2023-2025 AdventHealth Avista Community Health Plan

AdventHealth

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Acknowledgements

This community health plan was prepared by Bryan Trujillo, Regional Director of Community Health Improvement, with contributions from members of AdventHealth Avista's Community Health Needs Assessment Steering Committee and the Metro Denver Partnership for Health representing health leaders in the community and hospital leaders.

We are especially grateful for the internal and external partners who helped guide the development of the community health plan which will enable our teams to continue fulfilling our mission of Extending the Healing Ministry of Christ.

EXECUTIVE SUMMARY

Executive Summary

Portercare Adventist Health System d/b/a AdventHealth Avista will be referred to in this document as AdventHealth Avista or the “Hospital”.

Community Health Needs Assessment Process

AdventHealth Avista in Louisville, Colorado conducted a community health needs assessment in 2022. The assessment identified the health-related needs of the community including low-income, minority and other underserved populations. The priorities were defined, when possible, in alignment with Healthy People 2030, national public health priorities to improve health and well-being.

In order to ensure broad community input, AdventHealth Avista created a Community Health Needs Assessment Steering Committee (Steering Committee) to help guide the Hospital through the assessment process. The Committee included representation from the Hospital, public health experts and the broad community. This included intentional representation from low-income, minority and other underserved populations. The prioritization process sought to balance our ability to impact the greatest number of people who are facing the greatest disparities.

The Steering Committee met throughout 2021-2022. The members reviewed the primary and secondary data, helped define the priorities to be addressed and helped develop the Community Health Plan to address those priorities. Learn more about Healthy People 2030 at https://health.gov/healthypeople.

Community Health Plan Process

The Community Health Plan (CHP), or implementation strategy, is the Hospital’s action plan to address the priorities identified from the CHNA. The plan was developed by the Steering Committee, and input received from stakeholders across sectors including public health, faith-based, business and individuals directly impacted.

The CHP outlines targeted interventions and measurable outcomes for each priority noted below. It includes resources the Hospital will commit and notes any planned collaborations between the Hospital and other community organizations and hospitals.

The identified goals and objectives were carefully crafted, considering evidence-based interventions and AdventHealth’s Diversity, Equity, and Inclusion and Faith Accountability strategies. AdventHealth Avista is committed to addressing the needs of the community, especially the most vulnerable populations, to bring wholeness to all we serve.

Executive Summary

Priorities Addressed

The priorities addressed include:

1. Mental Health (Suicide Prevention)
2. Housing Stability
3. Food Security

Health Equity was identified as a priority to be consciously integrated into the strategies of the above priorities.

See page 9 for goals, objectives and next steps for each priority selected to be addressed.

Priorities Not Addressed

The priorities not addressed include:

1. Access To Primary Care

See page 15 for an explanation of why the Hospital is not addressing these issues.

The Community Health Plan is a three-year strategic plan and may be updated during implementation based on changing community needs or availability of resources. AdventHealth recognizes community health is not static and high priority needs can arise or existing needs can become less pressing. The Hospital may pivot and refocus efforts and resources to best serve the community.

Executive Summary

Board Approval

On November 16, 2022, the AdventHealth Avista Board approved the Community Health Plan (CHP) goals, objectives and next steps. A link to the 2023 Community Health Plan was posted on the Hospital's website. An update to plan was approved by the Hospital board on January 17, 2024

Ongoing Evaluation

AdventHealth Avista's fiscal year is January – December. The CHP will be evaluated annually for the 12-month period beginning January 1st and ending December 31st. Evaluation results will be attached to the Hospital's IRS Form 990, Schedule H. The collective monitoring and reporting will ensure the plan remains relevant and effective.

For More Information

Learn more about the Community Health Needs Assessment and Community Health Plan for AdventHealth Avista at https://www.adventhealth.com/community-health-needs-assessments.

ABOUT ADVENTHEALTH

About AdventHealth

AdventHealth Avista is part of AdventHealth. With a sacred mission of Extending the Healing Ministry of Christ, AdventHealth strives to heal and restore the body, mind and spirit through our connected system of care. More than 80,000 skilled and compassionate caregivers serve 4.7 million patients annually. From physician practices, hospitals, outpatient clinics, skilled nursing facilities, home health agencies and hospice centers, AdventHealth provides individualized, wholistic care at nearly 50 hospital campuses and hundreds of care sites throughout nine states.

Committed to your care today and tomorrow, AdventHealth is investing in research, new technologies and the people behind them to redefine medicine and create healthier communities.

About AdventHealth Avista

AdventHealth Avista is a comprehensive medical center known for its higher level of personalized, whole person care, that's been the hallmark of the organization for more than a century. The 114-bed full-service community hospital provides a full range of medical specialties and exceptional health care to the Louisville, Superior, Broomfield and surrounding Boulder County communities. It's known for its award winning joint and spine program, as well as its widely recognized New Life Center and the area's largest neonatal intensive care nursery.

PRIORITIES ADDRESSED

Mental Health (Suicide Prevention)

In Boulder and Broomfield counties, suicide and depression rates remain high. 50.2 per 100,000 patients were hospitalized in the ED for suicidal ideation and attempts. 1428.6 per 100,000 patients had other mental health problems. 17.3 per 100,000 population completed suicide in 2020. Rates of postpartum depression are rising as well. Stigma surrounding mental illness in our communities also prevents patients from seeking out care due to fear.

Goal 1: Increase identification of suicide risk by implementing Zero Suicide, an evidence-based/informed mental health/suicide prevention training that will result in improved post-discharge patient and community member outcomes including reducing community risk of deaths by suicide.

Objective 1.1: By 2024, scale the implementation of Zero Suicide post-discharge follow-up program for patients. This includes suicide screening and post-discharge follow-up support access to patients, including warm hand-off and referral to the Colorado State Crisis hospital post-discharge follow-up program, crisis service, and the National Suicide Prevention Service.

Target Population: Teenagers and adults presenting with behavioral health needs in Boulder and Broomfield Counties.

Activities/Strategies	Outputs	Hospital Contributions	Community Partnerships	Timeline		
				Y1	Y2	Y3
Advance Zero Suicide, an evidence based best practices framework for decreasing suicide risk in health care systems and their communities. By continuing to advance best practice trainings (Question Persuade Refer, Start, Applied Suicide Intervention Skills Training-ASSIST, Faith, Mental Health First Aid) and practices, the hospital will improve suicide risk identification, post risk identification support and patient and community outcomes.	Development of scalable model throughout the Rocky Mountain Region	The Psych Assessment Team – staff time to scale framework	LivingWorks, Colorado Mental Health First Aid, Rocky Mountain Crisis Services, Community Mental Health Centers, the State Office of Suicide Prevention, and Faith-based partners	X	X	X

Mental Health (Suicide Prevention)

Goal 1 continued: Increase identification of suicide risk by implementing Zero Suicide, an evidence-based/informed mental health/suicide prevention training that will result in improved post-discharge patient and community member outcomes including reducing community risk of deaths by suicide.

Objective 1.2: By 2024, offer Zero Suicide training and best practices to clinicians and caregivers.

Target Population: Teenagers and adults presenting with behavioral health needs in Boulder and Broomfield Counties.

Activities/Strategies	Outputs	Hospital Contributions	Community Partnerships	Timeline		
				Y1	Y2	Y3
Provide clinical and non-clinical trainings to associates.	# of staff trained # of participants attending trainings	Community Health, along with the Psych Assessment Team – staff time to deliver presentations, and strengthen relationships with community-based organizations	LivingWorks, Colorado Mental Health First Aid, Rocky Mountain Crisis Services, Community Mental Health Centers, the State Office of Suicide Prevention, and Faith-based partners		X	X
Community trainings in suicide prevention or mental wellness for caregivers offered or supported by our system trainers or partners.	# of community presentations provided # of participants attending trainings	Community Health, along with the Psych Assessment Team – staff time to deliver presentations, and strengthen relationships with community-based organizations	LivingWorks, Colorado Mental Health First Aid, Rocky Mountain Crisis Services, Community Mental Health Centers, the State Office of Suicide Prevention, and Faith-based partners		X	X

Housing Stability

In Boulder and Broomfield counties, housing prices have sharply risen. They are ranked 17 and 11 respectively amongst counties with more than 50% of household income spent on housing. Quality of housing is also a problem due to overcrowding, poor plumbing/kitchen utilities. Inflation during the pandemic has meant that families have less to spend on basic needs such as rental/mortgage payments and utilities.

Goal 1: Increase access to safe and stable housing and shelter within the community. Identify community members who report housing insecurity and refer them to appropriate resources in the community.

Objective 1.1: By 2023, participate in collaborative efforts to address affordable housing and homelessness in Boulder and Broomfield Counties.

Target Population: Adults in Boulder and Broomfield Counties.

Activities/Strategies	Outputs	Hospital Contributions	Community Partnerships	Timeline		
				Y1	Y2	Y3
Identify policy opportunities at various levels to impact housing stability. Collaborate with community to advance policy opportunities that promote stable housing. Furthermore, identify the role of health care within the housing and homelessness plans	Continue to collaborate with regional partners	The Mission and Community Health Team – staff time to attend meetings	Mental Health Partners, Colorado Community Health Alliance, Broomfield Public Health, Boulder County Public Health, Rocky Mountain Adventist Health, Boulder County Child Welfare, the region's Continuum of Care, and local community-based organizations	X	X	X

Housing Stability

Goal 1 continued: Increase access to safe and stable housing and shelter within the community. Identify community members who report housing insecurity and refer them to appropriate resources in the community.

Objective 1.2: By 2023, screen households for housing insecurity and refer them to resources in the community to promote stable housing.

Target Population: Adults in Boulder and Broomfield Counties.

Activities/Strategies	Outputs	Hospital Contributions	Community Partnerships	Timeline		
				Y1	Y2	Y3
Administer a Social Determinants of Health (SDoH) screening for patients which determines housing instability	# of SDoH screenings completed	Case Management – staff time to screen and refer	Mental Health Partners, Colorado Community Health Alliance, Broomfield Public Health, Boulder County Public Health, Rocky Mountain Adventist Health, Boulder County Child Welfare, UnitedWay 211, the region's Continuum of Care, and local community-based organizations	X	X	X
Establish referral pathways for screened patients to appropriate community-based organizations	# of screenings completed # of organizations funded to promote housing stability Continue to collaborate in existing coalitions and health alliances to address housing stability	The Mission and Community Health – staff time to attend coalitions and fund appropriate organizations	Mental Health Partners, Colorado Community Health Alliance, Broomfield Public Health, Boulder County Public Health, Rocky Mountain Adventist Health, Boulder County Child Welfare, UnitedWay 211, the region's Continuum of Care, and local community-based organizations	X	X	X

Food Security

According to Hunger Free Colorado, 1 in 3 people are struggling with hunger during the pandemic. A high cost of living exacerbates the gap between federal poverty guidelines and a living wage. In our service area, one in 10 people are food insecure. Blacks and Hispanics have greater rates of food insecurity at 14 and 13.4 percent, respectively.

Goal 1: Increase utilization of and access to affordable, fresh produce and federal food assistance programs and enhancements.

Objective 1.1: By 2023, screen and provide referrals for unmet social risks, including food insecurity.

Target Population: Children and adults in Boulder and Broomfield Counties.

Activities/Strategies	Outputs	Hospital Contributions	Community Partnerships	Timeline		
				Y1	Y2	Y3
Administer a Social Determinants of Health screening for patients which determines food insecurity	# of SDoH screenings completed	Case Management – staff time to screen	Colorado Blue Print to End Hunger, Nourish Colorado, Family Connects, Hunger Free Colorado, UnitedWay 211 Colorado	X	X	X
Establish referral pathways to appropriate community-based organizations	Continue to collaborate with Colorado's Blueprint to End Hunger to expand the network of community-based organizations that address food insecurity	Community Health – staff time to establish referral pathways, and attend meetings	Colorado Blue Print to End Hunger, Nourish Colorado, Family Connects, Hunger Free Colorado, UnitedWay 211 Colorado	X	X	X

Food Security

Goal 1 continued: Increase utilization of and access to affordable, fresh produce and federal food assistance programs and enhancements.

Objective 1.2: By 2024, partner with community-based organizations and businesses to increase utilization of benefits that promote food security.

Target Population: Children and adults in Boulder and Broomfield Counties.

Activities/Strategies	Outputs	Hospital Contributions	Community Partnerships	Timeline		
				Y1	Y2	Y3
Support local food businesses new acceptance of and or maintenance of the Supplemental Nutrition Assistance Program (SNAP), Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), or their program enhancements by supporting technology, technical assistance, outreach and promotion through community food advocates/navigators	# of organizations funded to determine feasibility of expanding benefits acceptance	Community Health – staff time to attend coalitions and fund appropriate organizations	Nourish Colorado and Hunger Free Colorado		X	X

PRIORITIES NOT ADDRESSED

Priorities Not Addressed

AdventHealth Avista also identified the following priorities during the CHNA process. In reviewing the CHNA data, available resources, and ability to impact the specific identified health need, the Hospital determined these priorities will not be addressed.

Access To Primary Care

Access to primary care was ranked fifth out of the five top priorities identified during the ranking process. Data focusing on access to primary care included 8.2% of adults are uninsured and 3.9% of children are uninsured. There are 1.1 Primary Care Physicians per 1000 residents. Primary care is a method to identify health needs early and connect people with necessary treatment and resources.

The Steering Committee discussed that access to care is a changing environment which we need to monitor due to continually changing guidelines and policies. After the pandemic, there will be a need to monitor how health coverage shifts when emergency coverage through Medicaid ends. However, they determined it would be best to focus on access to behavioral health care to maintain a strong focus on this issue and to have a greater impact with a greater focus on fewer priorities.

AdventHealth

Portercare Adventist Health System d/b/a
AdventHealth Avista

CHP Approved by the Hospital Board on: November 16, 2022

Updated and approved by the Hospital Board on: January 17, 2024

For questions or comments please contact:

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