AdventHealth Avista 2025 Community Health Needs Assessment

Extending the Healing Ministry of Christ

AdventHealth

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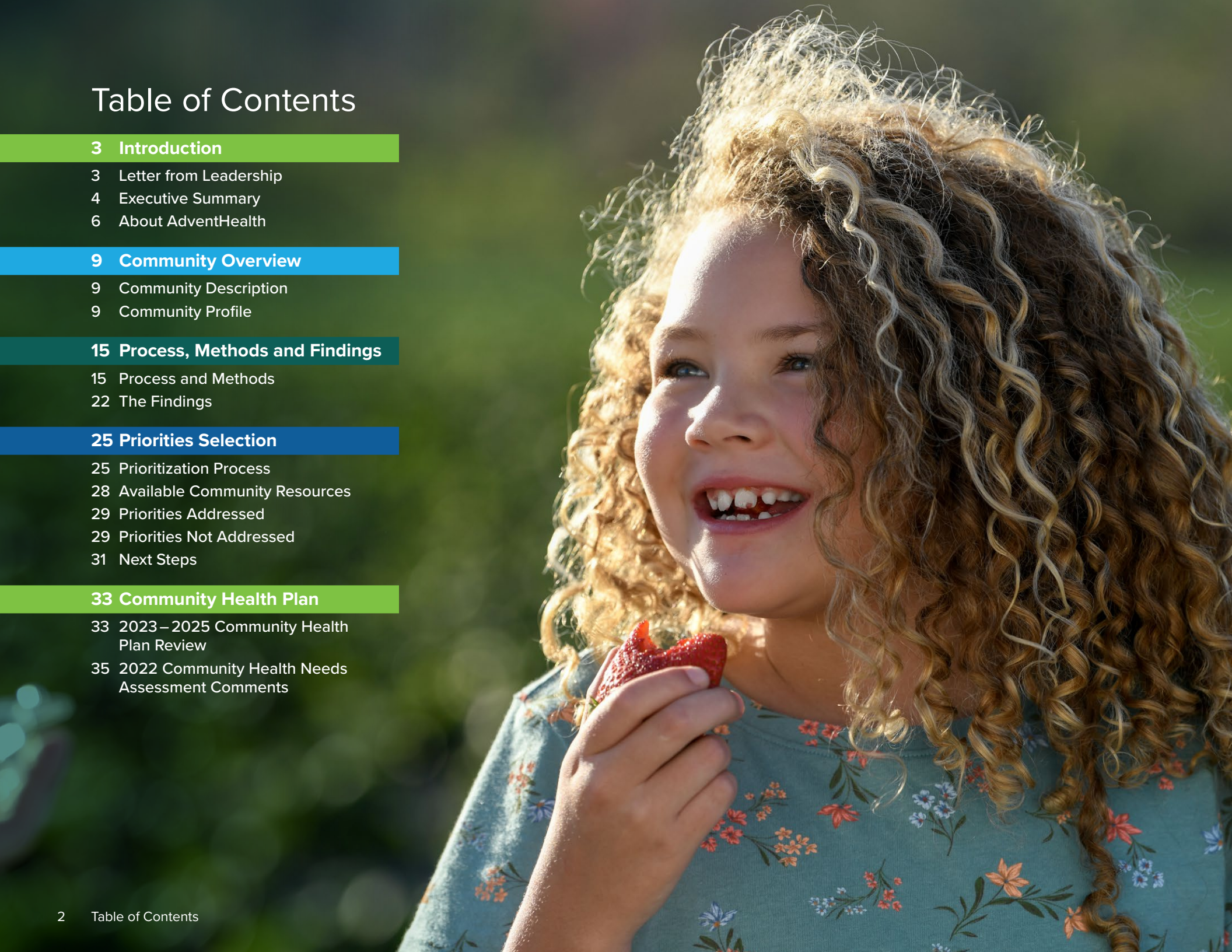


Letter from Leadership

At AdventHealth, we have a sacred mission of Extending the Healing Ministry of Christ. That obligation goes beyond our hospital walls and permeates into our communities. Our commitment is to address the health care needs of our community with a wholistic focus, one that strives to heal and restore the body, mind and spirit. We want to help our communities get well and stay well.

Every three years, AdventHealth hospitals across the nation complete a Community Health Needs Assessment. During this assessment, we talk and work with community organizations, public health experts and people like you who understand our communities best. This in-depth look at the overall health of our communities and the barriers to care they experience helps AdventHealth better understand the unique needs in the various communities we serve.

We use this information to create strategic plans that address the issues that impact our communities most. At AdventHealth, we know that a healthy community is not a “one size fits all” proposition—everyone deserves a whole health approach that meets them where they are and supports their individual health journey.

This work would not be possible without the partnership of public health experts, community organizations and countless community members who helped inform this report. Through these ongoing partnerships and collaborative efforts, AdventHealth will continue to create opportunities for better health in all the communities we serve.

In His service,

Terry Shaw

Our commitment is to address the health care needs of our community with a wholistic focus, one that strives to heal and restore the body, mind and spirit.

Executive Summary

Portercare Adventist Health System dba AdventHealth Avista will be referred to in this document as AdventHealth Avista or "The Hospital." AdventHealth Avista in Louisville, Colorado conducted a community health needs assessment from May 2024 to November 2024. The goals of the assessment were to:

- Engage public health and community stakeholders, including low-income, minority and other underserved populations.
- Assess and understand the community's health issues and needs.
- Understand the health behaviors, risk factors and social determinants that impact health.
- Identify community resources and collaborate with community partners.
- Publish the Community Health Needs Assessment.
- Use the assessment findings to develop and implement a 2026–2028 Community Health Plan based on the needs prioritized in the assessment process.

Broomfield Public Health and Environment and Health Systems Collaborative

To ensure broad community input, AdventHealth Avista took part in a Collaborative, known as the Broomfield Public Health and Environment and Health Systems Collaborative to help guide the Hospital through the assessment process. The Collaborative included representation from the Hospital, public health experts, other hospital systems and purposeful, routine engagement of community members. This included intentional representation from low-income, minority and other underserved populations.

The Collaborative includes representation from the Hospital, Adams County Public Health, Broomfield Public Health and Environment, Boulder Public Health, Children's Hospital Colorado, CommonSpirit Health, Intermountain Health and University of Colorado Health (UCHealth).

The Collaborative met monthly from March 2024 until November 2024. They reviewed primary and secondary data and helped to identify the top priority needs in the community.

See Process and Methods for a list of Collaborative members.

Hospital Health Needs Assessment Committee

AdventHealth Avista also convened two councils which functioned as the Hospital Health Needs Assessment Committee (HHNAC), the Professional Governance Council and the Sustainability Council. The purpose of the HHNAC was to select the needs the Hospital would address due to the findings in the assessment. The HHNAC made this decision by reviewing the priority needs that were selected and by compiling the internal hospital resources available. With this information, the HHNAC was able to determine where the Hospital could most effectively support the community.

See Prioritization Process for a list of HHNAC members.

Data

AdventHealth Avista in collaboration with the Broomfield Public Health and Environment and Health Systems Collaborative collected both primary and secondary data. The primary data included a stakeholder survey, key informant interviews and focus groups. Secondary data included internal hospital utilization data (inpatient, outpatient and emergency department). This utilization data showed the top diagnoses for visits to the Hospital from 2023–2024. In addition, publicly available data from state and nationally recognized sources were used. Primary and secondary data was compiled and analyzed to identify the top eight needs.

See Process, Methods and Findings for data sources.

Community Asset Inventory

The next step was to create a community asset inventory. This inventory was designed to help the Collaborative understand the existing community efforts being used to address the needs identified from the aggregate primary and secondary data. This inventory was also designed to prevent duplication of efforts.

See Available Community Resources for more.

Selection Criteria

The Collaborative identified the top eight significant health needs of the community and the Board of Health narrowed to the top three. The HHNAC then prioritized the top three needs, discussing each one, assessing available community resources, and considering the Hospital's own resources and strategies. Through this discussion, the Hospital determined the top three needs it is best positioned to impact.

See Prioritization Process for more.

The following criteria were considered during the prioritization process:

A. Impact on Community

What are the consequences to the health of the community of not addressing this issue now?

B. Resources

Are there existing, effective interventions and opportunities to partner with the community to address this issue?

C. Outcome Opportunities

Do interventions addressing this issue have an impact on other health and social issues in the community?

Priorities to Be Addressed

The priorities to be addressed are:

1. Mental Health
2. Economic Stability—Housing
3. Neighborhood and Built Environment—Food Security

See Priorities Addressed for more.

Approval

On March 19, 2025, the AdventHealth Avista board approved the Community Health Needs Assessment findings, priority needs and final report. A link to the 2025 Community Health Needs Assessment was posted on the Hospital's website prior to December 31, 2025.

Next Steps

AdventHealth Avista will work with the Collaborative and the HHNAC to develop a measurable implementation strategy called the 2026–2028 Community Health Plan to address the priority needs. The plan will be completed, board approved and posted on the Hospital's website prior to May 15, 2025.

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 100,000 talented and compassionate team members serve over 8 million patients annually. From physician practices, hospitals and outpatient clinics to skilled nursing facilities, home health agencies and hospice centers, AdventHealth provides individualized, whole-person care at more than 50 hospital campuses and hundreds of care sites throughout nine states.

Committed to your care today and tomorrow, AdventHealth is investing in new technologies, research and the brightest minds to redefine wellness, advance medicine and create healthier communities.

In a 2020 study by Stanford University, physicians and researchers from AdventHealth were featured in the ranking of the world's top 2% of scientists. These critical thinkers are shaping the future of health care.

Amwell, a national telehealth leader, named AdventHealth the winner of its Innovation Integration Award. This telemedicine accreditation recognizes organizations that have identified connection points within digital health care to improve clinical outcomes and user experiences. AdventHealth was recognized for its innovative digital front door strategy, which is making it possible for patients to seamlessly navigate their health care journey. From checking health documentation and paying bills to conducting a virtual urgent care visit with a provider, we're making health care easier—creating pathways to wholistic care no matter where your health journey starts.

AdventHealth is also an award-winning workplace aiming to promote personal, professional and spiritual growth with its team culture. Recognized by Becker's Hospital Review on its "150 Top Places to Work in Healthcare" several years in a row, this recognition is given annually to health care organizations that promote workplace diversity, employee engagement and professional growth. In 2024, the organization was named by Newsweek as one of the Greatest Workplaces for Diversity and a Most Trustworthy Company in America.

AdventHealth Avista

A Legacy of Caring for Our Community

At AdventHealth Avista, we're here to serve you and your family with a breadth of health care services, close to home in Louisville, Colorado. From our first-rate spine care center to our New Life Birth Center and the area's largest neonatal intensive care unit, you and your family can count on our award-winning, whole-person care.

AdventHealth Avista is a 114-bed facility nestled below Boulders iconic Flatirons. AdventHealth Avista originated in 1896 as the Boulder Sanitarium and changed its name to Boulder Memorial Hospital in 1962. In 1990, the hospital transitioned to Avista Adventist Hospital and moved into the building where we are located today. Following the principles of wellness that were started by founder, Dr. Harvey Kellogg, AdventHealth Avista places a priority on caring for mind, body and spirit.

With the mission of Extending the Healing Ministry of Christ, AdventHealth Avista supports our community with expert medical care and uncommon compassion. We have proudly served the Louisville, Boulder and surrounding communities for more than 127 years and counting.

Services

- Spine and Orthopedics
- New Life Birth Center
- Level III NICU
- Emergency and Trauma Care
- Breast Care
- Heart and Vascular
- Pain Management
- Pelvic Health
- Women's Health
- Outpatient Infusion Services

Awards and Recognition

- AdventHealth Avista is honored to be ANCC Pathway to Excellence Designated® for excellence in nursing from the American Nurses Credentialing Center.
- AdventHealth Avista is one of ten hospitals in Colorado that have achieved both a CMS 5-Star Rating and Leapfrog A.
- AdventHealth Avista's NICU received the 2023 Human Experience Guardian of Excellence Award from Press Ganey, ranking in the top 5% for patient experience nationwide.

We have proudly served Louisville, Boulder, Broomfield and surrounding communities for more than 127 years and counting.

- AdventHealth Avista was ranked among the top orthopedic facilities in Colorado by Atena for Medicare members.

Giving Back to Our Community

The AdventHealth Foundation supports our efforts to provide our neighbors with the care they need.

At AdventHealth Avista, we work to restore health, nurture struggling families and support our communities. But we can't do it alone. We are a not-for-profit hospital, which means that your contributions directly benefit the members of our community.

Tax-deductible gifts to the Foundation enable us to further our mission of providing the best, faith-based health care possible. We use these donations to purchase leading-edge technologies, fund community health programs and enhance our facilities, all focusing on serving the patients who entrust us with their care.

Community Overview

Community Description

Located in Louisville, Colorado, AdventHealth Avista defines its community as the Primary Service Area (PSA), the area in which 75–80% of its patient population lives. This includes 21 zip codes across Broomfield and Boulder Counties.

Demographic and community profile data in this report are from publicly available data sources such as the U.S. Census Bureau and the Center for Disease Control and Prevention (CDC), unless indicated otherwise. The Broomfield Public Health and Environment and Health Systems Collaborative conducted the CHNA with a county-level approach, therefore, data is reported for the combined counties of Broomfield and Boulder, which form Health Statistics Region 16, unless listed differently. Data is also provided to show how the community compares locally, in the state and at a national level for some indicators.

AdventHealth Avista's Primary Service Area includes 21 zip codes across Broomfield and Boulder Counties.

Community Profile

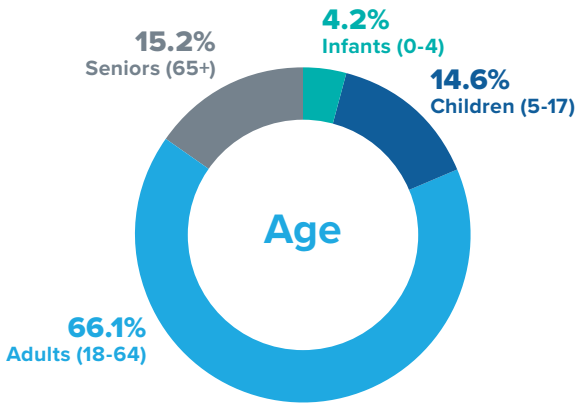
Age and Sex

The median age in the Hospital's community is 36.6, lower than that of Colorado which is 37.3 and the US, 38.5. Seniors, those 65 and older, represent 15.2% of the total population in the community.

Males are the majority, representing 50.35% of the population. Adults 18–64 are the largest demographic in the community at 66.1%.

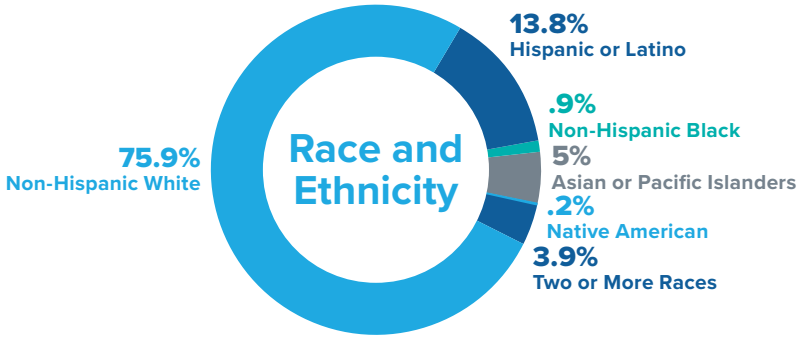
Children aged 0–17 make up 18.8% of the total population in the community. Infants, those zero to four, are 4.2% of that number. The community birth rate is 35.42 births per 1,000 women aged 15–50. This is lower than the U.S. average of 51.58 and lower than that of the state, 48.86. In the Hospital's community, the

highest percentages of residents in poverty are adults aged 18–39 (16.09%) and infants aged 0–4 (7.22%).



Race and Ethnicity

In the Hospital's community, 75.9% of the residents are non-Hispanic White, 0.9% are non-Hispanic Black and 13.8% are Hispanic or Latino. Residents who are of Asian or Pacific Islander descent represent 5% of the total population, while 0.2% are Native American and 3.9% are two or more races.



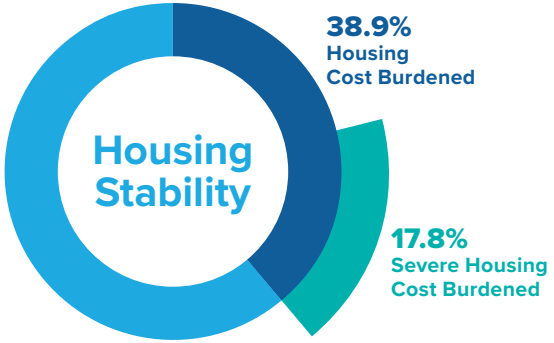
Economic Stability

Income

The median household income in the Hospital's community is $91,413. This is above the median for the state, which is $81,883. Although above the median, 10.1% of residents live in poverty, the majority of whom are between the ages of 18 and 37.

Housing Stability

Increasingly, evidence is showing a connection between stable and affordable housing and health.[1] When households are cost burdened or severely cost burdened, they have less money to spend on food, health care and other necessities. Having less access can result in more negative health outcomes. Households are considered cost burdened if they spend more than 30% of their income on housing and severely cost burdened if they spend more the 50%.



1 Severe housing cost burden* | County Health Rankings & Roadmaps

Education Access and Quality

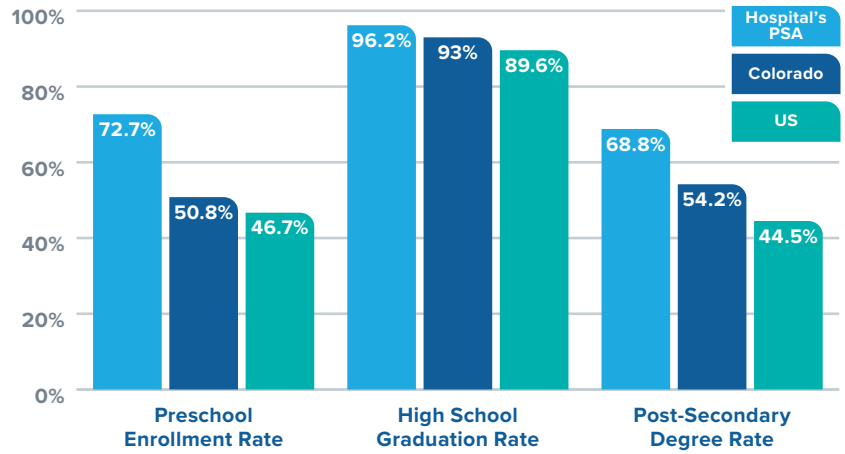
Research shows that education can be a predictor of health outcomes, as well a path to address inequality in communities.[2] Better education can lead to people having an increased understanding of their personal health and health needs. Higher education can also lead to better jobs, which can result in increased wages and access to health insurance.

In the Hospital's community, there is a 96.2% high school graduation rate, which is higher than both the state, (93%) and national average (89.6%). The rate of people with a post-secondary degree is higher in the Hospital's PSA than in both the state and nation.

Early childhood education is uniquely important and can improve children's cognitive and social development. It helps provide the foundation for long-term academic success, as well as improved health outcomes. Research on early childhood education programs shows that long-term benefits include improved health outcomes, savings in health care costs and increased lifetime earnings.[3]

In the Hospital's community, 72.7% of three- and four-year olds were enrolled in preschool. Although higher than both the state (50.8%) and the national (46.7%) averages, there is still a large percentage of children in the community who may not be receiving these early foundational learnings.

Educational Attainment



2 The influence of education on health: an empirical assessment of OECD countries for the period 1995–2015 | Archives of Public Health | Full Text (biomedcentral.com)

3 Early Childhood Education | U.S. Department of Health and Human Services

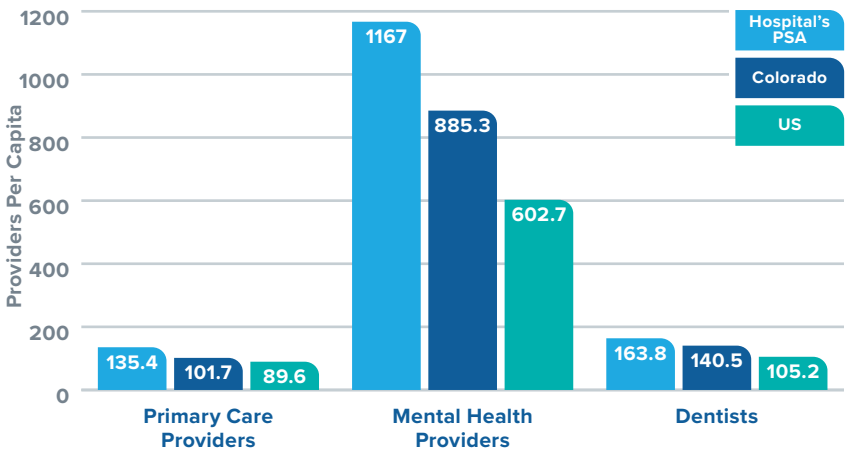
Health Care Access and Quality

In 2022, 8.5% of residents in Boulder County and 7.9% of residents in Broomfield County were found to lack health insurance. Without access to health insurance, these individuals may experience delayed care, resulting in more serious health conditions and increased treatment costs. Although health insurance coverage levels can be a strong indicator of a person's ability to access care, there are other potential barriers that can delay care for many people.[4]

Accessing health care requires more than just insurance. There must also be health care professionals available to provide care. When more providers are available in a community access can be easier, particularly for those experiencing transportation challenges. The Hospital's service area has 135.4 primary care providers per 100,000 residents, this is higher than the state average of 101.7 per 100,000.

Routine checkups can provide an opportunity to identify potential health issues and when needed develop care plans. In the Hospital's community, 67.5% of people report visiting their doctor for routine care.

Available Health Care Providers

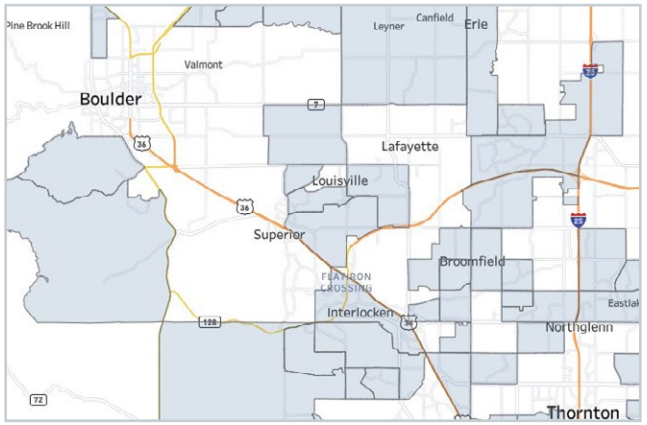


4 Health Insurance and Access to Care | CDC

Neighborhood and Built Environment

Increasingly, a community's neighborhoods and built environment are shown to impact health outcomes. If a neighborhood is considered to have low food access, which is defined as being more than ½ mile from the nearest supermarket in an urban area or ten miles in a rural area, it may make it harder for people to have a healthy diet. A very low food access area is defined as being more than one mile from your nearest supermarket in an urban area or 20 miles in a rural area.

A person's diet can have a significant impact on health, so access to healthy food is important. For example, the largest contributors to cardiovascular disease are obesity and type 2 diabetes, both of which can be impacted by diet.[5] In the Hospital's community, approximately 50% of the community lives in a low food access area. Areas identified in grey in the map below depict an area of low food access.



People who are food insecure, who have reduced quality or food intake, may be at an increased risk of negative health outcomes. Studies have shown an increased risk of obesity and chronic disease in adults who are food insecure. Children who are food insecure have been found to have an increased risk of obesity and developmental problems compared to children who are not.[6] Feeding America estimates for 2022,[7] showed the food insecurity rate in the Broomfield County as 9.3%.

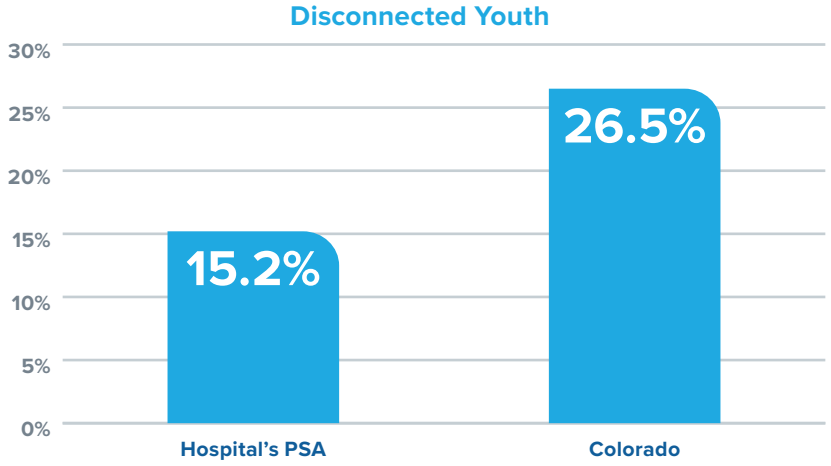
5 Heart Disease Risk Factors | CDC
6 Facts About Child Hunger | Feeding America
7 Map the Meal Gap 2022 | Feeding America

Access to public transportation is also an important part of a built environment. For people who do not have cars, reliable public transportation can be essential to access health care, healthy food and steady employment. In the community, 4.9% of the households do not have an available vehicle.

Social and Community Context

People's relationships and interactions with family, friends, co-workers and community members can have a major impact on their health and well-being.[8] When faced with challenges outside of their control, positive relationships with others can help reduce negative impacts. People can connect through work, community clubs or others to build their own relationships and social supports. There can be challenges to building these relationships when people don't have connections to create them or there are barriers, like language.

In the community, 15.2% of youth aged 16-19 were reported as disconnected, meaning they were neither enrolled in school nor working at the time. Disconnected youth are also referred to as opportunity youth, marginalized youth, disengaged youth and NEET (Not in Education, Employment, or Training).



Also, in the community 28.6% of seniors (age 65 and older) report living alone and 1.3% of residents report having limited English proficiency. All these factors can create barriers to feeling connected in the community.

8 Social and Community Context - Healthy People 2030 | U.S. Department of Health and Human Services

Social Determinants of Health

According to the CDC, social determinants of health (SDOH) are the conditions in the places where people live, learn, work and play that affect a wide range of health risks and outcomes. Social determinants of health are increasingly seen as the largest contributing factor to health outcomes in communities throughout the country.

The Hospital categorized and analyzed SDOH data following the Healthy People 2030 model. This approach was chosen so the Hospital could align its work with national efforts when addressing social determinants of health when possible. For the purposes of CHNA, the Hospital will follow this model for reporting any related data.

The Healthy People 2030 place-based framework outlines five areas of SDOH:

Economic Stability

Includes areas such as income, cost of living and housing stability.

Education Access and Quality

This framework focuses on topics such as high school graduation rates, enrollment in higher education, literacy and early childhood education and development.

Health Care Access and Quality

Covers topics such as access to health care, access to primary care and health insurance coverage.

Neighborhood and Built Environment

Includes quality of housing, access to transportation, food security, and neighborhood crime and violence.

Social and Community Context

Focuses on topics such as community cohesion, civic participation, discrimination and incarceration.

Process, Methods and Findings

Process and Methods

The Process

The health of people living in the same community can be very different, because there are so many influencing factors. To understand and assess the most important health needs of its unique community and the people in it, the Hospital in partnership with the Broomfield Public Health and Environment and Health Systems Collaborative, solicited input directly from the community and from individuals who represent the broad interests of the community. A real effort was made to reach out to all members of the community to obtain perspectives across age, race and ethnicity, gender, profession, household income, education level and geographic location. The Collaborative also collected publicly available and internal hospital utilization data for review.

The Hospital partnered with local community organizations and stakeholders, including those in public health and those who represent the interests of medically underserved, low-income and minority community members, to form the Broomfield Public Health and Environment and Health Systems Collaborative to guide the assessment process. The Collaborative is a regional effort through which health systems and Public Health Departments spanning Broomfield and Boulder counties work to improve community health by leading outcome driven initiatives addressing the needs found in the assessment. The Collaborative includes representation from the Hospital, Adams County Public Health, Broomfield Public Health and Environment, Boulder Public Health, Children's Hospital Colorado, CommonSpirit Health, Intermountain Health and University of Colorado Health (UCHealth).

Community organizations that participated in the Collaborative by providing feedback and connecting with the represented entities include Blueprint to End Hunger, Broomfield Family Practice, Broomfield FISH, Broomfield Housing Alliance, City and County of Broomfield Economic Vitality, Clinica Colorado, Mental Health Partners, One Colorado, Rise Above Colorado, Safehouse Progressive Alliance for Nonviolence, Signal Behavioral Health Network and The Refuge.

A real effort was made to reach out to all members of the community to obtain perspectives across age, race and ethnicity, gender, profession, household income, education level and geographic location.

Broomfield Public Health and Environment and Health Systems Collaborative Members

Individuals in the Collaborative represented large and specialty health care systems as well as the local departments of health, all sharing a unified vision of creating impactful community health improvement across the region. As part of this shared vision, Collaborative members recognized the value of voices of the community and the necessity of trusted relationships with all community members to affect real change. Collaborative members serving as stewards for the Broomfield and Boulder communities included:

- Bryan Trujillo, Regional Director of Community Health Improvement, AdventHealth
- Jonnathan Ward, Director of Mission Integration, AdventHealth
- Monica Kneusel, Community Benefit Coordinator, AdventHealth
- Ann Trebesch, Director of Mission, CommonSpirit
- Callie Preheim, Public Health Planning and Evaluation Senior Advisor, Adams County Public Health
- Elise Waln, Health Planning and Evaluation Manager, Boulder Public Health
- Katie Koblenz, Community Health Director, Intermountain Health
- Keith Peterson, Director of Community Benefit, University of Colorado Health
- Peggy Jarrett, Regional Director of Community Health, Intermountain Health
- Rachel Mintle, Health Planner, Boulder Public Health
- Sarah Mauch, Health Planning and Systems Manager, Broomfield Public Health
- Sara Torres, Data Lead, Broomfield Public Health
- Susan Goldenstein, Director of Community Impact, Children's Hospital Colorado

During data review sessions, members of the Collaborative provided insight on how health conditions and areas of need were impacting those they represented. The Collaborative used the data review and discussion sessions to understand the most important health needs and barriers to health the community was facing and to guide the selection of needs to be addressed in the 2025 CHNA.

Community Input

The Collaborative collected input directly from the community and from community stakeholders, including individuals working in organizations addressing the needs and interests of the community. Input was collected through a stakeholder survey, key informant interviews and four focus groups.

Stakeholder Survey

Community organizations serving under-represented or marginalized communities were asked about social determinants of health, health behaviors and health outcomes. Participants were asked to rate the topics above using the numbers 1 (going poorly and of concern) through 5 (going well and is not of concern). In total, 32 individuals representing 26 community organizations responded to the survey.

Organizations were identified as serving one or more of the following pre-selected populations:

- Youth or children
- People living with disabilities
- LGBTQ+ population
- Older adults
- Non-English-Speaking individuals
- People who are unhoused
- Individuals with mental health and substance use challenges
- Veterans
- Food insecure individuals
- Those with pending criminal matters
- Individuals experiencing domestic violence
- All Broomfield County residents

Key Informant Interviews

Eleven virtual interviews with key community leaders were conducted in July 2024. Discussion topics were based on the expertise of the individual and the conversation centered around how various health concerns affected the communities represented and Broomfield's community as a whole.

Key informants included representatives from:

- Broomfield Family Practice
- Broomfield Fellowship In Serving Humanity (FISH)
- Broomfield Housing Alliance
- City and County of Broomfield Economic Vitality
- Clinica Colorado
- Mental Health Partners
- One Colorado
- Rise Above Colorado
- Safehouse Progressive Alliance for Nonviolence
- Signal Behavioral Health Network
- The Refuge

Focus Groups

Four focus groups were carried out between July and August 2024. Focus groups were between 90–120 minutes and had between 4–10 participants.

Topics included

- Access to Behavioral Health Care
- Connectedness/Relationship and Loneliness
- Substance Use
- Healthcare Affordability and Preventative Care

Focus Group target populations include:

- Youth
- LGBTQ+ (conducted virtually)
- Spanish-speakers
- Older Adults

Public and Community Health Experts Consulted

A total of 21 stakeholders provided their expertise and knowledge regarding their communities, including:

Name	Organization	Services Provided	Populations Served
Sarah Mauch	Broomfield Public Health and Environment	Wide-ranging Health and Wellness Support for Broomfield County	Broomfield County Residents
Sara Torres	Broomfield Public Health and Environment	Wide-ranging Health and Wellness Support for Broomfield County	Broomfield County Residents
Kelsey Warren	Broomfield Public Health and Environment	Wide-ranging Health and Wellness Support for Broomfield County	Broomfield County Residents
Callie Preheim	Adams County Public Health	Wide-ranging Health and Wellness Support for Adams County	Adams County Residents
Elise Waln	Boulder County Public Health	Wide-ranging Health and Wellness Support for Boulder County	Boulder County Residents
Rachel Mintle	Boulder County Public Health	Wide-ranging Health and Wellness Support for Boulder County	Boulder County Residents
Julie Beaubain	Children's Hospital Colorado	Hospital and Outpatient Healthcare Services	Broomfield County Pediatric Population
Claire Peters	Children's Hospital Colorado	Hospital and Outpatient Healthcare Services	Broomfield County Pediatric Population
Susan Goldenstein	Children's Hospital Colorado	Hospital and Outpatient Healthcare Services	Broomfield County Pediatric Population
Katie Koblenz	Intermountain Health	Hospital and Outpatient Healthcare Services	Lafayette and Broomfield County Residents
Peggy Jarrett	Intermountain Health	Hospital and Outpatient Healthcare Services	City of Lafayette and Broomfield County Residents
Keith Peterson	UCHealth	Hospital and Outpatient Healthcare Services	City of Westminster and Broomfield County Residents
Kristen Hyser	Broomfield Housing Alliance	Housing Support	Broomfield County Residents
Kate Parker	Mental Health Partners (Now Clinica Family Health & Wellness)	Mental Health and Substance Use Support	Individuals Experiencing Mental Illness and/or Substance Use Disorders in Broomfield and Boulder County

Name	Organization	Services Provided	Populations Served
Kent MacLennen	Rise Above Colorado	Substance Use Support	Colorado Youth at Risk of Substance Use Disorder
Jenny Ketterling	The Refuge	Wraparound Social Support	Broomfield Residents — Focus on Social Collaboration and De-Marginalization
Kathy Escobar	The Refuge	Wraparound Social Support	Broomfield Residents — Focus on Social Collaboration and De-Marginalization
Nadine Bridges	One Colorado	Wraparound Social Support for LGBTQIA+	LGBTQIA+ Individuals in Colorado
Anne Tapp	SPAN Safehouse Progressive Alliance for Non-Violence	Wraparound Social Support for Survivors of Domestic Violence	Survivors of Domestic Violence in Broomfield and Boulder County
Chelsea Rubio	Signal Behavioral Health Network	Behavioral Health Connections for Providers	Colorado Behavioral Health Providers
Simon Smith	Clinica Colorado	Low and No-Cost Healthcare Services	Healthcare Services for Uninsured and Underinsured Individuals in Colorado

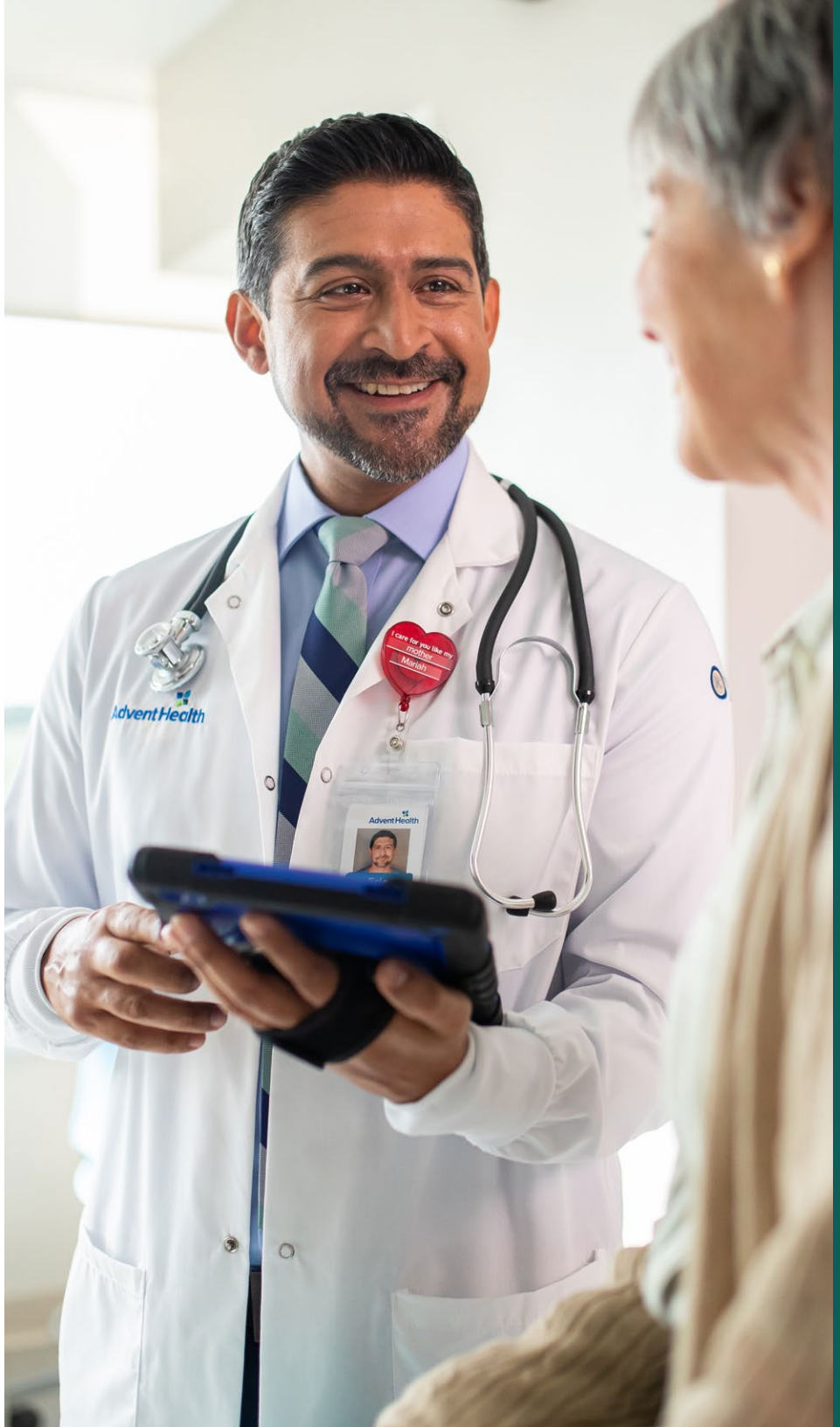
Secondary Data

To inform the assessment process, the Hospital collected existing health-related and demographic data about the community from public sources. This included data on health conditions, social determinants of health and health behaviors.

The most current publicly available data for the assessment was compiled and sourced from government and public health organizations including:

- VISION — Visual Information System for Identifying Opportunities and Needs
- Colorado Hospital Association 2022 Hospital Utilization Report
- CDPHE Drug Overdose Dashboard
- Colorado Blueprint to End Hunger Data Dashboard
- Colorado Health Access Survey (CHAS) Data Dashboard 2023
- Healthy Kids Colorado Survey Dashboard
- Colorado Motor Vehicle Problem ID Dashboard — Colorado Department of Transportation (codot.gov)
- Colorado Coalition for the Homeless — The State of Homelessness 2024
- Colorado Health Information Dataset (COHID) Deaths Dashboard

Hospital utilization data for uninsured or self-pay patients who visited the Hospital for emergency department, inpatient or outpatient services in 2024 was also used in the assessment. The top ten diagnosis codes were provided by the AdventHealth Information Technology Team.



The Findings

To identify the top needs, the Collaborative analyzed the data collected across all sources. At the conclusion of the data analysis, there were eight needs that rose to the top. These needs were identified as being the most prevalent in the community and frequently mentioned among community members and stakeholders.

The significant needs identified in the assessment process included:

Mental Health

Mental illnesses are conditions that affect a person's thinking, feeling, mood or behavior, such as depression, anxiety, bipolar disorder or schizophrenia. Such conditions may be occasional or long-lasting (chronic) and affect someone's ability to relate to others and function each day. Mental health includes our emotional, psychological and social well-being. It affects how we think, feel and act. It also helps determine how we handle stress, relate to others and make healthy choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood.

Drug and Alcohol Use

Substance use (including alcohol, illicit substances, tobacco, marijuana, vaping and other drugs) can create lasting health impacts. Overuse of substances can create dependency or lead to addiction in addition to any direct health impacts from the action of ingesting, smoking, or injecting said substance. Self-prescribed substance use to manage pain or mental health conditions can be dangerous and lead to greater suffering or unintended side effects. Substance use, especially among youth, can create tension within social relationships and affect mental health due to stigma and shame.

Environmental Health — Air and Water Quality

The rise in knowledge around climate and environment is reflected in health concerns related to air and water quality. Poor water quality can create a variety of issues from mineral buildup to disease transmission. Areas with a larger population of low-income individuals often suffer from poor water quality, including issues with sewage management or water with unsafe levels of lead or other heavy metals due to poor housing and pipe quality. Air quality continues to be a key indicator of health. Poor air quality can contribute to an increase in respiratory disease, or an exacerbation of existing conditions. This is especially a concern for the very old or the very young. In addition to poor air quality created by vehicle exhaust or nearby factory facilities, wildfire smoke can also create health concerns for those in many areas of Colorado.

Economic Stability — Housing

Housing is a key indicator of health. Having access to safe and stable housing permits individuals to stay safe from weather events and provides a space to sleep and prepare food. In addition to this, stable housing allows for access to nearby providers and for the building of community in the area where housing is located.

Economic Stability — Unemployment or Low Income

Individuals who are low-income or who are experiencing periods of unemployment may be unable to pay for needed health services for themselves or those they are supporting. In addition to gaps in healthcare due to an inability to pay for services, these circumstances may place individuals at risk of food insecurity or losing their stable housing. Experiencing prolonged unemployment or living with a low income can have profound effects on mental health and self-confidence. This effect is worsened by factors such as disability and limited English proficiency that may create additional challenges for job-seeking or system navigation.

Health Care Access and Quality

Accessible healthcare—particularly preventative services—can save lives and prevent suffering. Access to regular health screenings and physician services can catch life-threatening conditions early, increase knowledge of individual health risks and provide much-needed education on healthy life practices.

Health Care Access and Quality—Affordability

Affordable healthcare is the other side of healthcare access. A significant number of Colorado individuals are uninsured and this group has a disproportionate representation of people of color, individuals who are low-income and newcomers. Health issues that are unable to be addressed quickly due to cost will compound and create significantly worse health outcomes. This also extends to dental care and medication access.

Neighborhood and Built Environment—Food Security

Access to healthy food is a massive predictor of health and health outcomes. Individuals who are unable to feed themselves or their families healthy and nutritious food on a regular basis are more likely to have poor health outcomes and to experience additional health challenges. Many of the programs offered to close the food gap offer only shelf-stable foods and it is difficult to access fresh produce, dairy products and meat products. In addition to this, there is a shortage of culturally appropriate foods and foods that accommodate allergies or sensitivities. Those with medically required diets may also face barriers in accessing these foods if they are unable to buy them outright due to cost or access issues (i.e. living in food deserts or lack of transportation).

Priorities Selection

Prioritization Process

The Collaborative, through data review and discussion, prioritized the health needs of the community to a list of four. Community partners in the Collaborative represented the broad range of interests and needs, from, low-income and minority people in the community. During the spring of 2024, the Collaborative met to review and discuss the collected data and select the top community needs.

The prioritization of health needs by the Broomfield Public Health and Environment and Health Systems Collaborative took place from February to March 2024.

February 2024

Publicly available secondary data and the results of the stakeholder survey were presented to the Collaborative and the group was asked to consider the following questions while participating in a guided discussion to identify the top needs:

Consideration: Significance to Public Health

1. Does the issue impact a large number or high percentage of people in the community?
2. Do health disparities exist? Are sub-populations more affected than the general public?

Consideration: Ability to Impact the Issue

1. Do strategies exist that can be implemented locally to produce the desired outcome?
2. Does community support for change exist? Including the political will?
3. What did our community partners tell us were the most concerning issues facing the people they serve?

Community partners in the Collaborative represented the broad range of interests and needs, from, low-income and minority people in the community.

Out of the eight needs identified in the stakeholder survey, four emerged as particularly significant, demonstrating a remarkable percentage of respondents who ranked them as top health issues. These four pressing needs were subsequently presented to the Broomfield Board of Health and HHNAC for consideration. After reviewing the data, the Board of Health and HHNAC selected three of these needs as the primary focus areas for the Collaborative's Community Health Needs Assessment (CHNA), in alignment with city initiatives and Hospital initiatives and capacity. This selection underscores the importance of addressing these issues to enhance public health and ensure the well-being of the community.

The following needs rose to the top during the Collaborative's discussion and prioritization session. The needs receiving the most votes were considered the highest priority by the Collaborative.

Top Identified Needs	% of stakeholders who ranked as top health issue	Board of Health and HHNAC Selected
Healthcare Access and Quality—Affordability	44%	Yes
Economic Stability—Housing	29%	Yes
Mental Health	16%	Yes
Drug and Alcohol Use	11%	No

After the Board of Health and HHNAC completed the initial prioritization, Broomfield Public Health performed an internal capacity assessment for the three selected needs, to ensure that they had the capacity to address these health concerns for the next 5 years and to ensure that they were not duplicating the work of other partners. The capacity assessment included reviewing all public health programs that were currently in place to address each need, as well as reviewing the funding sources and planned longevity of each program. This process also helped identify gaps in programming and opportunities to collaborate with other partners.

March, 2024

In March 2024, Broomfield Public Health and Environment and Health Systems Collaborative participated in a secondary prioritization session to review the choices of the Board of Health and ensure that the healthcare partners represented were aligned with these efforts and to discuss collaborative efforts for the remainder of the year. During the session, the data behind each need was reviewed, followed by a discussion of the need, the impact it had on the community and the resources available to address it.

The following questions were used to guide the discussion:

A. Impact on Community

What are the consequences to the health of the community of not addressing this issue now?

B. Resources

Are there existing, effective interventions and opportunities to partner with the community to address this issue?

C. Outcome Opportunities

Do interventions addressing this issue have an impact on other health and social issues in the community?

After participating in the session, the Collaborative was in agreement with the Board of Health's recommendations as a whole and offered any needed support to Broomfield Public Health. In addition to this, those represented indicated interest in utilizing this process and the Board of Health's prioritization recommendations to inform their own CHNA processes.

After a list of the top three health needs of the community had been voted on by the Collaborative, they were presented to the Hospital Health Needs Assessment Committee (HHNAC). The HHNAC met and reviewed the data behind the selected needs and the available resources to address them in the community.

By having a high-level overview of the city initiatives, the HHNAC was able to identify key areas where hospital resources and operations could align more effectively with community health priorities. Understanding the pressing health needs recognized by respondents allowed the HHNAC to pinpoint specific gaps in services and resources within the Hospital that needed to be addressed to better serve the community.

This alignment between identified health issues and hospital capacity not only facilitated a targeted approach to improving internal operations but also ensured that the hospital's strategies were directly contributing to broader public health goals. Additionally, this approach fostered collaboration between the hospital and city initiatives, creating opportunities for shared resources and joint programming that could enhance overall community health outcomes. By closely examining how internal capabilities could support external needs, the HHNAC positioned the Hospital to be more responsive and proactive in addressing the significant health challenges faced by the community.

Members of the HHNAC included:

- Mark Smith, Chief Executive Officer
- Johnnathan Ward, Director of Mission Integration
- Erika Manuel, Human Resources Director
- Dr. Lisa Winkler, Clinical Physician
- Michael Darnell, Nursing Excellence Program Director
- Marlon Ortega, Environmental Service Team Lead
- Jessica Gutierrez, Clinical Nursing Manager
- Chloe Dean, Communications and Public Relations Manager
- Ashley Cook, Safety Manager
- Katherine Holcomb-Shrader, Social Work Care Manager
- Lauren Rees, Speech Language Pathologist
- Monica Kneusel, Community Benefit Coordinator
- Bryan Trujillo, Regional Director Community Health Improvement

The HHNAC narrowed down the list to three priority needs:

- Mental Health
- Economic Stability — Housing
- Neighborhood and Built Environment — Food Security

Available Community Resources

As part of the assessment process, a list of resources or organizations addressing the top needs in the community was created. Although not a complete list, it helped to show where there were gaps in support and opportunities for partnership in the community when the Collaborative chose which priorities to address.

Top Needs	Hospital and Community Programs Offered to Meet Need		Partnerships and Collaborations
Mental Health	**AdventHealth Programs** • Zero Suicide Programming • Family Connects • Naloxone Distribution • GeriActives — Movement Support • Caring Connections Calls • GriefShare Support Groups • Gun Safe Distribution	**Broomfield Public Health Programs** • Communities that Care • Family Connects • The Works (Harm Reduction) • Sources of Strength (Suicide Prevention) • Healthy Family America/GENESIS • Infant and Early Childhood Consultations • TEPP (Tobacco Education)	• Veteran's Hospital — Gun Safe Distribution • CDPHE's Zero-Suicide Grant
Neighborhood and Built Environment — Food Security	**AdventHealth Programs** • Coal Creek Meals on Wheels — Meals Vouchers after Hospital Stay	**Broomfield Public Health Programs** • WIC Program • SNAP in Association with Broomfield Human Services	• Broomfield WIC Program — Hospital-Provided Funding for Fresh Produce Boxes
Economic Stability — Housing		**Broomfield Public Health Programs:** • Radon Test Kit Distribution • Partnership in CCOB Housing Division • Broomfield Housing Solutions Forum	• Hospital Seat in the Broomfield Community Service Network • Upcoming Partnership with the Broomfield Housing Solutions Forum

Priorities Addressed

The priorities to be addressed include:

Mental Health

In the Hospital's community, behavioral health care continues to be a prevalent need. The percentage of adults reporting poor mental health has risen in the last three years, from 12.58% to 16.64%. The percentage of adults reporting depression in 2022 was 21.37%, with death by suicide on the rise in this community since 2022. This need was highlighted by the focus groups conducted among youth and older adults—with youth citing increased stress and continuing mental health effects from the COVID-19 pandemic and older adults bringing up the need for social connection to combat high levels of loneliness. The stakeholder survey indicates that mental health and the increase in suicides were the top concern for community organizations. Choosing to address this priority aligns the Hospital with public health and community organizations battling the rise in mental health conditions in this community.

Economic Stability—Housing

Access to safe and affordable housing continues to be a concern in this community. Housing instability is on the rise in the Hospital's community, increasing from 4.10% to 6.10% in the last three years. In addition to this, the median income needed to procure affordable housing (less than 30% of monthly income spent on housing) has increased. Homelessness is on the rise, with an alarming 39% increase reported by the Colorado Coalition for the Homeless in 2023. Homelessness continues to have a disproportionate effect on people of color, particularly Black and African American populations. The second most frequently reported reason for experiencing homelessness is an inability to pay rent or a mortgage.

Identified as a key determinant of health in the stakeholder survey, housing affects the health of the community in a wide and expansive way. Addressing this need will combine the Hospital's effort with that of several existing housing coalitions and groups.

Neighborhood and Built Environment—Food Security

Food insecurity is on the rise in Colorado, as indicated by an 8% increase in SNAP benefits claimed from 2020–2022, representing an additional 41,829 individuals who could not afford food without SNAP benefits. In the Hospital's community 6.5% of individuals report an inability to afford food. In particular, this concern was highlighted by the Spanish-speakers focus group, who indicated that rising food prices increase their stress and—for newcomers—are one of the basic needs that they struggle to meet. The older adult focus group report struggles to accommodate rising grocery prices on a fixed income that has not expanded to meet that need.

Addressing this priority can make a significant and life-changing difference for families and individuals in the community who struggle to meet the basic need of having adequate meals and nutrition. Increasing the number of people who can eat well and often will have far-reaching effects on the overall health of the community.

Priorities Not Addressed

The priorities not to be addressed include:

Drug and Alcohol Use

Substance use appeared on the stakeholder survey as an area of concern and was echoed by the youth focus group. The percentage of adults reporting marijuana use in the Hospital's community is higher than the state average, with 28.97% of Broomfield individuals reporting smoking marijuana, compared to the state average of 19.23%. However, drug overdose deaths are trending down in the Hospital's community, as is adolescent binge drinking, although the percentages reported are still 6% higher than state average.

Concerns about substance use continue to be voiced, especially since the rise in substance use since the COVID-19 pandemic. The Hospital's role in addressing this concern is already well-established and a part of routinely offered care. AdventHealth Avista provides programs to decrease the likelihood of or address addiction to

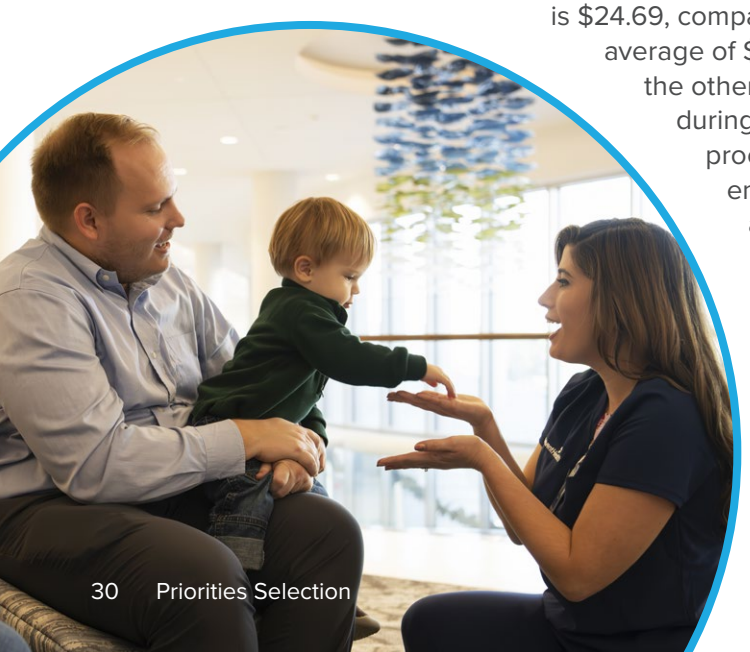
opioids (ALTO/MOUD programs) and is a Narcan distribution site. The Collaborative has agreed that the Hospital's efforts to address substance use in this area are significant and effective.

Environmental Health — Air and Water Quality

Air and water quality are a continuing source of concern for many individuals in Colorado. The Hospital's PSA does not suffer from significant and ongoing poor water or air quality, with the exception of the wildfire smoke that affects the Front Ranges of Colorado at specific times of the year. Although the Hospital is ready and willing to support collaboration in this area, this is not an area that can be significantly improved by the Hospital over the next three years.

Economic Stability — Unemployment or Low Income

Unemployment and low income are significant predictors of health and healthcare access. In Avista's PSA 10% of the community lives under the federal poverty line, compared to the state average of 16%. In addition to this, the unemployment rate in Broomfield County has stayed at 3% for the past four years, regardless of state-wide changes. In addition to the low unemployment rate, the average hourly wage earned in Broomfield County is $24.69, compared to the state average of $12.56. Compared to the other top needs that arose during the assessment process, the rates of employment and average income are not factors that the Hospital has a high level of impact on.

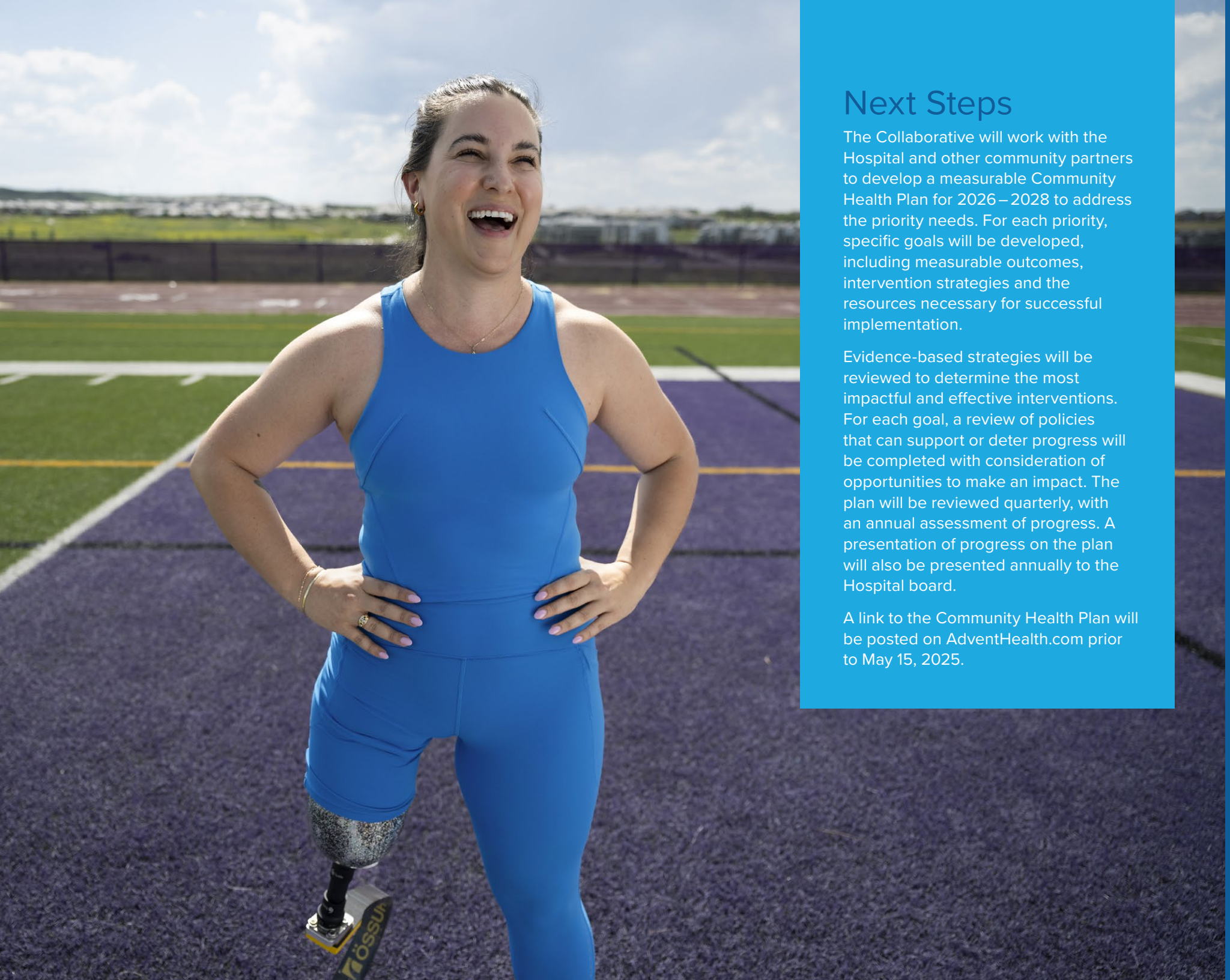


Health Care Access and Quality

Healthcare access continues to be a top priority for individuals in Colorado. In addition to the number of individuals who may not be able to access healthcare due to cost reasons (4.6% of Colorado individuals are uninsured), healthcare access issues can also be compounded by lack of transportation, prohibitive work schedules, lack of childcare and limited English proficiency. AdventHealth Avista PSA includes significantly more physicians, dentists and mental health practitioners per capita than the state average, with 22% of individuals visiting a general care provider and 30% visiting a mental health care provider in the last year according to the Colorado Health Access 2023 Survey. The Hospital chose not to prioritize this need but continues to work towards healthcare access by providing healthcare education opportunities for future health practitioners and by offering free healthcare services and screenings where possible.

Health Care Access and Quality — Affordability

Healthcare affordability was one of the top concerns voiced by the Spanish-speaking focus group and echoed by the stakeholder survey. In 2023, 4.60% of Colorado residents were uninsured, with 40.60% enrolled in Medicaid or Medicare insurance plans. In the Hospital's community, the median income is $10,000 above the state average and the cancer and cardiovascular screening behaviors of the community are on average 2–6% higher than the state average. Although healthcare affordability continues to be a casualty of the rising cost of living and a significant factor in the participation of health behaviors, the Hospital sees more of a benefit in supporting existing organizations and collaborations that are reaching the specific populations most affected by healthcare affordability in the Broomfield area.



Next Steps

The Collaborative will work with the Hospital and other community partners to develop a measurable Community Health Plan for 2026 – 2028 to address the priority needs. For each priority, specific goals will be developed, including measurable outcomes, intervention strategies and the resources necessary for successful implementation.

Evidence-based strategies will be reviewed to determine the most impactful and effective interventions. For each goal, a review of policies that can support or deter progress will be completed with consideration of opportunities to make an impact. The plan will be reviewed quarterly, with an annual assessment of progress. A presentation of progress on the plan will also be presented annually to the Hospital board.

A link to the Community Health Plan will be posted on AdventHealth.com prior to May 15, 2025.

Community Health Plan

2023 – 2025 Community Health Plan Review

The Hospital evaluates the progress made on the implementation strategies from the Community Health Plan annually. The following is a summary of progress made on our most recently adopted plan. The full evaluation is available upon request.

Priority 1: Mental Health — Suicide Prevention

In the 2022 CHNA, Mental Health and Suicide Prevention was identified as a priority. In Boulder and Broomfield counties, suicide and depression rates remained high. 50.2 per 100,000 patients were hospitalized in the ED for suicidal ideation and attempts. 1,428.6 per 100,000 patients had other mental health problems. 17.3 per 100,000 population completed suicide in 2020. Rates of postpartum depression were rising as well. Stigma surrounding mental illness in our communities also prevented patients from seeking out care due to fear.

A comprehensive suicide prevention pathway has been developed at the Hospital, including the universal screening of patients with the Columbia-Suicide Severity Rating Scale(C-SSRS) tool. Low-scoring patients are assessed by a behavioral health practitioner using the Safe-T model. Depending on need, the patient is provided with resources (including a connection to Caring Contact and a RMCP Hospital Follow-Up program) or referred to the crisis assessment team for a full assessment (Safe-T, Audit C+ Two, SBIRT, CALM (Counseling Access to Lethal Means) and a Stanley Brown Safety Plan (if discharged). Patients are either discharged home, sent to a crisis stabilization unit, an acute treatment unit, or inpatient behavioral health unit based on risk assessment.

The Hospital evaluates the progress made on the implementation strategies from the Community Health Plan annually.

Trainings provided to staff members at the Hospital from January 1, 2024 – September 30, 2024 include Institute of Reproductive Grief 8-hour training, The Birth Squad- Postpartum International Training, Access to Lethal Means Training (CALM) Training, C-SSRS Training Columbia Suicide Severity Rating Scale LEARN, LEARN for Perinatal Care. Community and caregiver trainings are on track to be offered during the remainder of the year. In addition to offering trainings throughout the year, AdventHealth Rocky Mountain Region Behavioral Health has partnered with the local Veterans Association to stage an event focused on mental health care for veterans. This event provided free gun safes and education on safe weapons handling. Two articles on suicide prevention were published on the internal SharePoint site for hospital employees in Q3, including resources for suicide prevention.

Priority 2: Housing Stability

During the 2022 needs assessment, housing stability was prioritized by the Hospital. Data showed in Boulder and Broomfield counties, housing prices had sharply risen. They ranked 17 and 11 respectively amongst counties with more than 50% of household income spent on housing. Quality of housing was also a problem due to overcrowding, poor plumbing/kitchen utilities. Inflation during the pandemic meant that families had less to spend on basic needs such as rental/ mortgage payments and utilities.

As the Hospital re-builds community partnerships post dis-affiliation, AdventHealth Rocky Mountain Region (which includes the Hospital) continues to actively pursue membership in collaborative efforts regarding housing in the Broomfield/Boulder service area. AdventHealth Rocky Mountain Region's community health team has become an attending member of the Broomfield Community Service Network, a collaborative of 30+ organizations that address SDOH (Social Determinants of Health) in the Broomfield area, including access to housing. SDOH (Social Determinant of Health) screenings assessing food, housing, transportation, utilities and safety are universally administered at all inpatient encounters. The Hospital reported 70 positive SDOH screenings for housing between January 1, 2024 – September 30, 2024.

Priority 3: Food Security

The Hospital also prioritized food security during the most recent CHNA. According to Hunger Free Colorado, 1 in 3 people were struggling with hunger during the pandemic. A high cost of living exacerbated the gap between federal poverty guidelines and a living wage. In the Hospital's service area, one in 10 people were food insecure. Blacks and Hispanics had greater rates of food insecurity at 14% and 13.4%, respectively.

AdventHealth Avista has partnered with Nourish Colorado and Broomfield WIC to provide fresh, local produce to their community by investing $6,500 to cover the program's administrative fees and the cost of produce delivery to families. In addition, AdventHealth Avista has solidified their partnership with Coal Creek Meals on Wheels, providing vouchers to hospital patients for hot meals served at their Lafayette location, as well as medically tailored meal delivery for a limited time. AdventHealth Avista was recently invited to a joint tour of the Community Food Share local farms with elected officials and organizational partners with the intention of learning more about local food growing efforts and how to engage in policy that will support Colorado agriculture. AdventHealth Avista continues their association with Sister Carmen Food Bank and The Refuge in Broomfield. AdventHealth Rocky Mountain Region is working with Hunger Free Colorado with the intention of establishing hospital staff as PEAS (Partners Engaging in Application Services) in order to provide SNAP and WIC sign-up services to patients in the surrounding community. This collaboration is expected to continue into the year.

SDOH (Social Determinant of Health) screenings assessing food, housing, transportation, utilities and safety are universally administered at all inpatient encounters. The Hospital reported 69 positive SDOH screenings for food security between January 1, 2024 – September 30, 2024. Advent Health Rocky Mountain Region has built a collaboration with the Colorado Blueprint to End Hunger that has provided workgroup access to efforts around policy and food access and has partnered with Blueprint to support the Hospital's needs assessment process by inviting the organization to speak at public community health improvement meetings across the region.

2022 Community Health Needs Assessment Comments

We posted a link to the most recently conducted CHNA and the most recently adopted implementation strategy, 2023 Community Health Plan on our hospital website as well as on AdventHealth.com prior to May 15, 2023 and have not received any written comments.

AdventHealth

Portercare Adventist Health System dba AdventHealth Avista

CHNA Approved by the Hospital board on: March 19, 2025

For questions or comments, please contact
AdventHealth Rocky Mountain Region Community Health
rmr.communityhealth@adventhealth.com

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