



2023-2025
AdventHealth
Parker
Community
Health Plan

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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 Parker’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



I Executive Summary

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

Community Health Needs Assessment Process

AdventHealth Parker in Parker, 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 Parker created a Community Health Needs Assessment Steering Committee (Steering Committee) to help guide the Hospital through the assessment process. The Steering 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 Parker 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. Substance Use Prevention
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. Intentional Injury
2. Access to Oral Health
3. Access to Primary Care

See page 16 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 15, 2022, the AdventHealth Parker Board approved the Community Health Plan 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 16, 2024

Ongoing Evaluation

AdventHealth'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 Parker at <https://www.adventhealth.com/community-health-needs-assessments>.



ABOUT ADVENTHEALTH



| About AdventHealth

AdventHealth Parker 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 Parker

Parker Adventist Hospital located at E-470 and Parker Road, offers leading medical experts, cutting edge technology and a broad array of clinical services. The Hospital performs complex spine surgery as well as weight-loss, orthopedic and joint replacement surgery. We are a Level II Trauma Center, offer oncology services and are an accredited chest pain center, and primary stroke center. We also provide high-risk pregnancy care and deliver babies as young as 28 weeks. As a regional medical center, we offer the medical care you need, close to home, and are committed to excellence in health care.



PRIORITIES ADDRESSED



Mental Health (Suicide Prevention)

In Douglas and Arapahoe Counties, suicide and depression rates remain high. 81.7 per 100,000 patients were hospitalized in the ED for suicidal ideation and attempts. 1662.7 per 100,000 patients were hospitalized for 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. There is a tension between immediate care and prevention that needs to be considered. Douglas and Arapahoe Counties have varying resources.

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 Douglas and Arapahoe 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 Douglas and Arapahoe 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

Substance Use Prevention

Douglas and Arapahoe Counties report that substance use has increased over the past three years and is important to address along with mental health. Adult smoking is 13.5% and excessive drinking is 19.6%. The community is experiencing an increase since the pandemic, as well.

Goal 1: Increase Emergency Department Medications for Opioid Use Disorder (MOUD) encounters (Buprenorphine inductions); increase administration and prescription of alternatives to opioids. Decrease in the administration and prescription of opioids; increase the distribution of Naloxone kits to support opioid overdose reversal.

Objective 1.1: By 2023, develop a framework for an opioid addiction intervention and prevention outcomes initiative.

Target Population: Adults in Douglas and Arapahoe Counties.

Activities/Strategies	Outputs	Hospital Contributions	Community Partnerships	Timeline		
				Y1	Y2	Y3
Collaborate with treatment partners to provide continuity of care and improve transitions back to community for individuals with Opioid Use Disorders.	Continue to collaborate with MOUD providers	The Psych Assessment Team – staff time to scale framework and meet with partners	ED Physician Groups, Colorado’s Hospital Transformation Program, MOUD Providers	X	X	X
Assure the Emergency Departments have access to ED Medications for Opioid Use Disorder (MOUD) and ED Alternatives to Opioids (Altos) and Naloxone distribution tools to advance care and outcomes for individuals with Opioid Use Disorders at risk of overdose.	# of ALTOs provided to appropriate community members	The Psych Assessment Team - staff time to train and screen ED Physicians, Pharmacy – staff time to screen and provide interventions	ED Physician Groups, Colorado’s Hospital Transformation Program, MOUD Providers	X	X	X

Substance Use Prevention

Goal 2: Advance Substance Use Disorder screening, Brief Intervention and Referral to Treatment (SBIRT) services.

Objective 2.1: By 2023, implement Screening Brief Intervention and Referral to Treatment (SBIRT) initiative.

Target Population: Adults in Douglas and Arapahoe Counties.

Activities/Strategies	Outputs	Hospital Contributions	Community Partnerships	Timeline		
				Y1	Y2	Y3
Expand universal prevention and early intervention programming to identify risk-level and provide appropriate care to address behavioral health needs.	# of screenings completed Continue to collaborate in existing coalitions and health alliances to address behavioral health needs	The Psych Assessment Team - staff time to attend meetings ED Physicians, Pharmacy – staff time to screen and provide interventions	ED Physician Groups, Colorado’s Hospital Transformation Program, MOUD Providers, Mile High Health Alliance, Colorado Community Health Alliance	X	X	X

Food Security

Although food security has improved, the cessation of benefits and extra services during the COVID pandemic, means that this is likely to worsen again in 2022. The community would like to continue existing efforts to ensure families have access to healthy foods and enough to eat.

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 Douglas and Arapahoe 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 Douglas and Arapahoe 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



I Priorities Not Addressed

AdventHealth Parker 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.

Intentional Injury

Intentional Injury was prioritized recognizing the impact of injuries such as suicide, homicide and violence. Through discussions with the Steering Committee, it was recognized that a focus on Mental Health and Substance Abuse would be a prevention strategy for Intentional Injury. The Committee felt strongly that we address those issues that align closely with Intentional Injury, recognizing we could impact both with this common focus. We are, therefore, addressing Intentional Injury through prevention related to Mental Health and Substance Use.

Access To Oral Health

Access to Oral Health Care was identified as a priority, in alignment with access to primary care in that there are fewer services and transportation can be a barrier. While oral health is an important part of human health, there was not alignment with community efforts nor Hospital efforts or capacity. We will monitor this over time and share with the community that this arose as an important health need.

Access to Primary Care

The Hospital's strategic priorities are addressing access to primary care through two large initiatives. Therefore, we will not create new implementation plans this priority because it's already embedded in our strategic priorities.





**Portercare Adventist Health System d/b/a
AdventHealth Parker**

CHP Approved by the Hospital Board on: November 15, 2022

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For questions or comments please contact:

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