO 80524-3929

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 17 th 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 17 th 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.

Organization Name	Organizational Contact	Organization Type	Engagement Activity	Connection to any specific HTP priority populations and / or project topics, as applicable
Catholic Charities	Joe Domko	Community organization addressing SDOH	Involvement	High Risk/Vulnerable Populations (Homeless)
CHA Opioid Summit	Ashley Baker	Consumer Advocates/Advocacy Organizations	Involvement	Behavioral Health
City of Fort Collins	Nina Bodenhamer	Community organization addressing SDOH	Involvement	Behavioral Health/Vulnerable Populations
Colorado Health & Human Services, Refugee Department	Carol Tumaylle	Community organization addressing SDOH	Consultation	Refugee Population
Colorado Health Literacy Coalition	Dana Abbey, Angela Brega	Community organization addressing social determinants of health	Partnership	Social Determinants of Health
Colorado Prevention Alliance	Lauren Ambrozic	Health Alliance	Involvement	Vulnerable Populations (Social Determinants of Health)
Co-SLAW working with NCO EDs	Leslie Brooks	Health Alliance	Involvement	Behavioral Health/Vulnerable Populations
Crisis Services NE Colorado	Dean Vincent	Mental Health Center	Consultation	All
FUSE	Holly LeMasurier	Community organization addressing social determinants of health	Involvement	Vulnerable Populations (Homeless)
Health District BH/SA Alliance	Lynn Wilder	Community organization addressing social determinants of health	Involvement	Behavioral Health/SUD



Organization Name	Organizational Contact	Organization Type	Engagement Activity	Connection to any specific HTP priority populations and / or project topics, as applicable
Healthy Harbors Advisory Committee	Stephen Thompson/Karen Ramirez	Community organization addressing social determinants of health	Involvement	High-Risk Pediatric Patients (and families) who have CPS involvement/formal child welfare concerns
Imagine Zero Suicide	Rachel Olsen	Community organization addressing social determinants of health	Partnership	Suicide Prevention/Behavioral Health/Vulnerable Populations
Imagine Zero Suicide Steering Committee	Rachel Olsen	Community organization addressing social determinants of health	Partnership	Behavioral Health/SUD
Imagine Zero Workgroup	Rachel Olsen	Community organization addressing social determinants of health	Partnership	Behavioral Health/SUD
Interagency-FCPD	Dan Dworkin	Community organization addressing social determinants of health	Partnership	High Utilizers/Vulnerable Populations
It Knows No Face Planning Group	Janet Werst	Consumer Advocates/Advocacy Organizations	Involvement	Behavioral Health/SUD
La Cocina	La Familia Executive Leadership	Consumer Advocates/Advocacy Organizations	Consultation	Vulnerable Populations (Social Determinants of Health)
Larimer County Health Depatient.	Kelsey Lyon	LPHA	Consultation	Vulnerable Populations/SUD/Behavioral Health
Local CoResponder	Laurie Stolen	Community organization addressing social determinants of health	Partnership	Behavioral Health/SUD
MACC stakeholder / oversight committee	Stephen Thompson	FQHC	Involvement	All - especially high utilizers, high-complexity/high-risk Medicaid patients; patients with significant barriers to accessing care
Mental Health Center	Stephanie Pixlar	Mental Health Center	Partnership	Behavioral Health
NCHA	Mark Wallace	Health Alliance	Involvement	SUD



Organization Name	Organizational Contact	Organization Type	Engagement Activity	Connection to any specific HTP priority populations and / or project topics, as applicable
Nicu Flash Rounds	Amy Sanford	Community organization addressing social determinants of health	Partnership	Vulnerable Populations
No CO Health Planners & Analysts	Annette Alfano	LPHA	Partnership	Community Health Assessments/Improvement Plans/Behavioral Health/SUD services/Vulnerable Populations (Pregnant Women, WIC eligible)
North Colorado Medical Center	Kathryn Perkins, MD	RAE	Partnership	Vulnerable Populations
Northern Colorado Health Planners	Cindy Kronauge	Community organization addressing social determinants of health	Consultation	Vulnerable Populations
Ombudsmen: Homeless Transitional Care	Amber Franzel	Community organization addressing social determinants of health	Consultation	High Risk/Vulnerable Populations (Homeless)
Poudre School District Level 2 (Threat Assessment) Team	Melanie Voegli-Morris	Community organization addressing social determinants of health	Involvement	Behavioral Health
PVH Nicu Flash Rounds	Amy Sanford	Community organization addressing social determinants of health	Partnership	Vulnerable Populations
RETAC	Kerry Borrego	RETACs	Partnership	All
RETAC	Jeff Schanels	RETACs	Partnership	High Risk/Trauma/Chronic Disease/Pediatrics
Rocky Mountain Health Plan	Meg Taylor/Louisa Wren	RAE	Partnership	All
Rocky Mountain Health Plan	Violet Willett	RAE	Partnership	Medicaid (Especially High Utilizers/ High-Complexity)
Rocky Mountain Health Plan	Meg Taylor	RAE	Consultation	Behavioral Health/High Utilizers/Vulnerable Populations
Skilled Nursing Facilities	Vivage	LTSS	Partnership	All
Statewide CoResponder	Laurie Stolen	Community organization	Partnership	Behavioral Health/SUD



Organization Name	Organizational Contact	Organization Type	Engagement Activity	Connection to any specific HTP priority populations and / or project topics, as applicable
		addressing social determinants of health		
SummitStone	Michael Allen	Mental Health Center	Partnership	Behavioral Health/SUD
The Family Center/La Familia	Deirdre Sullivan	Consumer Advocates/Advocacy Organizations	Consultation	Vulnerable Populations (Social Determinants of Health)
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 Protective Services (APS); Long Term Supportive Services (LTSS); Colorado Health Partnership (CHP); Federally Qualified Health Center (FQHC); Colorado Health Assessment Planning System (CHAPS); Colorado Coalition for the Medically Underserved (CCMU).				

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).

Engagement Activity	Location and Manners for Participation	Frequency of Activity	Partners Included	How Activity Was Noticed	Key Deliverables
Involvement	In person	x2	Catholic Charities, UCHHealth, EMS, Community Case Mangers, Community Paramedics	E-mail	Respite bed program discussed with stakeholders; process for patient placement in bed, appropriate types of patients, aligning resources, and communication tool for safe patient transitions. Alignment with HTP discussed.
Involvement	In person	x1	Several stakeholders	Public Announcement	Discuss ED MAT program, discussed HTP, made connections with community organizations and obtained key contacts from OBH.
Involvement	City Offices/In person	x1	City of Fort Collins, Colorado State	E-mail	Discussed shared community priorities and non-profit capacity. Discussed collective leadership in area to focus on



Engagement Activity	Location and Manners for Participation	Frequency of Activity	Partners Included	How Activity Was Noticed	Key Deliverables
			University, and several community non-profits (united way, community foundation, otter cares, blue ocean, dda, Colorado State University, Woodward, new Belgium foundation)		change. Gave update on HTP areas of focus and CHNA processes from UCHHealth perspective. Discussion on behavioral health as continued area of need.
Consultation	Phone	x1	Colorado Health & Human Services, Refugee Department and UCHHealth	E-mail	Discussed needs of refugees and HTP potential partnerships
Partnership	Phone	x1	Colorado Health Literacy Coalition and UCHHealth	E-mail	Capture the health literacy rates by county and discussed partnership opportunities.
Involvement	CIVHC Board Room/In person	x1	Health Systems, Payers, CDPHE, CCMU	E-mail	SDOH white paper put together by CPA; discussed SDOH.
Involvement	In person	x1	multi-stake holder, RAE, fqhc, ED, health district	E-mail	Education about MAT in EDs and northern Colorado.
Consultation	Phone	x1	Crisis services and UCHHealth	E-mail	Discussed crisis services in NE CO. Presented resources and materials and recommended use of public dashboard.
Involvement	In person	x1	MACC, Health District, local shelters, Community Outreach	E-mail	Discussion of progress of FUSE project (Housing First model) and next steps. Partnering with Corporation for supportive Housing (CSH) to assist with development.
Involvement	In person	Monthly	Mental health, schools, housing	E-mail	Discussed gaps in community services, working to improve



Engagement Activity	Location and Manners for Participation	Frequency of Activity	Partners Included	How Activity Was Noticed	Key Deliverables
			authority, Larimer county, health district, police, ED, Colorado State University,		frequent utilizers, addressing opioid epidemic
Involvement	In person	Quarterly	CO Depatient. of Corrections; Larimer County DHS/CPS; FMC; Foothills Gateway; Larimer County Depatient. of Health; Matthew's House; Mountain Crest; Realities for Children; SAFY (Specialized Alternatives for Family & Youth); Salud; SummitStone; Voice Carry Child Advocacy Center	E-mail	The Healthy Harbors (HH) program provides intensive, community-based care management support and services to high risk children who are DHS/CPS involved (or who have a history of CPS involvement); HH is fully-integrated with the MACC team. The Healthy Harbors Advisory Committee meets quarterly, and is comprised of a multitude of community agencies and partners who serve at-risk children (generally from birth to age 18). A presentation and overview on the HTP was provided to all of these community partners at this 1/18/19 meeting by Stephen Thompson.
Partnership	FCPD/In person	Quarterly	Summitstone, Health District, schools, MH and SA agencies, Clearview, Colorado State University, private practitioners, community members and	E-mail	Coalition of multiple agencies and individuals working to organize resiliency efforts, planning for 2019 event titled Shattering the Silence, make QPR/suicide prevention training available, address vulnerable groups' needs (i.e.: LGBTQ), and ultimately reduce the suicide rate in our area



Engagement Activity	Location and Manners for Participation	Frequency of Activity	Partners Included	How Activity Was Noticed	Key Deliverables
			survivors of suicide		
Partnership	Wild Boar/In person	Monthly	Imagine Zero Coordinator, Colorado State University, Summitstone, Suicide survivor, Health District	E-mail	Discussion and decision-making determining the direction of Imagine Zero Suicide Coalition
Partnership	Summitstone/In person	Monthly	Summitstone, Imagine Zero Coordinator, Health District, Colorado State University	E-mail	Collaborative subgroup of Imagine Zero Coalition focusing on implementation of Zero Suicide model within health systems and support of community initiatives
Partnership	In person	Monthly	FCPD, PFA, Summit Stone, Mountain Crest, RAE1, Community paramedics, Larimer City Sherriff, Connections	E-mail	Mental Health Holds/legislation, Clearview difficulty, Community Paramedics involvement with mental health first responders, HTP, high utilizer client discussion. Reviewed high utilizer clients with a interagency release, discussed upcoming changes with red flag law. 20+ community agencies come together to discuss any new policies/procedures/legal statues that impact the patients in the community.
Involvement	PVH/In person	x2	Timberline Church, Everyday Joe's Gallery, Imagine Zero, Randy Bacon	E-mail	Community effort to bring "It Knows No Face", art show re suicide survivorship to our area in September 2019
Consultation	In person	x1	REA	E-mail	Discussed gaps in addressing social determinants of health and potential community partnerships to address those gaps, specifically related to the Latin community.



Engagement Activity	Location and Manners for Participation	Frequency of Activity	Partners Included	How Activity Was Noticed	Key Deliverables
Consultation	In person	x1	Larimer County WIC program	E-mail	Completed Northern Colorado questions (demographics, etc.) and reviewed community inventory tool
Partnership	In person	Monthly	Police, Crisis Assessment Center, Summitstone	E-mail	Discussion around effectiveness of police/therapist team in intervening in suicide, SA, and mental health, intervening at the sight of contact. Getting patient to the appropriate facility by triaging in the community based on the appropriate discharge disposition.
Involvement	In person	Monthly	RMHP (as the RAE for region #1); Health District; SummitStone; FMC, AFM, Salud;	E-mail	MACC (Medicaid Accountable Care Collaborative) Oversight Committee meets monthly to provide strategic oversight and long-term planning for the MACC program, which provides intensive care management support to high-risk / high-complexity Medicaid patients (adults and children).
Partnership	In person	Monthly	SummitStone	E-mail	This meeting addresses the process and policies between SSHP Crisis Stabilization Unit and UCH emergency departments that impede the care of our patients. The goal is to provide the patient a smooth admission to the appropriate level of care upon engagement by either entity.
Involvement	In person	Quarterly	FMC, NCAP, Jails, FRC,	E-mail	Discussed opatientions for coordinating care in region and with hospital system
Partnership	PVH/In person	Weekly	UCHealth, Early Intervention, HCP, Healthy Harbors,	E-mail	Flash rounds in NICU to review status of infants and potential community needs to support families.
Partnership	PVH/In person	bimonthly	HDNLC, LCPH, WCPH	E-mail	Discussed shared community priorities and status of county-led health improvement plans. Gave



Engagement Activity	Location and Manners for Participation	Frequency of Activity	Partners Included	How Activity Was Noticed	Key Deliverables
					update on HTP areas of focus and CHNA processes from UCHHealth perspective. Discussion on behavioral health services planning due to passage of ballot initiative.
Partnership	Phone	x1	UCHHealth, Rocky Mountain Health Plan, North Colorado Medical Center	E-mail	Both entities are working on the Hospital Transformation Program for our Larimer county hospitals. Banner already held one community meeting to discuss community needs assessments and they are planning another. The community needs in Larimer are the same, so it made sense for both hospitals to be at the meetings.
Consultation	Phone	Bimonthly	Colorado State university, Health District of Larimer and Weld City, United Way, Poudre Fire Authority, Northern Colorado Health Alliance	E-mail	CHORDS, HTP, Colorado's 2018 Public and Environmental Assessment Survey, Aligning CHA/CHNA efforts.
Consultation	In person	Bimonthly	Fort Collins Healthcare (SAVA), Catholic Charities, Murphy Center	E-mail	Homeless patients discharges, SNF not accepting this vulnerable population and options for these individuals who no longer need hospital services.
Involvement	Poudre School District/In person	Monthly	Poudre School District staff, DHS, Health District/CAYAC program, Juvenile Justice, Forensic Psychologist,	E-mail	Review of potential threats posed by PSD students and discussion of possible responses and supports available to those situations



Engagement Activity	Location and Manners for Participation	Frequency of Activity	Partners Included	How Activity Was Noticed	Key Deliverables
			School Resource Officer		
Partnership	PVH/In person	Weekly	UCHealth, Early Intervention, HCP	E-mail	Flash rounds in Nicu to review status of infants and potential community needs to support families
Partnership	Phone	x1	RETAC-UCHealth	E-mail	Discussed HTP and potential RETAC NE roles/projects. Julie will present in person to the RETAC committee on HTP and related documents.
Partnership	In person	Monthly	Larimer, Weld, Washington City present, other members of NERETAC	E-mail	Presented information related to HTP and provided some education related to survey - to be sent via email
Partnership	In person	x1	RMHP-UCHealth	E-mail	Discussed current projects, status on HTP, and collaborations. Discussed RAE data needs for HTP mid-term report.
Partnership	In person	x1	RMHP, UCHealth	E-mail	Met 1:1 with relatively new supervisor for the local / Larimer County RMHP care team, Violet Willett, to discuss working relationship between the RMHP team and UCHealth MACC/Healthy Harbors.
Consultation	UCHealth/In person	x1	RMHP	E-mail	Discussed YVMC, BHO infrastructure, key transportation issues, ideas on how to better care for MH/BH patients and do inter-facility transport. Spoke about Larimer county and contacting JK Rollings to understand broad SUD strategy.
Partnership	In person	x1	Vivage and UCHealth	E-mail	Discussed Medicaid challenges and benefits related to transitions from hospitals to nursing homes. Discussed vulnerable populations and cross collaborations. RAE



Engagement Activity	Location and Manners for Participation	Frequency of Activity	Partners Included	How Activity Was Noticed	Key Deliverables
					involvement in SNF care. Potential partnerships.
Partnership	In person	Quarterly	Police, Crisis Assessment Center	E-mail	Discussion around effectiveness of police/therapist team in intervening in suicide, SA., and delivery to appropriate facility.
Partnership	In person	Quarterly	SummitStone	E-mail	Discuss a partnership for submitting an RFP to the state to respond to the 1A initiative. Sub. detox treatment to the community and avoid duplication of services while bringing more services to the community.
Consultation	In person	x1	REA	E-mail	Discussed gaps in addressing social determinants of health and potential community partnerships to address those gaps (i.e. housing, childcare, nutrition, and advocacy).



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)

We worked with all groups listed in the Action Plan. We expanded our list of organizations based on larger ongoing community meetings. We also set up separate HTP meetings to talk about the items needed in the mid-term report. We did not have any engagement gaps.

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 UCHHealth and community groups.

Lastly, we created HTP specific workgroups to address items in the mid-term report.

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.

For UCHealth Poudre Valley Hospital:

- 8.0% of its patients live in Weld County
- 76.0% of its patients live in Larimer County

This region is served by two Regional Accountable Entities:

- Rocky Mountain Health Plans
- Northeast Health Partners

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:

[1] <http://www.countyhealthrankings.org/app/colorado/2019/rankings/el-paso/county/outcomes/overall/snapshot>



- [2] https://data-cdphe.opendata.arcgis.com/datasets/5878e60d6a714c5395fd934ec7f864e9_2
- [3] <https://www.migrationpolicy.org/programs/data-hub/charts/us-immigrant-population-state-and-county>
- [4] <http://healthliteracymap.unc.edu/#>
- [5] <https://drive.google.com/file/d/1U4fGTIAyqEz1-jhmFBnnte1tgOXNHU8C/view>
- [6] <https://www.macpac.gov/wp-content/uploads/2018/11/Pregnant-Women-and-Medicaid.pdf>
- [7] <https://www.macpac.gov/wp-content/uploads/2015/06/Behavioral-Health-in-the-Medicaid-Program%E2%80%94People-Use-and-Expenditures.pdf>
- [8] https://www.samhsa.gov/data/sites/default/files/2015_Colorado_BHBarometer.pdf
- [9] PBI-MH/SUD-select hospital-select MH chronic dz, look for CCS of schizophrenia and suicide
- [10] <https://www.colorado.gov/pacific/cdphe/colorado-health-indicators>
- [11] <https://drive.google.com/file/d/1a2gju1FZQntQiZ6kgL3uNHyakwhOaABN/view>
- [12] CHAS
- [13] <http://www.c4a-colorado.org/wp-content/uploads/2018/12/Larimer-County-CASOA-Report-2018-FINAL-2.pdf>
- [14] RWJ County Healthy Rankings
- [15] <https://www.healthdistrict.org/2016-community-health-assessment>
- [16] <https://www.civhc.org/get-data/public-data/interactive-data/utilization/>
- [17] <https://www.governing.com/gov-data/health/county-suicide-death-rates-map.html>
- [18] 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)

The total number of people with Medicaid by service area was not available. To describe the Medicaid population, we drew from data seen on the Department of Health Care Policy and Financing (HCPF)'s website. We found data for enrollees who used hospital services during State Fiscal Year 2018.

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
- people with developmental disabilities

Data on these groups were gathered through qualitative methods. But, there is little quantitative data on hand to further show these important, anecdotal observations.

We addressed the gaps mentioned by leading many surveys and interviews with community groups. We used ongoing community meetings to ask for more details. We also looked at public documents that contained general population information.

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, Larimer County had 3,976 people, making up 6.1% of overall Colorado's population [1].

Race and Ethnicity

Larimer County

- 284,658 Non-Hispanic White or 82.8%



- 39,371 Latino/Hispanic or 11.4%
- 3,222 African Americans or 0.9%
- 8,314 Asian or 2.4%
- 335 Native Hawaiian/Other Pacific Island Native or 0.1%

Weld County

- 200,940 Non-Hispanic White or 66.0%
- 89,303 Latino/Hispanic or 29.3%
- 3,425 African Americans or 1.1%
- 5,101 Asian or 1.7%
- 473 Native Hawaiian/Other Pacific Island Native or 0.2%

Gender

Larimer County [1]

- 50.1% Female
- 49.9% Male

Weld County [1]

- 49.6% Female
- 50.4% Male

Population

Larimer County [1]

- 343,976 residents, comprising 6.1% of overall Colorado's population
- 39,901 rural residents (11.7%)

Weld County [1]

- 304,633 residents, comprising 5.4% of overall Colorado's population
- 62,449 rural residents (20.5%)



Age

Larimer County [1]

- 68,451 (19.9%) below 18 years of age
- 223,585 (65.0%) between ages 18 and 64 years of age
- 51,940 (15.1%) 65 years of age and older

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

Income and Employment Status

State of Colorado [1]

- state of Colorado at 12.7% [4] at FPL
- (2.8%) unemployment rate
- median household income \$69,100

Larimer County [1]

- 4.9% of individuals living at or below the Federal Poverty Level [2]
- unemployment rates (2.4%)
- median household income \$69,400
- homeownership rates (65%)

Weld County [1]

- 15.5% individuals living at or below the Federal Poverty Level [2]
- unemployment rate (2.7%)
- median household income \$68,700
- homeownership rates (72%)



Disability Status

Larimer County [2]

- West Larimer County had higher rates of people with a disability (11.7% to 45.8%) when compared to East Larimer County (6.9% to 9.3%).

Weld County [2]

- North Weld County had lower rates of people with a disability (9.4% to 11.6%) when compared to South Weld County (11.7% to 14.8%).

Immigration Status

According to the Migration Policy Institute in:

Larimer County [3]

- 4,400 foreign-born immigrants were living in Larimer County
- no refugee data available publicly

Weld County [3]

- 16,900 foreign-born immigrants were living in Weld County
- 173 refugees arrived in Weld County in 2017

There was no refugee data available publicly by county [3]. According to the Department of Health and Human Services, the three main refugee settlement areas included:

- Greeley (13%)
- Denver Metro (80%)
- Colorado Springs (7%) [3]

Housing

Larimer County [1]

- 65% or 84,626 people were homeowners

Weld County [1]

- 72% or 219,335 people were homeowners

Education and Health Literacy Status



State of Colorado

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

Larimer County [1]

- High school graduation rates (79%)

According to the Health Literacy Data Map:

- northern Larimer County health literacy rate was in the second lowest state quartile
- o the rest of Larimer County was within the two highest state quartiles [4]

Weld County [1]

- High school graduation rates (82%)
- northeast Weld County health literacy rate was within the second highest state quartile
- o the remainder of Weld County was within the two lowest state quartiles

Primary Languages Spoken

Larimer County [1]

- In 2019, there were 1% of residents with an English proficiency

Weld County [1]

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

Unique characteristics that influence the health of Larimer County and Weld County residents:

Larimer County and Weld County had high rates of people with mental health and substance use disorders. Plans are underway to develop a comprehensive behavioral health facility that will include a range of services and different levels of care. This will include residential substance use treatment and programming. This treatment is not available in Larimer County right now. Most often, agencies work well together to address a range of needs for clients who are involved with multiple systems.

Transportation is a big issue for both Larimer and Weld County residents. There are many places where people do not live. There are also places with little to no public transportation that can be used for people to get to and from visits.

The Greeley area is a refugee settlement area. In the federal fiscal year 2018, there were 101 new refugees that settled in the area. The most common countries people come from include:

- Afghanistan



- Democratic Republic of Africa [5]

Refugee populations:

- are socially complex
- have a difficult time navigating the U.S. health care system
- had lower health literacy rates
- do not believe in mental health diagnoses

Medicaid Population:

According to HCPF's Larimer County Fact Sheet, in 2017:

Larimer County

- 65,182 Health First Colorado Members [1]
 - o 24,738 (38.0%) were Affordable Care Act (ACA) expansion adults
 - o 24,109 (37.0%) were children

Weld County

- 70,240 Health First Colorado Members [1]
 - o 18,698 (26.6%) were Affordable Care Act (ACA) expansion adults
 - o 33,972 (48.4) were children

Treatments at UCHealth Poudre Valley Hospital

- 23,205 unique Medicaid citizens

Age

- 5,988 (25.8%) were below 18 years of age
- 16,193 (69.8%) were between 18 to 64 years of age
- 1,024 (4.7%) were 65 years of age and older

Gender

- 59.3% Female
- 40.7% Male



Race & Ethnicity

- 10,077 (43.4%) Non-Hispanic Whites
- 9,254 (39.9%) Multiple Races
- 279 (1.2%) African American
- 1,618 (7.0%) Latino/Hispanic
- 19 (0.1%) Native Hawaiian/Other Pacific Island Native

Disabilities

- 3,449 (14.7%) had permanent disabilities

Immigration Status

- 507 (2.5%) Legal permanent residents
- 18 (0.08%) refugees

Housing

- 863 people without a home

Primary Language Spoken

- Less than 2.8% Spoke languages other than English
- o But, the secondary language field had 23.2% missing responses. So, we may not have all of the facts [18].

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;

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



- 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)

Individuals with significant health issues, co-occurring conditions, and high health care utilizers:

In the past year, UCHHealth Poudre Valley Hospital evaluated 2,287 unique Medicaid high utilizers.

Age

- 442 (19.3%) below 18 years of age
- 1,842 (80.5%) were between 18 to 64 years old
- 3 (0.1%) were 65 years of age and older

Gender

- 1,380 or 60.3%) female
- 907 or 39.6%) male

Race & Ethnicity

- 987 (46.5%) Non-Hispanic Whites
- 953 (44.9%) Multiple Races
- 42 (1.9%) African American
- 137 (6.4%) Latino/Hispanic
- 2 (0.1%) Native Hawaiian/Other Pacific Islander

Disabilities

- 359 (15.6%) Medicaid enrollees had permanent disabilities;

Immigration

- 17 (0.7%) were legal permanent residents
- 4 (0.2%) were refugees.

Housing



- 265 people with no home and with Medicaid used UCHealth Poudre Valley Hospital in the past year.

Primary Language

- 1.2% of Medicaid enrollees who spoke languages other than English
- o But the secondary language field had 17.5% missing answers so we may not have all the details [18].

Most high utilizers

- are adults but a few were pediatric patients
- average age was 45 years of age
- race and ethnicity of high utilizers vary
- o majority are Non-Hispanic Whites
- primary language spoken is English
- o some members speak Spanish as well
- health literacy is low to poor
- challenging to engage in receiving care

High utilizers struggle to:

- set up visits
- follow up on diagnoses that need more care
- taking medicines as ordered
- get and keep a job
- have an income

High prevalence of:

- having no homes
- housing instability

The most common chronic diseases:

- severe substance use disorder



- o mostly alcohol use disorders
- o severe persistent mental illness

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

In the state of Colorado, 16.7% of all new mothers had Medicaid a month before pregnancy [6].

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

Individuals with behavioral health disorders:

- single largest payer in the U.S. for behavioral health disorders including:
 - o mental health
 - o substance use disorders [7]
- 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.

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:

People with no homes

- more likely to be males than females
- often have co-morbid mental health and substance use disorders
- common physical chronic disease is high blood pressure (hypertension)

Our community partners in Weld County said that only 77 people reported not having a home. But, for many nights at Sunrise Montfort Family Clinic they were over capacity (80 clients) for several days during the winter.

RAE region 2

- 1,401 without a home

RAE region1

- 3,685 without a home

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

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:

Age-adjusted death rate due to suicide

Larimer County

- 17.15 for each 100,000 people

Weld County

- 15.08 for each 100,000 people

State of Colorado

- 19.5 for each 100,000 people [17]

According to the state dataset, there were no ED visits to UCHHealth Poudre Valley Hospital for serious mental health disorders for those who use services more than others (ED high utilizers). This is defined as 4 or more ED visits in 12 months [18].

When reviewing the statewide Medicaid dataset, there were no ED visits for primary serious mental health diagnosis [18]. However, the state dataset may be limited to only physical health claims. It might not account for behavioral health claims.

According to SAMHSA,

4.2% of adults in Colorado live with serious mental health conditions such as:

- schizophrenia
- bipolar disorder
- major depression [8]

Only 1.85% of all UCHHealth Poudre Valley Hospital visits for people with 1 or more mental health disorder was for a serious mental health condition, such as:



- schizophrenia
- psychotic disorders [9]

Of all patients who utilized UCHHealth Poudre Valley Hospital, when compared to patients that have commercial insurance, those with Medicaid insurance were 2 times more likely to use the hospital for:

- schizophrenia
- psychotic disorder treatment

- 3.1% of all visits for people with 1 or more mental health disorders were for suicidal ideation or attempt.

Of all patients who came to UCHHealth Poudre Valley Hospital, when compared to patients with commercial insurance, those with Medicaid insurance were 1.2 times more likely to use the hospital for suicidal ideation or attempt.

- 16.6% of all patients using UCHHealth Poudre Valley Hospital had 1 or more mental health diagnoses.
- 21.5% of all Medicaid enrollees using UCHHealth Poudre Valley Hospital had 1 or more mental health diagnoses.

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]

According to Colorado's Medicaid dataset, alcohol abuse and dependence diagnosis was a common cause of hospital admission for many Medicaid members with chronic conditions.

In 2016, there were 459,249 opioid prescriptions dispensed to Larimer County residents [13]. Opioids represented half of all prescriptions dispensed, and benzodiazepines represented about a quarter of prescriptions.

Larimer County

- 131 prescription opioid-related ED visits rates
- 219 prescription opioid-related reasons for being admitted to the hospital

12th highest in opioid-related deaths [13]

Other significant physical chronic conditions:

The leading causes of death in Larimer County were:

- cancer (malignant neoplasms) (157.9 for each 100,000 people)
- heart disease (136.5 for each 100,000 people)
- unintentional injuries (53.8 for each 100,000 people)
- chronic lower respiratory disease (60.4 for each 100,000 people)
- cerebrovascular diseases (37.0 for each 100,000 people) [10]

High blood pressure

- most often diagnosed chronic disease in the state of Colorado (12%) [16]

In Larimer County

- 35.2% of people diagnosed with high blood pressure have Medicare insurance
- 7.2% of people diagnosed with high blood pressure have Medicaid
- 3.5% of people diagnosed with high blood pressure have commercial insurance [16]

Diabetes

- same rates of type 1 diabetes as across the State (an auto-immune condition and thought to be genetic)



- higher rates of type II diabetes (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.
- 79.8% residents with diabetes get their hemoglobin A1C test on a set schedule.
- o This is higher the state of Colorado.
- 78.2% of people with Medicaid residents have their A1C checked
- 86.1% of people with commercial plans have their A1C checked [14]

Larimer County

- higher rates of breast and lung cancer compared to residents in Colorado [16]
- 81% 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 42% [16].

Larimer County had similar levels of chronic respiratory diseases as the state of Colorado. These include:

- asthma
- chronic obstructive pulmonary disease [16]

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)

High utilizers & Physical Health Conditions that commonly co-occur with mental health diagnosis:

According to the state's high utilizer dataset:



- 1,961 emergency department (ED) high utilizers

- o which resulted in for 8,256 ED visits

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

The average number of ED visits per Medicaid high utilizer for UCHHealth Poudre Valley Hospital was 4.2 ED visits a year.

The average number of visits was a much lower ED visit rate for a Medicaid high utilizer as compared to 6.3 ED visits a year in the state of Colorado [18].

When reviewing the UCHHealth electronic health record data, a little over 89.2% of all Medicaid UCHHealth Poudre Valley Hospital high utilizers live in Larimer County.

The most common chronic diseases of Medicaid high utilizers who received care at UCHHealth Poudre Valley Hospital were:

- mental health
- substance use disorders

The top diagnosis linked to hospital use by Medicaid high utilizers at UCHHealth Poudre Valley Hospital was alcohol-related disorders.

Being seen by a provider after leaving the hospital was linked with lower return rates to the hospital. Medicaid's RAE 1 had 54.9% of people being seen by a provider after leaving the hospital. In the state, Colorado's Medicaid baseline rates were 53.4%.

People with Medicaid working with a primary care provider or medical home was vital to avoid going to the hospital. Medicaid's RAE 1 ambulatory well visit rates were 31.4%, compared to the Medicaid state of Colorado of 29.2%.

Opioid use

- 906 hospital users had opioid use disorders
- o 44.0% of all patients had Medicare insurance
- o 35.4% had Medicaid
- o 16.9% had commercial insurance

These 906 hospital users accounted for 3,069 hospital visits

- most common reason for visit being substance-related diagnoses
- 235 Medicaid members had opioid use disorder



o accounted for 862 UCHHealth Poudre Valley Hospital visits

The top reasons for utilization for this population were:

- substance-related disorders
- alcohol-related disorders

Data suggested that 73% of all patients with opioid use disorders also have mental health disorder diagnoses.

- 30% of patients with opioid use disorder also had alcohol use disorder
- 12% had no home

Maternal Health, perinatal and improved birth outcomes:

Live births in 2019

- 3,321 in Larimer County
- 4,244 in Weld counties

In Larimer and Weld counties, 8.0% of all deliveries were low birth weight babies [11].

According to the RAE,

- 59.5% of pregnant women with Medicaid had adequate prenatal care
- 29.6% of pregnant women with Medicaid had adequate post-partum care

State of Colorado

- 53.4% of pregnant women with Medicaid had adequate prenatal care
- 30.6% of pregnant women with Medicaid had adequate post-partum care

In the US

- 84% of all mothers with private insurance had pre-natal care
- 64% of all mothers with Medicaid insurance had pre-natal care
- 94% of all mothers with private insurance started prenatal care in the first trimester
- 79% of all mothers with Medicaid started prenatal care in the first trimester

At UCHHealth Poudre Valley Hospital, there were

1,236 emergency department visits made by pregnant women.



- 58.4% of all visits were covered by Medicaid.

Pregnant women with Medicaid were almost twice as likely to visit the ED while pregnant when compared to pregnant women with commercial plans.

There were 1,141 Medicaid covered deliveries performed at UCHHealth Poudre Valley Hospital during state fiscal year 2018.

- Medicaid covered 84.1% of all deliveries for all moms with a substance use disorder diagnosis.
- Medicaid covered 46.1% of all deliveries for moms with one or more mental health disorder diagnosis.

Of all Medicaid enrolled new moms:

- 21.9% had at least 1 maternal mental health disorder as well.
- 11.6% of all new moms had at least 1 substance use disorder as well.

Pregnancy is the most common cause of being admitted to the UCHHealth Poudre Valley Hospital among Medicaid members who have asthma [18].

The most common causes of ED use by pregnant women with Medicaid in our hospital service area is:

- a medical visit indicator
- related to an issue right before giving birth (antepartum) diagnoses [18]

End of Life Care:

- 43% of Larimer County residents had an advance care directive
- 27% of Weld County residents had an advance care directive
- In the state of Colorado, 35.7% of all residents had an advance care directive [12].

For all Medicaid members at UCHHealth Poudre Valley Hospital who had hospice care, the most common diagnoses were for:

- sepsis (blood poisoning)
- acute leukemia (blood cancer)

The diagnosis with the highest cost of payment for being in the hospital was related to infectious and parasitic diseases including HIV with an operating room procedure.



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)



Primary Care:

There is a surplus of primary care providers in Larimer County. For every primary care provider, there are 1,140 residents [1]. In contrast, Weld County has a shortage of primary care providers. For every primary care provider, there are 2,030 residents when compared to the state of Colorado where for every primary care provider there are 1,230 residents.

According to the Rocky Mountain Health Plans:

- 52,442 Medicaid members are assigned to a Primary Care Medical Home in Larimer County.

For the past year, the top 3 primary care medical homes for UCHHealth Poudre Valley Hospital's Medicaid users were:

- UCHHealth Family Medicine Clinic
- Salud Family Health Center-Fort Collins
- Associates in Family Medicine

These 3 practices use collaborative population health and care coordination strategies via the Medicaid Accountable Care Collaborative (MACC) team. See complex care management and care coordination below.

Specialty care services:

The most common specialty care services needed are offered in Larimer County. Community groups stressed the need for:

- mental health and substance use disorder services
- neurology
- endocrinology

Long Term Care:

In 2018:

- 50% of older residents in Larimer County said they give care to someone else
- 24% get care [13]

In a survey of Larimer County residents who are 55 years of age and over, 60% stated that they are fully retired [13].

One-fourth of elderly residents in Larimer County rated the availability of long-term care and day time care options favorably [13].



- 1,219 Medicaid clients get long term care services and use UHealth Poudre Valley Hospital [18]
- 337 Medicaid UHealth Poudre Valley Hospital users live in a nursing home right now [18].

These are the 3 home health agencies that most often accept Medicaid patients from UHealth Poudre Valley Hospital:

- Banner Home Care Colorado
- Spring Creek Health Care Center
- Columbine Poudre Home Health Care

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

All Medicaid members in Larimer County get care coordination, which includes basic and complex care coordination services. This comes from either:

- Rocky Mountain Health Plans
- Northeast Health Partners (RAEs)

The RAE either gives direct care coordination services, or subcontracts care coordination services to centralized teams, namely the MACC team and North Colorado Health Alliance. For UHealth hospitals, the MACC team provides care coordination for the 3 main clinics in the area:

- Salud
- AFM
- FMC

The MACC team most often uses the definition of 4 or more ED visits a year as a high utilizer. The goal of the MACC team is to gather the primary care and hospital stakeholders to address the needs of the high utilizers to reduce the number of overall hospital visits.

Rocky Mountain Health Plans is actively looking at developing a new tool that provides the clinic and the MACC team with claims-based data on:

- high utilization
- associated diagnosis
- point of care information



The MACC team also provides wrap-around community-based care management services. They often work together with agencies and community partners such as Murphy Center to address this population's complex needs.

The 3 clinics mentioned above also provide:

- primary care
- behavioral health integrated care
- transitions of care with follow up

The North Colorado Health Alliance:

- gathers local providers to:
 - o talk about efforts in place
 - o shares best practices
- provides care coordination and complex care management
 - o focuses on those who need complex medical and social services
- supports several practices in RAE region 2
 - o provides centralized care coordination services to Medicaid members

The NCHA has connections with several community organizations that help address social determinants of health.

Sunrise Clinic subcontracts with NCHA to provide care coordination to its high utilizers.

Maternal Health, perinatal and improved outcomes:

UCHealth Poudre Valley Hospital is a birthing center, serving Larimer and Weld County residents.

According to the RAE:

- 59.5% of pregnant women with Medicaid had adequate prenatal care
- 29.6% of pregnant women with Medicaid had adequate postpartum care

State of Colorado

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



Unfortunately, these Medicaid state rates were below the 10th percentile HEDIS national benchmark ranking.

There are many OB providers in the Larimer and Weld County areas. The local public health department has a nurse postpartum home visit program that offers postpartum care to vulnerable, new moms. The local public health agency also connects women with Women, Infants, and Children (WIC) services.

Sadly, rates of substance use disorder and mental health disorders for mothers in Larimer and Weld counties were high. There is a shortage of mental health, and substance use providers. Getting a timely visit set up after leaving the hospital for those with the conditions mentioned is a challenge.

RAE 2 is focusing efforts on caring for women to improve care before having a baby and after giving birth. Also, they have asked community groups to find the next best step in addressing substance use disorders and mental health for new moms on Medicaid.

End of Life Care:

The older population of Larimer County is expected to grow over the next 10 years. Larimer County residents with a regular health-care provider (39%) were almost 4 times more likely to have completed an advance care directive than those that do not have a regular provider (10%) [15].

These hospice agencies have accepted Medicaid members who were admitted to UCHealth Poudre Valley Hospital in 2018:

- Pathways Hospice
- Front Range Hospice and Palliative Care

Of all patients discharged with hospice services, only 6.4% had Medicaid insurance.

Behavioral Health:

There is a shortage of mental health providers in Larimer and Weld County. For every mental health provider in Larimer County, there are 320 residents.

In Weld County, there are 430 residents for each 1 provider when compared to the state of Colorado where there are 300 residents for each 1 provider [14].

Several practices in Larimer and Weld County can provide integrated physical and behavioral health services.

The local psychiatric hospital is UCHealth Mountain Crest. Medicaid members with a sudden change of their mental illness who need an inpatient psychiatric stay, are evaluated by the local community mental health center. SummitStone evaluates the person at a UCHealth hospital facility.



According to the SAMSHA buprenorphine provider locator, there are 47 medical providers able to prescribe buprenorphine. This is a medicine used to treat opioid use disorder [16]. But, it is unclear how many of those providers are actively prescribing buprenorphine and accepting new Medicaid members.

The CO-SLAW program is a newly funded SAMHSA program that serves both Larimer and Weld County residents. The program takes a hub and spoke model approach for addiction treatment. They have a 1-800 call line connected to a group of care coordinators that help facilitate continuity of care for individuals with opioid use disorder to get ambulatory care in the community. To help identify, initiate treatment and continue medication-assisted treatment in the community, they have partnered with the:

- Local Federally Qualified Health Centers
- Community Mental Health Centers
- Regional Accountable Entity
- Local hospitals
- o UCHHealth
- o Banner

Other Outpatient Services:

Partners did not name any other outpatient services needed that have not already been talked about in other areas.

Population screenings, outreach, and other population health supports and services:

The UCHHealth Medical Group participates in providing population health services and supports. For both Larimer and Weld counties the MACC team and North Colorado Health Alliance provide:

- population health services
- review of data
- alignment of efforts

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



- o 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, care management group subcontractors will ease communications as Medicaid members move from the hospital to their communities. The MACC team, which serves the 3 main primary care clinics in the Larimer County area, could also provide a centralized location to allow for hospital and clinics to work together.

HTP Priority Area: Behavioral Health

Both SummitStone 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.

Finally, as the new mental health center is built in Larimer County, there will be future chances to partner in:

- developing services
- sharing content expertise
- transitions of care projects

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 Medicaid moms by improving care before getting pregnant and after giving birth. Also, rates of substance use disorder and mental health care for Medicaid enrolled members, specifically the new mom population, is high. There are chances for many groups to partner.

Perceived gaps:



In talks with the community, nursing homes and housing for aging populations was brought up as a perceived gap in the community.

There is a high number of people with no home in Larimer and Weld County, yet homeless services are lacking. There are no local medical homeless respite programs available in the area. Local groups, such as Catholic Charities and the Murphy Center, are willing to act as a team in developing an innovative program for people with no home that have complex medical needs. There are not enough detox facilities to meet the current volume of patients in need of substance use disorder detoxification.

Community partners also mention transportation as a challenge for patients who live both in Larimer and Weld Counties. While programs are being started to treat opioid use disorder, there is little emphasis on the treatment of alcohol use disorders with medication-assisted therapy.

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.

Many groups serve and help the community, but most have limited resources.

Employment and job training:

Employment and job training challenges were not named during the community health needs engagement.

Transportation:

Transportation is the main barrier in getting health and social resources in Larimer and Weld counties. While non-emergency transportation is a covered Medicaid benefit, patients must set up these rides ahead of time. This means Medicaid patients who need urgent visits, and face transportation challenges, cannot make it to their visit. This may lead Medicaid members to use the emergency department.



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.

Facility Type	Facility Name	Facility Address	Services Offered
Hospital	UCHealth Poudre Valley Hospital	1024 S. Lemay Avenue, Fort Collins, CO 80524	Hospital – inpatients services including but not limited to Adolescent Medicine, Allergy, Allergy & Immunology, Anesthesiology, Cardiovascular Disease, Child & Adolescent, Psychiatry, Critical Care Medicine, Dermatology, Dermatopathology, Diabetes, Diagnostic Radiology, Emergency Medicine, Endocrinology, Diabetes & Metabolism, Family Medicine, Foot and Ankle Orthopedic Surgery, Gastroenterology, General Practice, General Surgery, Geriatric Medicine, Gynecology, Hand Surgery, Hematology/Oncology, Hepatology, Holistic Medicine, Infectious Disease, Internal Medicine, Medical Oncology, Neonatal-Perinatal Medicine, Nephrology, Neurological Surgery, Neurology, Neuroradiology, Obstetrics & Gynecology, Occupational Medicine, Ophthalmology, Optometry, Oral & Maxillofacial Surgery, Orthopedic Adult Reconstructive Surgery, Orthopedic Surgery, Orthopedic Surgery Of Spine, Otolaryngology,



Facility Type	Facility Name	Facility Address	Services Offered
			Pain Management, Pathology, Pediatrics, Physical Medicine & Rehabilitation, Plastic Surgery, Podiatric Medicine, Psychiatry, Psychology, Public Health & General Preventive Medicine, Pulmonary Critical Care, Pulmonary Disease, Radiation Oncology, Radiology, Reproductive Endocrinology, Rheumatology, Sleep Medicine, Sports Medicine, Thoracic Surgery, Traumatic Surgery, Urology, Vascular & Interventional Radiology, Vascular Surgery
Hospital	UCHealth Harmony Campus	2121 East Harmony Road, Fort Collins, CO 80528	Medical Campus – Inpatient and Outpatient Care
Outpatient Clinic	UCHealth Bariatric Center of the Rockies	1024 S. Lemay Avenue, Fort Collins, CO 80524	Endocrinology, Surgery, Weight Loss
Outpatient Clinic	UCHealth Diabetes and Medical Nutrition Therapy - Fort Collins	1024 S. Lemay Avenue, Fort Collins, CO 80524	Diabetes, Endocrinology, Weight Loss
Laboratory	UCHealth Laboratory - Poudre Valley Hospital	1024 S. Lemay Avenue, Fort Collins, CO 80524	Laboratory, Pathology
Outpatient Clinic	UCHealth Outpatient Infusion Clinic - Poudre Valley Hospital	1024 S. Lemay Avenue, 1st floor Fort Collins, CO 80524	Cancer Treatment, Infusion, Oncology
Outpatient Clinic	UCHealth Palliative Care - Poudre Valley Hospital	1024 S. Lemay Avenue, Fort Collins, CO 80524	Counseling, Pain Management, Palliative Care, Program, Support Services
Outpatient Clinic	UCHealth Wound Care Clinic - Fort Collins	1024 S. Lemay Avenue, Fort Collins, CO 80524	Wound Care
Outpatient Clinic	UCHealth Regional Neuroscience Center - Poudre Valley Hospital	1024 South Lemay Avenue, Fort Collins, CO 80524	Neurology, Surgery



Facility Type	Facility Name	Facility Address	Services Offered
Radiology	UCHealth Breast Diagnostic Center - Harmony Campus	2127 E. Harmony Road, Building B Fort Collins, CO 80528	Imaging, Mammography
Outpatient Clinic	UCHealth Heart and Vascular Clinic - Harmony Campus	2121 E. Harmony Road, Suite 100 Fort Collins, CO 80528	Cardiology, Heart and Vascular, Surgery
Outpatient Clinic	UCHealth Surgical Clinic - Harmony Campus	2121 E. Harmony Road, Suite 330 Fort Collins, CO 80528	Surgery
Laboratory	UCHealth Laboratory - Harmony Campus	4630 Snow Mesa Drive, Fort Collins, CO 80528	Laboratory, Pathology
Urgent Care	UCHealth Urgent Care - Harmony Campus	2127 E. Harmony Road, Suite 140 Fort Collins, CO 80528	Urgent Care
Outpatient Clinic	UCHealth Cancer Clinical Research - Harmony Campus	2121 East Harmony Road, Suite 330 Fort Collins, CO 80528	Cancer Treatment, Oncology, Research
Outpatient Clinic	UCHealth Radiation Oncology - Harmony Campus	2121 East Harmony Road, Suite 160 Fort Collins, CO 80528	Cancer Treatment, Oncology, Radiology
Outpatient Clinic	UCHealth Pulmonology Clinic - Harmony Campus	2121 E. Harmony Road, Suite 300 Fort Collins, CO 80528	Pulmonology, Respiratory, Sleep Disorders
Outpatient Clinic	UCHealth Urology Clinic - Harmony Campus	2315 E. Harmony Road, Suite 140 Fort Collins, CO 80528	Kidney and Bladder, Urology
Outpatient Clinic	UCHealth Brain and Spine Clinic - Fort Collins	1107 S. Lemay Avenue, Suite 240 Fort Collins, CO 80524	Neurology, Surgery
Outpatient Clinic	UCHealth Cancer Care and Hematology Clinic - Estes Park	555 Prospect Avenue, Estes Park Medical Center Estes Park, CO 80517	Blood Disorders, Cancer Treatment, Hematology
Outpatient Clinic	UCHealth Cancer Center - Harmony Campus	2121 East Harmony Road, Suite 170 Fort Collins, CO 80528	Blood Disorders, Cancer Treatment, Hematology, Imaging, Infusion, Laboratory, Oncology, Pathology, Radiology
Outpatient Clinic	UCHealth Heart and Vascular Clinic - Estes Park	555 Prospect Avenue, Estes Park, CO 80517	Cardiology, Heart and Vascular
Outpatient Clinic	UCHealth Children's Therapy Services - Fort Collins	1500 S. Lemay Avenue, Fort Collins, CO 80524	Counseling, Genetics, Neurology, Rehabilitation
Outpatient Clinic	UCHealth Diabetes and Endocrinology Clinic - Prospect	1106 E. Prospect Road, Suite 100 Fort Collins, CO 80524	Diabetes, Endocrinology



Facility Type	Facility Name	Facility Address	Services Offered
Outpatient Clinic	UCHealth Family Medicine Center - Fort Collins	1025 Pennock Place, Fort Collins, CO 80524	Education and Training, Family Medicine, Flu Shot, Obstetrics/Gynecology, Pediatrics, Pregnancy Care, Primary Care, Seniors Health, Training and Education, Women's Health
Outpatient Clinic	UCHealth Walk-In Clinic - Family Medicine Center	1025 Pennock Place, Suite 121 Fort Collins, CO 80524	Family Medicine
Outpatient Clinic	UCHealth Gastroenterology Clinic - Fort Collins	1025 Garfield Street, Suite B Fort Collins, CO 80524	Digestive Health, Gastroenterology
Outpatient Clinic	UCHealth Internal Medicine Clinic - Prospect	1106 E. Prospect Road, Suite 100 Fort Collins, CO 80525	Flu Shot, Primary Care
Outpatient Clinic	UCHealth Mountain Crest Behavioral Health Center - Fort Collins	4601 Corbett Drive, Fort Collins, CO 80528	Addiction, Behavioral Health, Counseling
Outpatient Clinic	UCHealth Neurology Clinic - Fort Collins	2315 E. Harmony Road, Suite 110 Fort Collins, CO 80528	Neurology
Outpatient Clinic	UCHealth Occupational Medicine and Rehabilitation Clinic - Harmony Campus	2315 East Harmony Road, Suite 170 Fort Collins, CO 80528	Occupational Medicine
Outpatient Clinic	UCHealth Physical Therapy and Rehabilitation Clinic - Prospect	1106 E. Prospect Road, Suite 200 Fort Collins, CO 80524	Occupational Therapy, Physical Therapy, Rehabilitation, Speech Therapy
Laboratory	UCHealth Laboratory - Garfield	1025 Garfield Street, Suite C Fort Collins, CO 80524	Laboratory, Pathology
Outpatient Clinic	UCHealth Internal Medicine and Pediatric Care Clinic - Snow Mesa	4674 Snow Mesa Drive, Suite 200 Fort Collins, CO 80528	Diabetes, Flu Shot, Pediatrics, Primary Care
Outpatient Clinic	UCHealth Pulmonology Clinic - Estes Park	555 Prospect Avenue, Estes Park, CO 80517	Pulmonology, Respiratory
Outpatient Clinic	UCHealth Sleep Lab - Poudre Valley Hospital	1107 South Lemay Avenue, Suite 260 Fort Collins, CO 80524	Sleep Disorders
Urgent Care	UCHealth Urgent Care - Estes Park	131 Stanley Avenue, Timberline Medical Center, Suite 202 Estes Park, CO 80517	Urgent Care



Facility Type	Facility Name	Facility Address	Services Offered
Outpatient Clinic	UCHealth Lactation Support Program - Fort Collins	1107 S. Lemay Avenue, Suite 160 Fort Collins, CO 80524	Neonatal, Program, Support Services
Outpatient Clinic	UCHealth Rheumatology Clinic - Harmony Campus	2121 E. Harmony Road, Suite 200 Fort Collins, CO 80528	Rheumatology
Outpatient Clinic	UCHealth Internal Medicine Clinic - Snow Mesa	4674 Snow Mesa Drive, Suite 100 Fort Collins, CO 80528	Primary Care
Outpatient Clinic	UCHealth Primary Care Clinic - Estes Park	131 Stanley Avenue, Timberline Medical Center, Suite 202 Estes Park, CO 80517	Family Medicine, Flu Shot, Primary Care
Radiology	UCHealth Radiology - Poudre Valley Hospital	1024 S. Lemay Avenue, Fort Collins, CO 80524	Imaging, Radiology
Birth Center	UCHealth Birth Center - Poudre Valley Hospital	1024 South Lemay Avenue, Fort Collins, CO 80524	Birth Center, Neonatal, Pregnancy Care
Inpatient Care	UCHealth Neonatal Intensive Care Unit - Poudre Valley Hospital	1024 S. Lemay Avenue, Fort Collins, CO 80524	Neonatal
Outpatient Clinic	UCHealth Hyperbaric Medicine - Poudre Valley Hospital	1024 S. Lemay Avenue, Fort Collins, CO 80524	Wound Care
Outpatient Clinic	UCHealth Orthopedics Surgery Center - Poudre Valley Hospital	1024 S. Lemay Avenue, Fort Collins, CO 80524	Orthopedics, Sports Medicine, Surgery, Training and Education
Outpatient Clinic	UCHealth Urology Clinic - Estes Park	555 Prospect Avenue, Estes Park Medical Center Estes Park, CO 80517	Kidney and Bladder, Urology
Outpatient Clinic	UCHealth Cancer Care and Hematology Clinic - Harmony Campus	2121 East Harmony Road, Suite 170 Fort Collins, CO 80528	Blood Disorders, Cancer Treatment, Hematology, Oncology
Outpatient Clinic	UCHealth Lung Nodule Clinic - Harmony Campus	2121 E. Harmony Road, Suite 300 Fort Collins, CO 80528	Oncology, Pulmonology, Respiratory
Outpatient Clinic	UCHealth The Wellness Place - Harmony Campus	2121 East Harmony Road, Suite 150 Fort Collins, CO 80528	Counseling, Oncology, Palliative Care, Physical Therapy, Support Services
Emergency Room – Freestanding	UCHealth Emergency Room - Harmony Campus (Freestanding)	4630 Snow Mesa Drive, Fort Collins, CO 80528	Emergency Room, Pathology, Pharmacy
Pharmacy	UCHealth Pharmacy - Poudre Valley Hospital	1024 S. Lemay Avenue, Suite E1051 Fort Collins, CO 80524	Pharmacy
Emergency Room	UCHealth Emergency Care - Poudre Valley	1024 S. Lemay Avenue, Fort Collins, CO 80524	Emergency Room



Facility Type	Facility Name	Facility Address	Services Offered
	Hospital (Hospital-based)		
Outpatient Clinic	UCHealth Walk-In Clinic - Lake Street	151 W. Lake Street, Suite 1500 Fort Collins, CO 80525	Family Medicine
Outpatient Clinic	UCHealth Physical Medicine and Rehabilitation Clinic - Fort Collins	2315 E. Harmony Road, Suite 110 Fort Collins, CO 80528	Physical Therapy, Rehabilitation
Outpatient Clinic	UCHealth Physical Therapy and Rehabilitation Clinic - The Wellness Place	2121 E. Harmony Road, Suite 150 Ft Collins, CO 80528	Occupational Therapy, Physical Therapy, Rehabilitation, Speech Therapy
Administrative Offices	Hospital Medical Staff - Northern Colorado	1024 S. Lemay Avenue, Fort Collins, CO 80526	Administrative Offices
Outpatient Clinic/Laboratory	UCHealth Garth Englund Blood Center - Fort Collins	1025 Pennock Place, Suite 104 Fort Collins, CO 80524	Blood Donation
Outpatient Clinic	UCHealth Brain and Spine Tumor Multidisciplinary Clinic - Harmony Campus	2121 East Harmony Road, Suite 160 Fort Collins, CO 80528	Cancer Treatment, Neurology, Oncology
Outpatient Clinic	UCHealth Pediatric Care - Poudre Valley Hospital	1024 S. Lemay Avenue, 3rd floor Fort Collins, CO 80524	Flu Shot, Pediatrics
Outpatient Clinic	UCHealth Occupational Medicine Clinic - Lake Street	151 W. Lake Street, Suite 1500 Fort Collins, CO 80523	Occupational Medicine
Outpatient Clinic	UCHealth Diabetes and Endocrinology Clinic - Harmony Campus	2121 E. Harmony Road, Suite 230 Fort Collins, CO 80528	Diabetes, Endocrinology
Pharmacy	UCHealth Pharmacy - Harmony Campus	4630 Snow Mesa Drive, Fort Collins, CO 80528	Pharmacy
Radiology	UCHealth Radiology - Lake Street	151 W. Lake Street, Suite 1500 Fort Collins, CO 80523	Imaging, Radiology
Outpatient Clinic	UCHealth Timberline Medical Center	131 Stanley Avenue, Estes Park, CO 80517	Primary Care, Urgent Care
Outpatient Clinic	UCHealth Physical Therapy and Rehabilitation Clinic - Lake Street	151 W. Lake Street, Suite 1500 Fort Collins, CO 80523	Physical Therapy, Rehabilitation
Inpatient Unit	UCHealth Rehabilitation Unit - Poudre Valley Hospital	1024 South Lemay Avenue, Fort Collins, CO 80524	Rehabilitation
Outpatient Clinic	UCHealth Plastic and Reconstructive Surgery Clinic - Fort Collins	2315 E. Harmony Road, Suite 160 Fort Collins, CO 80528	Plastic and Reconstructive Surgery



Facility Type	Facility Name	Facility Address	Services Offered
Outpatient Clinic	UCHealth Heart and Vascular Clinic - Westbridge	1107 S. Lemay Avenue, Suite 100 Fort Collins, CO 80524	Cardiology, Heart and Vascular

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)

No other major topics were named other than the ones we already mentioned in this form.

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:

- o the RAE
- o local public health agencies
- o 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 UCHHealth 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 have no additional information.



Appendix I: Community Inventory Tool¹

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

Provider or Agency	Transitional Care Services [Examples]	Yes	No
Community health centers, federally qualified health centers	<ul style="list-style-type: none"> • Salud Clinic • Sunrise Health Clinic 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Accountable care organization with care management or transition care	<ul style="list-style-type: none"> • Refer to MACC team • Refer to RMHP (if needed) 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Medicaid managed care organizations	<ul style="list-style-type: none"> • Refer to RMHP (if needed) 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Program of All-inclusive Care for the Elder (PACE), Senior Care Options (SCO), Duals Demonstration providers	<ul style="list-style-type: none"> • PACE representative 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Medicaid health homes	<ul style="list-style-type: none"> • AFM • FMC 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Multiservice behavioral health centers, including behavioral health homes	<ul style="list-style-type: none"> • SummitStone • Mountain Crest Outpatient—not many • Connections—work with health district 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Behavioral health providers	<ul style="list-style-type: none"> • SummitStone • Mountain Crest Outpatient—not many • Connections—work with health district • Front Range Clinic 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Substance use disorder treatment providers	<ul style="list-style-type: none"> • North Range Behavioral Health 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Heart failure, chronic obstructive pulmonary disease (COPD), HIV, dialysis, or cancer center clinics	<ul style="list-style-type: none"> • UCH-Medical Group • HIV: Health District • Cancer Clinic 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Pain management or palliative care	<ul style="list-style-type: none"> • Pathways Hospice 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Physician/provider home visit service	<ul style="list-style-type: none"> • FMC • AFM: Support patients in Independent Living facilities 	<input checked="" type="checkbox"/>	<input type="checkbox"/>

¹ Adapted from: Designing and Delivering Whole-Person Transitional Care. Content last reviewed June 2017. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/index.html>



Provider or Agency	Transitional Care Services [Examples]	Yes	No
Skilled nursing facilities	<ul style="list-style-type: none"> Applewood Living Center Berthoud Living Center Columbine Center 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Home health agencies	<ul style="list-style-type: none"> Ability Home Health Care Accent Care Home Health Alliant Home Care 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Hospice	<ul style="list-style-type: none"> Pathways Hospice 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Adult day health	<ul style="list-style-type: none"> PACE program Elder Haus Gateway Community Service 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Public health nurses	<ul style="list-style-type: none"> Home visits post-partum, flu shots, outreach 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Pharmacies	<ul style="list-style-type: none"> PACE—home deliveries 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Durable medical equipment	<ul style="list-style-type: none"> Major Medical 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Other		<input type="checkbox"/>	<input type="checkbox"/>

Social Services

Provider or Agency	Transitional Care Services [Examples]	Yes	No
Adult protective services	<ul style="list-style-type: none"> DHS 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Area Agency on Aging (AAA)	<ul style="list-style-type: none"> Answers on Aging 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Aging and Disability Resource Centers	<ul style="list-style-type: none"> Unknown 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Assisted living facilities	<ul style="list-style-type: none"> Columbine Commons Assisted Living Eagles Nest Assisted Living Fox Meadows Assisted Living 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Housing with services	<ul style="list-style-type: none"> Redtail Ponds: Care Management, Social Work, Bus Line FUSE program: high utilizer housing that includes Care Management, Social Work, Transportation 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Housing authority or agencies	<ul style="list-style-type: none"> Housing Catalyst Murphy Center for Hope 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Legal aid	<ul style="list-style-type: none"> Murphy Center for Hope 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Faith-based organizations	<ul style="list-style-type: none"> Catholic Charities 	<input checked="" type="checkbox"/>	<input type="checkbox"/>



Provider or Agency	Transitional Care Services [Examples]	Yes	No
Transportation	<ul style="list-style-type: none"> Vayo eligible Saint program Heart and soul transportation: wheel chairs available to get patients into their home 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Community corrections system	<ul style="list-style-type: none"> UCHealth Community paramedic team to establish a program when discharging (medical passport) Working in halfway house 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Other	<ul style="list-style-type: none"> Healthy U (smoking cessation) Healthy Harbors (under 18) 	<input checked="" type="checkbox"/>	<input type="checkbox"/>



Appendix II: Hospital Care Transitions Activities Inventory Tool²

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

ADMINISTRATIVE ACTIVITIES/ASSETS	For Which Patients?
<input checked="" type="checkbox"/> Specified readmission reduction aim	All Patients
<input checked="" type="checkbox"/> Executive/board-level support and champion	All patients
<input checked="" type="checkbox"/> Readmission data analysis (internally derived or externally provided)	All patients
<input checked="" type="checkbox"/> Monthly readmission rate tracking (internally derived or externally provided)	All patients
<input type="checkbox"/> Periodic readmission case reviews and root cause analysis	None
<input checked="" type="checkbox"/> Readmission activity implementation measurement and feedback (PDSA, audits, etc.)	Yes, including General Surgery, Bariatric Surgery, Medicine, Neurology, Orthopedics
<input checked="" type="checkbox"/> Provider or unit performance measurement with feedback (audit, bonus, feedback, data, etc.)	Service line specific (i.e. Medicine, Palliative Care)
<input type="checkbox"/> Other:	N/A

HEALTH INFORMATION TECHNOLOGY ASSETS	For Which Patients?
<input checked="" type="checkbox"/> Readmission flag	All Patients
<input checked="" type="checkbox"/> Automated ID of patients with readmission risk factors/high risk of readmission	All Patients (i.e. Congestive Heart Failure Patients)
<input type="checkbox"/> Automated consults for patients with high-risk features (social work, palliative care, etc.)	None
<input checked="" type="checkbox"/> Automated notification of admission sent to primary care provider	All Patients
<input checked="" type="checkbox"/> Electronic workflow prompts to support multistep transitional care processes over time	All Patients

² Adapted from: Designing and Delivering Whole-Person Transitional Care. Content last reviewed June 2017. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/index.html>



HEALTH INFORMATION TECHNOLOGY ASSETS	For Which Patients?
<input checked="" type="checkbox"/> Automated appointment reminders (via phone, email, text, portal, or mail)	All Patients
<input type="checkbox"/> Other:	N/A

TRANSITIONAL CARE DELIVERY IMPROVEMENTS	For Which Patients?
<input checked="" type="checkbox"/> Assess "whole-person" or other clinical readmission risk	All Patients
<input checked="" type="checkbox"/> Identify the "learner" or care plan partner to include in education and discharge planning	All Patients
<input checked="" type="checkbox"/> Use clinical pharmacists to enhance medication optimization, education, reconciliation	All Patients, Diabetic Patients
<input checked="" type="checkbox"/> Use "teach-back" to improve patient/caregiver understanding of information	All Patients, Geriatric Patients
<input checked="" type="checkbox"/> Schedule follow-up appointments prior to discharge	All Patients
<input checked="" type="checkbox"/> Conduct warm handoffs to post-acute and/or community "receivers"	All Patients, High Risk Patients, Homeless Patients, Post Acute Patients
<input checked="" type="checkbox"/> Conduct post discharge follow-up calls (for patient satisfaction or follow-up purposes)	All Patients
<input type="checkbox"/> Other:	N/A

CARE MANAGEMENT ASSETS	For Which Patients?
<input checked="" type="checkbox"/> Accountable care organization or other risk-based contract care management	All payors
<input type="checkbox"/> Bundled payment episode management	None
<input type="checkbox"/> Disease-specific enhanced navigation or care management (heart failure, cancer, HIV, etc.)	None
<input checked="" type="checkbox"/> High-risk transitional care management (30-day transitional care services)	All Patients
<input type="checkbox"/> Other:	N/A

CROSS-CONTINUUM PROCESS IMPROVEMENT COLLABORATIONS WITH:	FOR WHICH PATIENTS?
<input checked="" type="checkbox"/> Skilled nursing facilities	All Patients
<input checked="" type="checkbox"/> Medicaid managed care plans	All Patients



CROSS-CONTINUUM PROCESS IMPROVEMENT COLLABORATIONS WITH:	FOR WHICH PATIENTS?
<input checked="" type="checkbox"/> Community support service agencies	Skilled Nursing Facilities, Home Health Agencies
<input checked="" type="checkbox"/> Behavioral health providers	Summit Stone and Mountain Crest
<input type="checkbox"/> Other:	

