

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 Yampa 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 Central Park Dr

Steamboat Springs, CO 80487

Hospital Executive Name: Steve Schwartz

Hospital Executive Title: Chief Financial Officer

Hospital Executive Address: 1024 Central Park Dr

Steamboat Springs, CO 80487

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
NW Health Partnership	Ken Davis	Consumer Advocates/Advocacy Organizations	Partnership	All
Mind Springs	Gina Toothaker	Community Mental Health Center	Partnership	Behavioral Health
Craig/Women's Care Clinic/Pain Medicine Clinic	Ted Morton	PCMH	Partnership	All
Casey's Pond	Shani Bohlin	LTSS	Consultation	Vulnerable Populations
CHA Opioid Summit	Ashley Baker	Consumer Advocates/Advocacy Organizations	Involvement	Behavioral Health
Rocky Mountain Health Plan	Meg Taylor/Louisa Wren	RAE	Partnership	All
Regional Health Connector	Stephanie Monahan	Community organization addressing social determinants of health /Consumer advocates-advocacy organizations	Partnership	All
CHAPS	Kari Ladrow	LPHA, RHC, Hospital, CMHC, FQHC, community advocacy organization and community organization addressing SDOH	Partnership	All
Colorado Prevention Alliance	Lauren Ambrozic	Health Alliance	Involvement	Vulnerable Populations (Social Determinants of Health)



Organization Name	Organizational Contact	Organization Type	Engagement Activity	Connection to any specific HTP priority populations and / or project topics, as applicable
Colorado Health Literacy Coalition	Dana Abbey, Angela Brega	Community organization addressing social determinants of health	Involvement	Social Determinants of Health
Memorial Regional Health	Andy Daniels, CEO	Other: hospitals	Consultation	Vulnerable Populations
CDPHE, Refugee Department	Carol Tumaylle	Community organization addressing social determinants of health	Consultation	Refugee Population
RETAC	Kerry Borrego	RETAC	Consultation	All

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
Partnership	UCHealth/In person	X3	YVMC and NW Health Partnership	E-mail	Identify community organizations, resources/services delivered, gaps in YVMC partnerships.
Partnership	Via phone	Monthly + Add hoc (x6)	YVMC and Mind Springs	E-mail	Improve behavioral health care transitions.
Partnership	In person	x1	YVMC and PCMH director	E-mail	Reviewed clinics in the area that serve Medicaid clients, SDOH and potential partnerships.
Consultation	Casey's Pond/In person	x1	UCHealth and Casey's Pond	E-mail	Reviewed challenges related to aging populations and LTSS.
Involvement	In person	x1	Hospitals, OBH, CMHC, PCMH, FQHC, RAE,	Public Announcement	Discuss ED MAT program, HTP, and opioid use disorder treatment bias.



Engagement Activity	Location and Manners for Participation	Frequency of Activity	Partners Included	How Activity Was Noticed	Key Deliverables
			CDPHE, CHA, advocates		
Partnership	In person	Bi-monthly and ad-hoc (x3)	RMHP and YVMC	E-mail	Discussed current projects, status on HTP, and collaborations. Discussed RAE data needs for HTP mid-term report.
Partnership	Phone	x1	LPHA, RHC, Hospital, CMHC, FQHC, community advocacy organization	E-mail	Discuss which organizations need to be engaged in during CHNA for public health department and which ones need to be engaged. How and what information are needed for HTP during this process
Partnership	Via phone	Bi-weekly (x4)	LPHA, RHC, Hospital, CMHC, FQHC, community advocacy organization	E-mail	Organizing the CHNA process. Discussion on topics and questions to ask the community
Involvement	CIVHC Board Room/In person	x1	Health Systems, Payers, CDPHE, CCMU, PCMH	E-mail	SDOH white paper put together by CPA; recommendations on SDOH and referral tools
Involvement	In person	x1	Colorado Health Literacy Coalition and UCHHealth	E-mail	Capture the health literacy rates by county and discussed partnership opportunities.
Consultation	In person	x1	Memorial Regional Health and YVMC	E-mail	Discussed potential of collaboration with YVMC and MRH related to action items coming out of HTP reports in the future
Partnership	Phone	x1	Colorado Health & Human Services, Refugee Department and UCHHealth	E-mail	Gain information on refugee populations, locations, and opportunities for collaboration



Engagement Activity	Location and Manners for Participation	Frequency of Activity	Partners Included	How Activity Was Noticed	Key Deliverables
Consultation	Phone	X1	Northeast CO RETAC	Email	Discuss HTP and possible data-sharing
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).					



III.b. Please respond to the following questions to tell us about your experiences of executing your Action Plan, including the challenges you have faced and how, if at all, you have had to adjust in light of those challenges.

1. Please use the space below to describe:

- Any organizations that you expected to engage but were unable to or that are no longer engaged and your understanding of why; and
- How you have attempted to address these gaps in engagement

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

UCHealth Yampa Valley Medical Center is a rural hospital in Routt County. Stephanie Monahan works as the regional health connector for the Northwest region. She helped us find several groups in the local community to work with.

We met one-on-one with several groups leaders and also relied on regular community meetings. We worked with the Colorado Health Assessment Planning System (CHAPS) to do a community wide health needs assessment.

This included a partnership between the:

- Local public health agency
- Federally Qualified Health Center
- Community mental health center
- Regional health connector
- Community advocacy organizations

These groups were focused on the community health needs assessment. But, they were also open to including the Hospital Transformation Program priority populations and questions into the community wide survey.

We worked with all groups listed in the Action Plan. We also had separate HTP meetings to discuss the items needed in the mid-term report. We did not have any engagement gaps.

All community partners were open to working with YVMC staff and in helping with parts of the HTP mid-term report. We were able to meet with all 10 groups listed in the Action Plan.

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 the timing between Action Plans and Midpoint Reports. The state urged using regular meetings to discuss gathering data and information needed for this report.



But, since many community groups meet every 3 months and hospitals were only given 3 months to conduct the Midpoint report activities, this was a challenge. Also, hospitals did not want to exhaust community groups with similar questions and meetings. It was a challenge to arrange hospitals within one area to gather the same partners.

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 partners listed in our Action Plan. We also met with other partners we had not worked with before during our Action Plan phase. We used larger community meetings to get partner feedback when needed. We also used input and community partnerships in place between UHealth and community groups. Lastly, we worked with the CHAPS team to gather information needed from community citizens. This was in addition to our one-on-one meeting with key community organization providers.

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.

The people who get care from Yampa Valley Medical Center named Routt County as the main county of residence. Those patients using Yampa Valley Medical Center who were not from Routt County were reported as residents of northwest Colorado.

Throughout this application, we focused our efforts on Routt County facts. However, we worked closely with our Regional Accountable Entity (RAE) and community partners in leading a joint 2019 community health needs assessment survey. This targeted residents from:

- Moffatt County
- Routt County
- Rio Blanco County

The RAE also gave us regional data that included northwest Colorado.

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 conducted several surveys and interviews with community organizations. We leveraged ongoing community meetings to ask for pertinent information and reviewed public documents that contained general population information. We would like to thank all of our community partners for helping us convene community stakeholders and in gathering data for the mid-term report.

In addition, we developed an internal UCHealth data workgroup to evaluate our internal electronic health record data. Finally, we collaborated with the Regional Accountable Entity and received data pertinent to the Medicaid population. The Health Policy and Finance Center also provided hospitals with de-identified data on Medicaid members that utilized the hospital identified in this application.



References:

- [1]
<http://www.countyhealthrankings.org/app/colorado/2019/rankings/teller/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] 2019 Community Health Needs Assessment (CHNA) survey. We used pre-liminary, incomplete survey results due to the HTP mid-term report deadline of April 19, 2019. Results will be made publicly available soon.
- [6]
https://www.colorado.gov/pacific/sites/default/files/Routt%20County%20Fact%20Sheet_0.pdf
- [7] Health Care Policy and Finance, Hospital Transformation Program Data Source
- [8] <https://www.colorado.gov/pacific/cdphe/vision-data-too>
- [9] <https://www.cohealthdata.dphe.state.co.us/chd/Resources/vs/2015/Routt.pdf>
- [10] https://www.colorado.gov/pacific/sites/default/files/PF_Maternal-Mortality-fact-sheet.pdf
- [11] [<https://www.colorado.gov/pacific/cdphe/vision-data-tool>].
- [12] Coloradohealthinstitute.org (2017 CHAS Regional Data).
- [13] <https://www.coloradohealthinstitute.org/research/suicides-colorado-reach-all-time-high>
- [14] <https://www.colorado.gov/pacific/cdphe/prescription-drug-data-profiles>
- [15]
https://www.colorado.gov/pacific/sites/default/files/PW_ISVP_Colorado%20Rx%20Drug%20Data%20Profile.pdf
- [16] <https://docs.google.com/spreadsheets/d/1yjXg9jXaobbLr-tHklzQM64GXSqYHlv965W6hfJPpEO/edit#gid=507796616>
- [17] <https://s3.amazonaws.com/uchealth-wp-uploads/wp-content/uploads/sites/4/2017/11/20131131/YVMC-Yampa-Valley-Community-Health-Needs-2015.pdf>

IV.c. Please use the space below to describe any data gaps encountered while conducting the environmental scan, and how these were accounted for.



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

We found many data gaps in the Medicaid population. Most public and community group datasets are full and not broken out by payor source or special groups.

We were not able to get details from the state or the RAE on these items:

- income
- employment status
- education
- health literacy levels

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

1. Data telling us about Medicaid enrollees that use the hospital services may not be the same as to the Medicaid population as a whole in that area.
2. Knowing how much a person uses the hospital can't be known for sure since data about a person was only used once. It was not used for each time they came to the hospital for care.
3. The data we have may not show the true amount that people on Medicaid use on a service at the hospital. People may have Medicaid only part of the year based on life changes effecting their enrollment status. These Changes in Medicaid enrollment status is called "churn".

There were very few details about the features of the enrolled Medicaid population but especially the HTP at risk populations.

For example, question IV.d.ii: We were not able to find these demographics for local citizens with mental health concerns:

- income
- employment status
- housing status
- education
- health literacy for Medicaid clients with behavioral health issues

We were unable to find these demographics for new mothers with Medicaid:

- income
- employment status



- disability status
- immigration status
- housing status
- main languages spoken

We gathered the details listed in this question from national data and qualitatively (observed to gather data that is not a number) from our community groups. Finally, we were unable to find demographics for Medicaid members getting hospice or palliative care. We asked several community partners, the Regional Accountable Entity (RAE) and the Health Policy and Finance Center (HCPF) for this information and neither were able to provide this.

No data source tells us the number of providers in Colorado accepting Medicaid, including by specialty type.

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:

Routt County

- 25,220 residents, making up 0.5% of overall Colorado's population [1]
- 11,399 rural residents (45.2%) [1]

Gender

47.8% female



52.2% male [1]

Race and Ethnicity

- 22,637 (89.8%) Non-Hispanic Whites
- 200 (0.8%) African American
- 1,768 (7.0%) Latino/Hispanic
- 207 (0.8%) Asian
- 23 (0.1%) Native Hawaiian/Other Pacific Island Native [1].

Age

- 4,590 (18.2%) were below 18 years of age
- 16,973 (67.3%) between 18 and 64 years of age
- 3,656 (14.5%) 65 years of age and older [1].

Income and Employment Status

State of Colorado

- 2.8% unemployment rate
- 12.7% live at or below the Federal Poverty Level (FPL)
- Average household income was \$69,100

Routt County

- 2.4% unemployment rate
- 10.5% live at or below the FPL [2].
- Average household income was \$76,500 [1].



Disability Status

- Southeast Routt County had lower rates of people with a disability (0.0% to 6.8%) compared to North Routt County (6.9% to 9.3%) and Southwest Routt County (9.4% to 11.6%) [2].

Immigration Status

As stated by the Migration Policy Institute

- no foreign-born immigrants [3]
- No refugees arrived during 2018 [3]

Housing

- About 70% of all residents were homeowners

Education and Health Literacy Status

State of Colorado

- High school graduation rate is 79%

Routt County

- High School graduation rate is 94%

As stated on the Health Literacy Data Map:

- North Routt County health literacy rate was in the second highest state quartile,
- South Routt County was in the second lowest state quartile [4].

Primary Language

- In 2017, 2% of people lacked an English proficiency [1].

Unique characteristics that impact the health of YVMC service area:

Routt County is a rural community with long-term residents. The county also has workers that are employed by ski resorts or coal mining companies for some part of the year (seasonal). Seasonal employment brings up several issues linked to the unstable social factors of health and health care coverage. There are unique needs linked to workforce development and sustainability challenges:

- Issues finding affordable housing.



- Steamboat Springs is a destination resort. The cost of rental properties during the ski season and summer months adds to lack of housing available for residents.
- Minimum wage workers having to commute to and from nearby counties.
- The cost of rental properties during the ski and summer seasons contributes to the lack of housing available for residents.
- Lack of child care services. Concerns have been raised by working parents and employers. During the 2019 CHNA survey, residents noted access to childcare services as one of the top three priorities for their community [5].

2019 CHNA survey findings:

- About 43.9% of respondents noted very good overall health.
- Less than 6% noted overall fair to poor health.
- Residents in our hospital service area noted that they get timely and coordinated health services [5].
- Finally, according to the survey, the 3 most important factors to a healthy community included:
 - o good paying jobs and livable wages (59.5%)
 - o affordable health care (42.2%)
 - o quality of education (33.8%)

Please note that a little over 70% of all respondents had employer-based insurance [5].

Medicaid Population:

- 3,761 (14.9%) Health First Colorado Members enrolled each month.
 - o 1,709 (45.4%) were Affordable Care Act (ACA) expansion adults
 - o 1,303 (34.6%) were children [6]
- UCHealth Yampa Valley Medical Center evaluated 2,177 unique Medicaid citizens [7].

Age

- 521 (23.9%) were below 18 years of age



- 1,572 (72.2%) were between 18 to 64 years old

Gender

- 58.2% females
- 41.8% males [7]

Race and Ethnicity

- 1,187 (54.5%) Non-Hispanic Whites
- 570 Multiple Races (26.2%)
- 10 (0.5%) African American
- 111 (5.1%) Latino/Hispanic
- 5 (0.2%) Native Hawaiian/Other Pacific Islander [7].

Disability

- 222 (10.2%) Medicaid enrollees had permanent disabilities

Refugee

- 49 (2.3%) were legal permanent residents
- No refugees

Housing

- 30 people without homes [7]

Main Language

- Less than 2.4% of Medicaid enrollees spoke languages other than English [7]. But, the secondary language field had 22% missing responses. So, we may not have all the facts. [7].

We were not able to get details from the state or the RAE on these items:

- income
- employment status
- education



<ul style="list-style-type: none"> health literacy levels
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IV.d.ii. Please also provide information about the HTP populations of focus within the hospital's service area, including:

- Individuals with significant health issues, co-occurring conditions, and / or high health care utilizers;
- Vulnerable populations including related to maternal health, perinatal, and improved birth outcomes as well as end of life care;
- Individuals with behavioral health and substance use disorders; and
- Other populations of need as identified by your landscape assessment. Please consider those at-risk of being high utilizers to whom interventions could be targeted. This should include populations that may not currently receive care in the hospital but are known to community organizations and reflected in the response to IV.d.i.

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

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

UCHealth Yampa Valley Medical Center looked at 120 Medicaid enrollees who are high health care service users during a 12 month period.

Age

- 19 (15.8%) were below 18 years of age
- 95 (79.2%) were between 18 to 64 years old
- 6 (5.0%) were 65 years of age and older [8].

Gender

- 61.7% females
- 38.3% males

Race/Ethnicity

- 71 (59.1%) Non-Hispanic Whites
- 30 (25.0%) Multiple Races



- 1 (0.8%) African American
- 6 (5.0%) Latino/Hispanic [8].

Disability

- 18 (15.0%) Medicaid enrollees had permanent disabilities

Immigration status

- 1 Medicaid enrollee (0.8%) was a legal permanent resident.
- no refugees

Main Language

- less than 2% of Medicaid enrollees spoke languages other than English [8]

People living without a home are more likely to be high users of the health care system when compared with those who have stable housing.

- 7 people without homes and on Medicaid were high users of Yampa Valley Medical Center
- 30 people without homes and on Medicaid used Yampa Valley Medical Center during the state fiscal year 2018 [7].
- The Medicaid population of those living without homes made up less than 1% of the total Medicaid population using Yampa Valley Medical Center.

We were not able to get details from the state or the RAE on these items:

- income
- employment status



- education
- health literacy levels

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

In the state of Colorado, 16.7% of all Medicaid pregnant women had insurance a month before pregnancy.

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

- be between 20 to 34 years of age
- 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

We were not able to get details about Medicaid members getting hospice or palliative care.

People with behavioral health disorders:

- single largest payer in the U.S. for behavioral health disorders including:
 - o mental health
 - o substance use disorders [10]
- most common mental health disorder is major depressive disorder
- females are more likely to have a mental health disorder than male enrollees



- African Americans and Latino/Hispanics with Medicaid are more likely to have a mental health disorder, compared to Whites.
- Members with disabilities are more likely to also have a mental health disorder or substance use disorder.
- About 1 in 4 Medicaid members diagnosed with a mental health disorder also have some other issues such as substance use disorder.
- More likely to be divorced or separated compared to people with mental health disorders that have private insurance.
- Less likely to work full time compared to a person with behavioral health disorders that have private insurance.
- are mostly young, between ages 18 and 55 years of age
- Chronic physical health and behavioral health issues in this group is like the broad population. 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.
- In total, 12% of all Medicaid enrollees had one more mental health disorder. These enrollees most often used Yampa Valley Medical Center for:
 - o alcohol-related disorders
 - o mood disorders
 - o anxiety disorders

Other populations of need:

Community residents and group leaders mentioned high Medicaid turnover rates. This lead to instability of receiving health care services, especially for seasonal workers. 14.5% of the Routt County population is older than 65 years old compared to 13.8% of Colorado residents older than 65 [1]. Aging populations are at high risk of becoming high utilizers. According to UCHHealth's electronic health record, 20% of all patients who are 65 and older have Medicaid insurance, and many seniors have Medicare or private insurance.

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 and Substance Use Disorders:

The age-adjusted death rate due to suicide is:

- less than 8.5 people per 100,000 Routt County residents
- 19.5 people per 100,000 in the state of Colorado [13]

But, 50% of all respondents of the 2019 CHNA survey said they knew someone who had suicidal thoughts or attempted suicide [6].

The data suggest that the most undertreated conditions are:

- depression (76.2%)
- anxiety (60.3%)
- suicidal thoughts (51.3%)

According to the state dataset, there were no emergency department (ED) visits to UCHHealth Yampa Valley Medical Center for serious behavioral health disorders for those who are emergency department high utilizers. This is defined as 4 or more ED visits in 12 months [7]. Also, when reviewing the statewide Medicaid dataset, there were no ED visits for primary serious mental health diagnosis [7]. This finding may be linked to the fact that the State Medicaid dataset only includes physical health data and not behavioral health data.

Alcohol-related disorders

- top substance use disorder
- made up 55% of all visits for those who have 1 or more substance use disorder conditions
- data shows that the most common linked conditions were:
 - o mental health disorders
 - o alcohol-related disorders

Alcohol-impaired driving deaths

Routt County

- 56% rates of death

The state of Colorado

- 34% rates of death [1]



Alcohol abuse and dependence diagnosis

- leading cause of being admitted to the hospital for many Medicaid members with chronic conditions [7]

In working with Rocky Mountain Health Plans, we were told that alcohol use disorder was the top potentially avoidable cost category.

Also, chronic respiratory conditions such as asthma and chronic obstructive pulmonary disease are linked with depression and anxiety and are often seen together.

In 2017 in Routt County

- 7,264 unique patients received 34,763 opioid prescriptions [14]
- The top payer source for opioid prescriptions was private insurance
 - o followed by Medicare
 - o Medicaid
- is in the lowest quartile for ED visits related to prescription opioids at 4.1 to 9.8 visits for each 100,000 people
- 5.1 to 10.9 hospital admissions for each 100,000 people related to prescription opioids
- the second highest rate of age-adjusted opioid-related deaths at 6.7 to 9.6 deaths for each 100,000 people
- Age-adjusted heroin-related overdose rates were the second lowest in the state of Colorado at 1.7 to 2.6 deaths for each 100,000 people [15].

Results from the 2019 CHNA survey showed that almost 70% of all respondents know someone who has either drug addiction or alcohol use disorder [5].

The community named these as the 3 substance use disorder diagnoses that are most concerning:

- heroin (60.0%)
- alcohol (55.9%)
- methamphetamines (50.0%) [5]
- 12% of all Routt County residents smoke cigarettes



- 16% of people in the state of Colorado smoke cigarettes [1]

Other Significant Physical Chronic Conditions:

According to public datasets, compared to Colorado, in Routt County:

- 12.9% of people have asthma
- 3.3% of people have diabetes
- 1.1% of people have coronary artery disease (1.1), [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)

Top Chronic Conditions Accounting for Most Hospital Utilization:

- 55.2% of Routt County residents have 1 or more chronic diseases
- 62.7% of people in Colorado have 1 or more chronic diseases [8]

Quality of life markers

Routt County

- 2.9 poor physical days [1].
- poor mental health days

The state of Colorado

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

According to the state's Medicaid high utilizer dataset, there are 94 emergency department (ED) high utilizers. This is defined as 4 or more ED visits in 12 months.

- This resulted in 269 ED visits [7].



- The average number of ED visits by a high user of services by someone on Medicaid for UCHHealth Yampa Valley Medical Center was 2.9 ED visits a year.

o This was lower than the 6.3 ED visits a year in the state of Colorado [7].

In working with Rocky Mountain Health Plans, alcohol use disorders were at the top of the potentially avoidable costs category.

In reviewing Yampa Valley Medical Center's electronic health record data, people with a mental health disorder on Medicaid came to the hospital most often for:

- alcohol-related disorders
- mood disorders
- anxiety disorders

- The alcohol-related disorders were the main reason for being admitted to the hospital for Medicaid members with mental health disorders.

- Mood disorders were the main reason for Medicaid members with mental health disorders using the ED. 91

- Medicaid members who used Yampa Valley Medical Center had 1 or more mental health disorders. This resulted in 179 visits over a period of 6 months.

When reviewing the UCHHealth electronic health record data, high utilizers most often use Yampa Valley Medical Center for non-chronic disease conditions such as:

- belly (abdominal) pain
- injury
- sprains

The 5th leading cause of hospital use by high utilizers is alcohol-related disorders. About 13% of Medicaid high utilizers of Yampa Valley Medical Center have 1 or more mental health disorders. 10% have a diagnosis of alcohol use disorder.

In working with Rocky Mountain Health Plans, depression and anxiety is the 5th leading cause of the potentially avoidable costs category. We did not get data on any linked diagnosis with these issues.

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

Routt County



- 12.8% rates of depression
- 1.9% rates of anxiety

The state of Colorado

- 18.4% rates of depression
- 16.4% rates of anxiety [10]

In reviewing the UCHHealth electronic health record, we found that about 8.6% of all Yampa Valley Medical Center Medicaid covered visits were for people with 1 or more substance use disorders.

Alcohol-related disorders are the 4th and 8th leading cause of emergency department use for those with Medicaid insurance and all payers.

Diabetes and high blood pressure were the 2 most common co-morbidities leading to hospital inpatient stays.

However, there are very low rates of diabetes or high blood pressure related diagnoses for Medicaid members who are admitted to Yampa Valley Medical Center.

In reviewing the state's vulnerable population dataset, there were fewer than 5 visits for each Medicaid enrollee with chronic conditions. Even for those with the most common chronic disease (high blood pressure), the most common hospital admission was for non-chronic disease related admissions such as a hip replacement.

Related to maternal, perinatal and improved outcomes:

According to UCHHealth's electronic health record data:

- 7% of all mothers who deliver their babies at Yampa Valley Medical Center have 1 or more maternal mental health diagnosis that affected their pregnancy.
- Mothers covered by Medicaid are twice as likely to have 1 or more perinatal mental health diagnosis compared to those who have private insurance.
- Less than 2% of all mothers have a substance use disorder diagnosis that leads to pregnancy-related complications.

In 2017, there were 236 total live births in Routt County

- 9% of those births leading to low birth weight babies [1,9].
- 76.1% of pregnant women had adequate prenatal care
- 63.2% of pregnant women had adequate prenatal care in the state of Colorado [17]



- 9 teen births in Routt County
- 22 teen births in the state of Colorado (22) [1]
- Routt County has the same rates of low birthweight babies (9%) when compared with the state of Colorado (9%) [1].
- Child death prevalence is not indicated for Routt County. So, it cannot be compared with the state of Colorado (40) [1].
- Vaginal deliveries and Cesarean sections were noted in the state dataset as the top 2 diagnosis accounting for the highest amount of Medicaid paid dollars to Yampa Valley Medical Center [7].
- Colorado ranks 29th in the U.S. for maternal mortality rates.
- Over 60% of all maternal mortality occurs in the post-partum period.
- Behavioral health has been identified as the leading cause of maternal death [10].
- Routt County mothers have slightly higher rates of postpartum depression (12.3%) when compared with the state of Colorado (11.2%) [11].
- There are few mental health providers in the area that can address postpartum maternal mental health.
- 44.6% of people in Routt County have an advanced directive. This is slightly higher compared to 35.7% in the state as a whole [12].
- 92 Medicaid patients who came to Yampa Valley Medical Center during the fiscal year 2018 had home-based community services.
- 35 Medicaid patients lived in a nursing home [7]

Related to end of life care:

People making the end of life care decisions require education and understanding of the goals of an advanced directive. When making decisions about palliative and hospice care, it is vital to be sure that a behavioral health condition does not impair the patient's decision-making ability.

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:

Routt County

- primary care provider to resident ratio of 880 to 1



- well below the top U.S. performers and Colorado's rate [1].

This means that primary care providers have small panels. This lets them spend time with their patients. This shows that access to primary care in this community should not be a challenge [1]. The 2019 CHNA survey validates the statement mentioned above in that about 80% of all survey respondents have a primary care provider [6].

In working with Rocky Mountain Health Plans, we noted the top 3 primary care attribution clinics for Medicaid members who use Yampa Valley Medical Center to be:

- Steamboat Medical Partners
- Northwest Colorado Health
- Yampa Valley Medical Associates

Gaps in primary care access are related to transportation and distance from the Medicaid enrollee's home and the PCMH.

Specialty Care:

According to the community health needs assessment (CHNA) survey, Routt County residents have to travel to urban areas for many specialty care services.

Nearly half of all residents in Routt and Moffat counties had to leave their home community for medical services [6]. To not have to travel to get health care services, residents note a need for:

- endocrinology
- addiction specialists

Both of these specialties are great options for telehealth-based services.

Long Term Care:

During the fiscal year of 2018:

34 Medicaid members who came to Yampa Valley Medical Center were discharged to a nursing home facility [8].

- Casey's Pond is the only nursing home facility in Routt County.

In talks with Casey's Pond staff, they expressed challenges related to caring for residents with behavior needs. This often comes with a dementia diagnosis.

The team at Casey's Pond noted that they have a hard time with employment given high turnover and lack of people available to work in nearby areas. Due to the high cost of living, most employees live in surrounding towns such as Hayden or Craig.



They also noted that since hiring a dedicated hospital care coordinator, they had seen large improvements in transitions of care.

The care coordinator visits patients:

- admitted to the hospital
- before discharge
- to be sure they are a good fit for Casey's Pond

Northwest Colorado Health provides home health services to all Routt County residents. In talks with members of Northwest Colorado Health, 30-day hospital re-admission rates for Medicaid members receiving home health services were indicated.

Reasons for these high re-admission rates included:

- complex patient population
- high social needs

Complex Care Management:

- conduct a face-to-face assessment of all patients admitted to the hospital
- is responsible for assessing and addressing social determinants of health
- initiating nursing home placement
- When needed, the care managers will also create a detailed care plan with the patient.

Rocky Mountain Health Plans subcontracts care management services with Northwest Colorado Health Partnership.

- This agency receives notices each day of Medicaid members who were recently admitted to the hospital and were seen in the ED.
- They conduct telephone outreach and can outreach about 40% of all clients.

Northwest Colorado Health, also has a team of care managers who do outreach and transitions of care for all its members.

Care Coordination via Primary Care or Other Providers:

The Federally Qualified Health Center in the area is Northwest Colorado Health. They provide care coordination for all of its members.



Northwest Colorado Health works with the Northwest Colorado Health Partnership care coordinators so they don't offer the exact same services.

- The RAE is accountable for providing care coordination to all of its Medicaid members.

Maternal Health, perinatal health, and improved birth outcomes:

- 76.1% of pregnant women received adequate prenatal care
- 63.2% of pregnant women received adequate prenatal care in Colorado [17]

Medicaid maternal care is mostly provided by Northwest Colorado Health and Yampa Valley OB/GYN clinics.

Very few pregnant women had a diagnosis of diabetes and delivery complications from their chronic disease.

Northwest Colorado Health is also the local public health agency. They provide family planning and home visits after a woman gives birth.

According to the UCHHealth electronic health record data, substance use disorder rates in pregnant women who came to the hospital are very low. At Yampa Valley Medical Center, all patients who are "high risk" have a care management assessment and post-partum follow up visits.

Gaps include:

- getting women to their visits after giving birth because of transportation challenges
- finding specialists in treating mental health disorders after giving birth

End of Life Care:

In talks with community stakeholders, Routt County sees a growth in the aging population. Residents of Colorado and other states see Routt County as a "great place to retire."

Routt County residents are more likely to have an advanced directive compared to residents in the rest of the state. The Northwest Health Partnership provides hospice care for Routt residents. At this time, the hospital care manager approaches patients who are interested in getting hospice care. The manager explains services and make connections with North West Health Partnership staff. Gaps include having access to palliative care specialists and hospice inpatient care.

Behavioral Health:

- Many community stakeholders said there is poor access to limited mental health and substance use disorder services for those who live in Routt County.



- Most mental health providers only accept cash payments and are not contracted with insurance companies.
- The major community mental health center for Routt County Medicaid members is Mind Springs. They provide mental health and substance use disorder services.
- The local clinic that takes Medicaid and offers medication-assisted treatment to Routt County Medicaid citizens is Road to Recovery.

The North West Health partnership has a prescription drug education program. The role of their community liaison is to:

- lead a prescription task force
- offer medical education for medical providers
- visit primary care provider offices

Most recently, the community liaison shared a documentary on behavioral health and substance use disorder to community residents to further their education on this topic.

Right now, no detoxification centers available for Routt County residents with Medicaid insurance. Providers in the area claim the lack of reimbursements in those areas is the main barrier in keeping such a program.

Other Outpatient Services:

Community stakeholders mentioned not having access to dialysis outpatient centers in Routt County. Other specialized services are also not available locally. This makes Routt County residents have to travel long distances for care.

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

Northwest Colorado Health and Northwest Health Partnership work closely with the RAE in setting up the state approved RAE population health plan.

Northwest Colorado Health provides:

- family planning
- health screenings
- preventative care outreach
- immunizations
- chronic disease education classes
- primary care services



Perceived Gaps and Social Services Resources Available in the Community:

In talks with community and hospital care managers, major gaps in the community include:

- lack of nursing homes that will accept Medicaid members
 - o mostly those with wound care and behavioral health needs
- not enough detoxification centers to treat those with substance use disorders
- transportation issues

At this time, the closest inpatient psychiatric facility is about 3 hours away from Steamboat Springs. The local emergency medical services company is not able to do inter-facility transfers for Medicaid members who need to receive inpatient psychiatric care. Their resources are limited, and they must stay close to attend to local emergency calls. Police officers or local transportation companies must transport Medicaid members with mental health issues.

Routt residents who present to Yampa Valley Medical Center are seen by Mind Springs if they have a sudden change in their psychiatric condition and need:

- inpatient psychiatric care
- intensive outpatient treatment
- partial hospitalization

Medicaid does not reimburse the latter.

Due to not enough space and service areas that are distant from one another, at times, it may take many hours before a behavioral health evaluation can be completed.

Only 30% of community members who completed the 2019 CHNA survey noted that behavioral health disorder programs in the area met their needs. These programs include:

- facilities that special in anxiety and depression treatment

Community residents also mentioned that the top 3 areas that need improvement are:

- access to behavioral health programs such as:
 - o support for depression and anxiety
- pay that can be lived on for basic needs
- access substance use disorder programs

Available resources and partners that can be leveraged:



Northwest Colorado Health is a multi-service center. They offer:

- primary care for vulnerable populations
- hospice and home health agency services
- local public health agency services

We have met with their leaders. They want to build a stronger partnership that will better help provide care transitions to Medicaid clients coming to Yampa Valley Medical Center.

Yampa Valley Medical Center has sponsored school-based counselors to provide services to young children and adolescents. This partnership between the hospital and many community stakeholders is being started and evaluated this year. The goal is to decrease suicide rates in children and adolescents.

Northwest Colorado Health Partnership is a subcontractor of Rocky Mountain Health Plans and provides complex care coordination. Their leadership is also very invested in working closely with the hospital to provide care transitions to Medicaid members who come to Yampa Valley Medical Center. Also, members of their team are starting an Accountable Health Communities model that assesses and addresses social determinants of health. This program will also evaluate current community resource capacity and gaps in services.

Mind Springs is the local community mental health center. West Springs is the inpatient psychiatric hospital. They would like to partner in caring for those with mental health and substance use disorders.

Rocky Mountain Health Plans recently won the crisis services bid for RAE Region 1. This may also provide great chances for partnership and introduction of innovative tools. This will help us better care for those with behavioral health needs.

Perceived gaps:

Community stakeholders brought up that the cost of living is very high in Routt County. Many mentioned that most minimum wage workers live in nearby counties and have to commute to work. This affects building a workforce and retaining employees, including but not limited to health care workers. About, 18% of all 2019 CHNA respondents mentioned having lack of access to housing.

In reviewing the state dataset and our internal hospital dataset, we noted that there are less than 30 people who have no home and are covered by Medicaid who came to Yampa Valley Medical Center. But, when talking to the hospital staff, they mentioned that the few people with no homes have no safe place to go, given the cold weather conditions. There are also no available shelters in the area. This results in longer stays in the hospital that did not have to happen.



In talks with community groups and hospital employees, medical-legal needs did not come up as a common issue. There are volunteer legal agencies and lawyers that offer free services to community members.

Food insecurity came up in many talks with community groups. But, only 5% of the 2019 CHNA respondents noted food insecurity as a personal challenge [6]. Over 70% of all survey respondents mentioned that they have access to quality foods [6].

Routt County is part of the Accountable Health Community grant. This looks at and addresses social determinants of health. The grant requires a multi-stakeholder partnership and the use of standardized social determinants of health assessment tools.

In total, 13.3% of all Routt County residents are obese, which is lower than the state of Colorado rates (21.7%).

Housing/Homeless:

Nearly all community partners named housing as one of the most significant gaps in social supports for HTP priority populations. This ranged from safe housing environments, especially for older adults or frail elderly as well as children with special health care needs.

Permanent supportive housing that includes “wrap around” services to address needs in the areas of:

- medical
- behavioral health
- social needs is needed

These are in short supply for people with behavioral health and physical health concerns.

One major need that was noted is the lack of housing that can be afforded for people in the County. This includes apartments.

Partners see people moving around often. This impacts whether and how they get care. This movement that is due to no fault of their own but it may also have a negative impact on behavioral health. People with low wages have long term and health issues may less resources to devote to other basics like food and housing as they struggle to cover health care costs.

Legal, Medical/Legal and Financial Services:

This item was not brought up as an issue for those living in our hospital service area. There are centers that help address legal issues with no charge to people.

Nutrition:



There are some community resources and services available to meet patients' nutritional needs. This may include local community groups, as well as the local public health department (SNAP/WIC).

We found community groups that provide food delivery or food pantry services to Routt County residents. Many of those groups are supported by donations and grants. We were not able to find a meals-on-wheels program.

Employment and Job Training:

In general, workforce development and retention are challenging in Routt County. The cost of living is high. The minimum wages do not cover basic expenses and it is hard to recruit, train and retain:

- certified nursing assistants
- nurses
- medical specialists such as
 - o high-risk obstetricians
 - o critical care
 - o operating room nurses

Transportation:

Transportation is a major barrier, both for inter-facility transportation, as well as for Routt County residents to get to and from visits. Emergency service companies often are not able to provide transfers from 1 place to another such as hospital to a nursing home. To help with patient transfers, hospital care managers rely on:

- family members
- friends
- local limousine transportation companies

Medicaid does not pay for any of these transportation options.



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 Yampa Valley Medical Center	1024 Central Park Drive, Steamboat Springs, CO 80487	Hospital Inpatient Services including but not limited to: addiction medicine, adolescent medicine, allergy, cardiovascular disease, dermatology, diabetes, diagnostic radiology, emergency medicine, family medicine, gastroenterology, general practice, general surgery, hand surgery, internal medicine, obstetrics & gynecology, ophthalmology, orthopedic surgery, orthopedic surgery of the spine, otolaryngology, pain management, pediatrics, plastic surgery, podiatric medicine, psychiatry, psychology, radiology, sports medicine, urology
Outpatient Clinic	UCHealth Pulmonology Clinic - Steamboat Springs	940 Central Park Drive, Suite 202, Steamboat Spring, CO 80487	Pulmonology, Respiratory
Outpatient Clinic	UCHealth Jan Bishop Cancer Center - Steamboat Springs	1024 Central Park Drive, Suite 2000, Steamboat Springs, CO 80487	Cancer Treatment, Infusion
Outpatient Clinic	UCHealth Gloria Gossard Breast Care Center - Steamboat Springs	1024 Central Park Drive, Suite 1100, Steamboat Springs, CO 80487	Mammography, Women's Health
Outpatient Clinic	UCHealth Orthopedics - Yampa Valley Medical Center	1024 Central Park Drive, Steamboat Springs, CO 80487	Orthopedics, Physical Therapy, Rehabilitation, Sports Medicine, Surgery
Emergency Room	UCHealth Emergency Care - Yampa Valley Medical Center (Hospital-based)	1024 Central Park Drive, Steamboat Springs, CO 80487	Emergency Room, Emergency Transport, Surgery, Trauma, Wound Care
Pharmacy	UCHealth Yampa Valley Medical Center Pharmacy	1024 Central Park Drive, Steamboat Springs, CO 80487	Pharmacy
Radiology	UCHealth Radiology - Yampa Valley Medical Center	1024 Central Park Drive, Steamboat Springs, CO 80487	Imaging, Radiology



Facility Type	Facility Name	Facility Address	Services Offered
Outpatient Clinic	UCHealth SportsMed Clinic - Steamboat Springs	1024 Central Park Drive, Steamboat Springs, CO 80487	Occupational Therapy, Physical Therapy, Rehabilitation, Speech Therapy, Sports Medicine, Wound Care
Outpatient Clinic	UCHealth SportsMed Clinic - Hayden	300 S. Shelton Lane, Hayden, CO 81639	Physical Therapy, Rehabilitation
Outpatient Clinic	UCHealth SportsMed Clinic - Oak Creek	300 Main Street, Oak Creek, CO 80467	Physical Therapy, Rehabilitation
Outpatient Clinic	UCHealth SportsMed Pediatric Therapy Clinic - Steamboat Springs	940 Central Park Drive, Suite 290, Steamboat Springs, CO 80487	Pediatrics
Outpatient Clinic	UCHealth Heart and Vascular Clinic - Steamboat Springs	940 Central Park Drive, Suite 202, Steamboat Springs, CO 80487	Cardiology, Heart and Vascular
Birth Center	UCHealth Birth Center - Yampa Valley Medical Center	1024 Central Park Drive, Steamboat Springs, CO 80487	Birth Center, Obstetrics/ Gynecology, Pregnancy Care
Laboratory	UCHealth Laboratory - Yampa Valley Medical Center	1024 Central Park Drive, Steamboat Springs, CO 80487	Laboratory
Outpatient Clinic	UCHealth Nutrition Services - Yampa Valley Medical Center	1024 Central Park Drive, Steamboat Springs, CO 80487	Nutrition, Diabetes, Weight Loss
Outpatient Clinic	UCHealth Occupational Medicine Clinic - Steamboat Springs	3001 S. Lincoln Avenue, Suite A, Steamboat Springs, CO 80487	Occupational Medicine
Outpatient Clinic	UCHealth Pain Management Clinic - Steamboat Springs	3001 S. Lincoln Avenue, Suite A, Steamboat Springs, CO 80487	Pain Management
Outpatient Clinic	UCHealth Sleep Lab - Steamboat Springs	1024 Central Park Drive, Steamboat Springs, CO 80487	Sleep Disorders
Outpatient Clinic	UCHealth Surgical Care - Yampa Valley Medical Center	1024 Central Park Drive, Steamboat Springs, CO 80487	Surgery
Outpatient Clinic	UCHealth Women's Care Clinic - Steamboat Springs	1100 Central Park Drive, Suite 1000, Steamboat Springs, CO 80487	Obstetrics/ Gynecology, Pregnancy Care, Women's Health
Outpatient Clinic	UCHealth Pulmonary Rehabilitation - Yampa Valley Medical Center	1024 Central Park Drive, Steamboat Springs, CO 80487	Pulmonology, Respiratory
Outpatient Clinic	UCHealth Cardiac Rehabilitation - Yampa Valley Medical Center	1024 Central Park Drive, Steamboat Springs, CO 80487	Cardiology, Heart and Vascular, Rehabilitation



Facility Type	Facility Name	Facility Address	Services Offered
Outpatient Clinics (Multiple)	UCHealth Outpatient Pavilion - Yampa Valley Medical Center	1100 Central Park Drive, Steamboat Springs, CO 80487	Outpatient Clinics
Outpatient Clinic	UCHealth Diabetes Education - Yampa Valley Medical Center	1024 Central Park Drive, Steamboat Springs, CO 80487	Diabetes
Outpatient Clinic	UCHealth Endocrinology Clinic - Steamboat Springs	1100 Central Park Drive, Jan Bishop Cancer Center, Suite 2000, Steamboat Springs, CO 80487	Diabetes, Endocrinology
Outpatient Clinic	UCHealth Integrative Medicine Clinic - Steamboat Springs	3001 S. Lincoln Avenue, Suite A, Steamboat Springs, CO 80487	Integrative Medicine
Outpatient Clinic	UCHealth Ear, Nose and Throat Clinic - Steamboat Springs	940 Central Park Drive, Suite 207, Steamboat Springs, CO 80487	Ear Nose and Throat

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)

Community stakeholders talked about the bias around behavioral health as a disease area. This gives great chances to provide mental health and substance use care in primary care medical homes.

Seasonal employment was also brought up as an issue in Routt County. This leads to high unemployment rates and instability of social determinants of health.

Routt County residents also noted that the growth of the aging population has resulted in many of the county's residents living alone. Loneliness in the elderly population was pointed out as an issue when discharging patients from the hospital. They often need extra support and don't have social connections that often leads to depression.

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.

We have no other details.



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"> North West Community Health (seen within 14 days) Steamboat Medical Group Yampa Valley Medical Alliance Pediatrics of Steamboat Sleeping Bear Pediatrics Steamboat Springs Family Medicine (concierge only) 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Accountable care organization with care management or transition care	<ul style="list-style-type: none"> Health Partnership serves Medicaid, uninsured, dually eligible, Medicare, and undocumented Transitions process: not a direct liaison, but receives calls from SW Services: appointments, social needs, transportation, housing, connection to non-covered services (dental/hearing), home visits (60 question assessment), identify other needs not identified in referral (documented in SSETT–reformed to model after HCM) 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Medicaid managed care organizations	<ul style="list-style-type: none"> Behavioral health for Medicaid patients with majority of referrals to Mind Springs Health. Issue with timely appointments, undetermined if there is a limit for Medicaid patients Mind Springs does telehealth with psychiatrists in Summit County, 1-2 psychiatrists accept Medicaid (i.e. Kathy Gibbs) 	<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
Program of All-inclusive Care for the Elder (PACE), Senior Care Options (SCO), Duals Demonstration providers	<ul style="list-style-type: none"> Unclear if any exist. 	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Medicaid health homes	<ul style="list-style-type: none"> Primary Care Services UCHealth Craig Clinic Northwest Health Partnership Yampa Valley Medical Associates 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Multiservice behavioral health centers, including behavioral health homes	<ul style="list-style-type: none"> Mind Springs 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Behavioral health providers	<ul style="list-style-type: none"> Mind Springs 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Substance use disorder treatment providers	<ul style="list-style-type: none"> Mind Springs Mountain Medical (1-year around) does MAT Road to Recovery Foundry offers detox for private payors 	<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"> Cancer Center at Yampa Valley Medical Center No HIV clinic No pulmonology clinic No dialysis centers 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Pain management or palliative care	<ul style="list-style-type: none"> Pain management clinic at Yampa Valley Medical Center Road to Recovery 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Physician/provider home visit service	<ul style="list-style-type: none"> North West Colorado Health 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Skilled nursing facilities	<ul style="list-style-type: none"> Casey's Pond will accept Medicaid for the DOAK (hospital transitions for rehab) No long term care available Other SNFs include: Sand Rock Ridge – Craig, CO and The Haven – North West Colorado Health Assisted Living includes: Cliff View in Kremmling 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Home health agencies	<ul style="list-style-type: none"> People Care offers home aide North West Colorado Health 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Hospice	<ul style="list-style-type: none"> North West Colorado Health 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Adult day health	<ul style="list-style-type: none"> None 	<input type="checkbox"/>	<input checked="" type="checkbox"/>



Provider or Agency	Transitional Care Services [Examples]	Yes	No
Public health nurses	<ul style="list-style-type: none"> North West Colorado Health 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Pharmacies	<ul style="list-style-type: none"> No medication deliveries 	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Durable medical equipment	<ul style="list-style-type: none"> GNG Medical (Craig, CO) Nepenthe (Colorado Springs and Pueblo) Billi beds are a gap 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Other	<ul style="list-style-type: none"> N/A 	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Social Services

Provider or Agency	Transitional Care Services [Examples]	Yes	No
Adult protective services	<ul style="list-style-type: none"> Routt's DPS/DHS exists Moffatt DHS leadership in flux 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Area Agency on Aging (AAA)	<ul style="list-style-type: none"> Routt County Council on Aging – transportation for seniors, offers ride services for grocery shopping, home meal delivery, and community lunches in Steamboat, South Routt and Hayden Budget Center – Moffatt county transportation for all Medicaid patients use Medicaid ride vouchers 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Aging and Disability Resource Centers	<ul style="list-style-type: none"> Center for Independence – focus on disabilities and maintain independence; help with creating budgets Horizons – local non-profit, care coordinators for patients with advanced disabilities, horizons classes for ADLs. All billed through Medicaid. 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Assisted living facilities	<ul style="list-style-type: none"> Casey's Pond Haven – wait times unknown Cliff View – wait times minimal Sand Rock (Craig, CO) – two other locations near sand rock Sunset Meadows – independent living 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Housing with services	<ul style="list-style-type: none"> Rolling Stone Respite House – same building as home health, under North West Colorado Health 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Housing authority or agencies	<ul style="list-style-type: none"> Yampa Valley Housing Authority – for everyone Health Partnership can refer patients Lift up – food assistance, hoteling for 1-2 nights, utility support (Angela) 	<input checked="" type="checkbox"/>	<input type="checkbox"/>



Provider or Agency	Transitional Care Services [Examples]	Yes	No
Legal aid	<ul style="list-style-type: none"> Yampa Valley Law and Advocacy Center – supports family and children issues, income based center, specific about services, Sherri Tolliver is a contact through YV Law and Advocacy Services Colorado Pro-Bono Regional service offers free clinic periodically NW Colorado Community College 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Faith-based organizations	<ul style="list-style-type: none"> Sk8 church - Prescription drug education and prevention, youth focused, counseling offered Love Inc. (Craig, CO)- food assistance, medical equipment Steamboat Christian Center – starting a faith based recovery center 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Transportation	<ul style="list-style-type: none"> Free bus system within Steamboat Small fee for bus from Steamboat to Craig but only in morning and evening (limited times) No transportation to South Routt, no shuttles offered Community Budget Center (Craig, CO)- need to call ahead of time Routt – unless over 65 and disabled it is challenging 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Community corrections system	<ul style="list-style-type: none"> Receive a notice through Medicaid that someone has been released, only a handful for all the counties CAPS (correctional alternative placement services)- residential and non-residential services for people in corrections, job placement RMHP – conducting internal transitions for large prisons 	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Other	<ul style="list-style-type: none"> N/A 	<input type="checkbox"/>	<input checked="" 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	Readmissions from Casey's Pond, ED Readmissions, Discharge Process
<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 checked="" type="checkbox"/> Periodic readmission case reviews and root cause analysis	All patients (seen by Heather Hack, NP)
<input checked="" type="checkbox"/> Readmission activity implementation measurement and feedback (PDSA, audits, etc.)	All Patients
<input checked="" type="checkbox"/> Provider or unit performance measurement with feedback (audit, bonus, feedback, data, etc.)	All Patients
<input type="checkbox"/> Other:	

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, CHF 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 type="checkbox"/> Use clinical pharmacists to enhance medication optimization, education, reconciliation	None
<input checked="" type="checkbox"/> Use "teach-back" to improve patient/caregiver understanding of information	All Patients
<input checked="" type="checkbox"/> Schedule follow-up appointments prior to discharge	High Risk Patients
<input checked="" type="checkbox"/> Conduct warm handoffs to post-acute and/or community "receivers"	High Risk Patients
<input type="checkbox"/> Conduct post discharge follow-up calls (for patient satisfaction or follow-up purposes)	None
<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	Medicaid
<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
<input checked="" type="checkbox"/> Community support service agencies	Skilled Nursing Facilities, Home Health Agencies
<input checked="" type="checkbox"/> Behavioral health providers	All Patients



CROSS-CONTINUUM PROCESS IMPROVEMENT COLLABORATIONS WITH:	FOR WHICH PATIENTS?
<input type="checkbox"/> Other:	N/A

