2016 Community Health Needs Assessment

Kaiser Permanente Colorado

Approved by KFH Board of Directors
September 21, 2016

To provide feedback about this Community Health Needs Assessment, email CHNA-communications@kp.org

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KAISER PERMANENTE COLORADO REGION
COMMUNITY BENEFIT
2016 CHNA REPORT

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Acknowledgements
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Table of Contents

The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, included new requirements for nonprofit hospitals in order to maintain their tax exempt status. The provision was the subject of final regulations providing guidance on the requirements of section 501(r) of the Internal Revenue Code. Included in the new regulations is a requirement that all nonprofit hospitals must conduct a community health needs assessment (CHNA) and develop an implementation strategy (IS) every three years (http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf).

While Kaiser Permanente has conducted CHNAs for many years to identify needs and resources in our communities and to guide our Community Benefit plans, these new requirements have provided an opportunity to revisit our needs assessment and strategic planning processes with an eye toward enhancing compliance and transparency and leveraging emerging technologies. The CHNA process undertaken in 2016 and described in this report was conducted in compliance with current federal requirements.

Kaiser Permanente Colorado (KPCO) identified and prioritized six health needs for the communities it serves. Economic stability and vitality, healthy eating and active living, and mental health are high priority health needs. Access to primary and specialty care, climate change, and substance use are medium priority health needs. These high and medium needs are listed below alphabetically.

High Priority Health Needs

Economic Stability and Vitality

Individuals and families need a strong economic foundation upon which to build healthy lives. Economic stability promotes good health and healthy communities. Essential ingredients for a stable and vital economy include educational achievement, livable wages and safe places to live, work and play.

The communities served by KPCO lag in third-grade reading proficiency and high school graduation, with achievement disparities greatest among Hispanic and black youth. Nearly one-in-three residents in communities served by KPCO live below 200 percent of the federal poverty level. Approximately 14 percent of residents experience food insecurity, or lacks reliable access to sufficient, affordable and nutritious foods. Hourly wages are lower than the state average, and in some counties the unemployment rate is 50 percent higher than the state rate. Some urban counties, including Pueblo and Denver, have rates of assault and robbery that are nearly double or higher than the community overall.

Healthy Eating and Active Living

A lifestyle that includes healthy foods and exercise improves a person's physical and mental health. It lowers risks for cardiovascular disease, obesity and other health problems. It reduces anxiety and depression. Exercise can foster social connections, especially for older adults. Healthy eating and active living is best supported in communities where residents feel safe and have opportunities to make choices that promote well-being.

But a healthy lifestyle is the exception rather than the rule for many residents of communities served by KPCO. More than half of adults are overweight or obese, putting them at higher risk for costly and debilitating diseases such as cancer and diabetes. Nearly one-in-five young people are overweight or obese, with non-Hispanic black youth more likely to be in this category. The communities served by KPCO have fewer per capita grocery stores and WIC-authorized outlets and more fast food restaurants than the nation overall. One quarter of residents live in food deserts, with limited access to fresh foods while more than one in ten are food insecure. Healthy eating and active living is a flagship public health priority for Colorado and a top priority of local public health agencies.

Mental Health

Poor mental health impacts all areas of life, including a person's physical well-being, ability to work and perform well in school and to participate fully in family and community activities. Access to programs and services that promote social and emotional wellness for everyone is an important first step in improving mental health.

Addressing mental health is a top priority among the majority of local public health agencies and nonprofit hospitals in the communities served by KPCO as well as statewide. The average suicide rate for the communities served by KPCO exceeds the national rate and the Healthy People 2020 target. The rate in Park County is over three times greater than the Healthy People 2020 target. More than half of middle schoolers have been bullied on school property, while one-in-five high schoolers stopped doing some usual activities due to feeling sad or hopeless. The urban county of Pueblo has the highest rates of poor mental health among adults and Medicare beneficiaries, as well as the highest rate of assault, of all communities served by KPCO.

Medium Priority Health Needs

Access to Primary and Specialty Care

Primary and specialty health care helps individuals manage their diseases and learn skills for healthy living. Health insurance reforms led to record enrollment and eliminated patient cost-sharing for preventive services, making it more economical to obtain screenings and counseling. Expanded insurance coverage lowered one barrier to care, but placed greater demands upon a primary and specialty care workforce that is struggling to meet these needs.

Communities served by KPCO have a lower average rate of prenatal care and preventive cancer screenings when compared with the nation. However, the infant mortality rate exceeds the Healthy People 2020 target. When it comes to getting a needed appointment, individuals living in communities served by KPCO have more difficulty than people in the rest of the state. Several counties have few or no primary care providers. Access to care is the most frequently identified health need priority among nonprofit hospitals in the communities served by KPCO.

Climate Change

Climate change poses health concerns today and for future generations. Drought threatens economic stability throughout the communities served by KPCO, from agricultural counties in the east to mountain communities in the west. Poor air quality exacerbates respiratory and cardiovascular conditions. Abundant clean air and water are necessary for good health.

Signs of a changing climate are impacting the communities served by KPCO. The rate of severe drought exceeds the national average. Drought severity in the urban community of Pueblo is double the national rate. Lack of moisture can also contribute to Colorado's limited canopy cover and create challenges for improving this environmental factor. These are early indications of a health need with long-term implications.

Substance Use

Misuse of substances such as alcohol, marijuana, prescription drugs or tobacco harms individual and community health. Substance use among individuals of all ages can raise health risks for cancer, damage mental health and lead to poor decisions with tragic results. Legal marijuana and state alcohol laws make these substances readily available, raising concerns about access to underage youth.

Excessive alcohol consumption and expenditures surpass national rates. In Summit County, a mountain community, the rate of alcohol consumption is double the national average. Per capita access to liquor stores in the communities served by KPCO is more than double the national rate. Black and Hispanic white youths use alcohol and marijuana at higher rates than their peers. Nine local public health agencies and six nonprofit hospitals in the communities served by KPCO prioritized substance use as a health need. It is also a flagship public health priority for the state of Colorado.

C. Summary of Needs Assessment Methodology and Process

Data collection and analysis

The Colorado Health Institute, serving as a consultant, worked closely with the KPCO CHNA Core team members to identify appropriate and relevant data on health needs. Kaiser Permanente's CHNA Data Platform, pre-populated with common indicators on demographics, health outcome and other health factors data, served as a main resource.

These data were supplemented with secondary data from recent surveys that measure the impacts of health reform, health and health behaviors among Colorado's middle school and high school youth, and economic factors in Colorado. A complete list of data sources is in Appendix A.

Primary data were not collected during the needs assessment process in order to minimize burden on partners and leverage existing assessments that had already been conducted in the communities served by KPCO. These existing assessments incorporated primary data collected from their respective community members. Findings from two state, 21 local public health and 10 nonprofit hospital community health assessments and health improvement plans provided community and public health input for KPCO's assessment.

Data were organized according to potential health needs, with the performance value of communities served by KPCO for each indicator compared with the national performance value. The Healthy People 2020 target, when available, was also included. The region's performance was also compared with the state's overall performance value for Colorado-only data sources. Racial and ethnic disparities were also flagged, when data were available, as well as the poorest performing county in the KPCO community.

Identification of health needs

Members of the KPCO CHNA Leadership Group reviewed data for the 13 potential health needs identified in the CHNA data platform. Twelve KPCO employees from across the organization served as

the CHNA Leadership Group to identify and prioritize community health needs. These departments were selected to bring diverse perspectives to the process. Data from the platform were supplemented with additional sources. Their discussion centered on health needs in which the communities served by KPCO performed poorly compared with the nation, Healthy People 2020 and/or the state, and the presence of geographic and racial/ethnic disparities. They also considered the frequency with which state and local public health agencies and nonprofit hospitals prioritized the health needs. This led the Leadership Group to identify six health needs: access to primary and specialty care, climate change, economic stability and vitality, healthy eating and active living, mental health, and substance use.

Prioritization of health needs

The Leadership Group prioritized the six health needs based on overall need and feasibility criteria. Criteria for overall need included the community's performance against a benchmark; incidence/prevalence of the health need; and the presence of disparities. Feasibility criteria included community prioritization; existing resources, activities and political will focused on the health need; and opportunity for prevention. In the end, the Group identified three high priorities: economic stability and vitality; healthy eating and active living; and mental health. Access to primary and specialty care, climate change, and substance use were medium priorities.

II. INTRODUCTION/BACKGROUND

A. About Kaiser Permanente (KP)

Founded in 1942 to serve employees of Kaiser Industries and opened to the public in 1945, Kaiser Permanente is recognized as one of America's leading health care providers and nonprofit health plans. We were created to meet the challenge of providing American workers with medical care during the Great Depression and World War II, when most people could not afford to go to a doctor. Since our beginnings, we have been committed to helping shape the future of health care. Among the innovations Kaiser Permanente has brought to U.S. health care are:

- Prepaid health plans, which spread the cost to make it more affordable
- A focus on preventing illness and disease as much as on caring for the sick
- An organized coordinated system that puts as many services as possible under one roof—all connected by an electronic medical record

Kaiser Permanente is an integrated health care delivery system comprised of Kaiser Foundation Hospitals (KFH), Kaiser Foundation Health Plan (KFHP), and physicians in the Permanente Medical Groups. Today we serve more than 10 million members in eight states and the District of Columbia. Our mission is to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve.

Care for members and patients is focused on their Total Health and guided by their personal physicians, specialists, and team of caregivers. Our expert and caring medical teams are empowered and supported by industry-leading technology advances and tools for health promotion, disease prevention, state-of-the-art care delivery, and world-class chronic disease management. Kaiser Permanente is dedicated to care innovations, clinical research, health education, and the support of community health.

B. About Kaiser Permanente Community Benefit

For more than 70 years, Kaiser Permanente has been dedicated to providing high-quality, affordable health care services and to improving the health of our members and the communities we serve. We believe good health is a fundamental right shared by all and we recognize that good health extends beyond the doctor's office and the hospital. It begins with healthy environments: fresh fruits and vegetables in neighborhood stores, successful schools, clean air, accessible parks, and safe playgrounds. These are the vital signs of healthy communities. Good health for the entire community, which we call Total Community Health, requires equity and social and economic well-being.

Like our approach to medicine, our work in the community takes a prevention-focused, evidence-based approach. We go beyond traditional corporate philanthropy or grantmaking to pair financial resources with medical research, physician expertise, and clinical practices. Historically, we've focused our investments in three areas—Health Access, Healthy Communities, and Health Knowledge—to address critical health issues in our communities.

For many years, we've worked side-by-side with other organizations to address serious public health issues such as obesity, access to care, and violence. And we've conducted Community Health Needs Assessments to better understand each community's unique needs and resources. The CHNA process informs our community investments and helps us develop strategies aimed at making long-term, sustainable change—and it allows us to deepen the strong relationships we have with other organizations that are working to improve community health.

C. Purpose of the Community Health Needs Assessment (CHNA) Report

The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, included new requirements for nonprofit hospitals in order to maintain their tax exempt status. The provision was the subject of final regulations providing guidance on the requirements of section 501® of the Internal Revenue Code. Included in the new regulations is a requirement that all nonprofit hospitals must conduct a community health needs assessment (CHNA) and develop an implementation strategy (IS) every three years (http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf). The required written IS plan is set forth in a separate written document.

D. Kaiser Permanente's Approach to Community Health Needs Assessment

Kaiser Permanente has conducted CHNAs for many years, often as part of long standing community collaboratives. The new federal CHNA requirements have provided an opportunity to revisit our needs assessment and strategic planning processes with an eye toward enhanced compliance and transparency and leveraging emerging technologies. Our intention is to develop and implement a transparent, rigorous, and whenever possible, collaborative approach to understanding the needs and assets in our communities. From data collection and analysis to the identification of prioritized needs and the development of an implementation strategy, the intent was to develop a rigorous process that would yield meaningful results.

Kaiser Permanente's innovative approach to CHNAs include the development of a free, web-based CHNA data platform that is available to the public. The data platform provides access to a core set of approximately 150 publicly available indicators to understand health through a framework that includes social and economic factors; health behaviors; physical environment; clinical care; and health outcomes.

In addition to reviewing the secondary data available through the CHNA data platform, and in some cases other local sources, KPCO reviewed primary data collected from local partners. KPCO's primary data consisted of reviewing state and local public health agency priorities and nonprofit hospital community health needs assessments and incorporating these findings into health needs identification and prioritization. Since these assessments used community input to identify priorities, KPCO did not want to overburden community partners by collecting this information again. The CHNA process also included an identification of existing community assets and resources to address the health needs.

Each hospital/collaborative developed a set of criteria to determine what constituted a health need in their community. Once all of the community health needs were identified, they were all prioritized, based on identified criteria. This process resulted in a complete list of prioritized community health needs. The process and the outcome of the CHNA are described in this report.

In conjunction with this report, Kaiser Permanente Colorado will develop an implementation strategy for the priority health needs it will address. These strategies will build on Kaiser Permanente's assets and

resources, as well as evidence-based strategies, wherever possible. The Implementation Strategy will be filed with the Internal Revenue Service using Form 990 Schedule H. Both the CHNA and the Implementation Strategy, once they are finalized, will be posted publicly on our website, www.kp.org/chna.

III. COMMUNITY SERVED

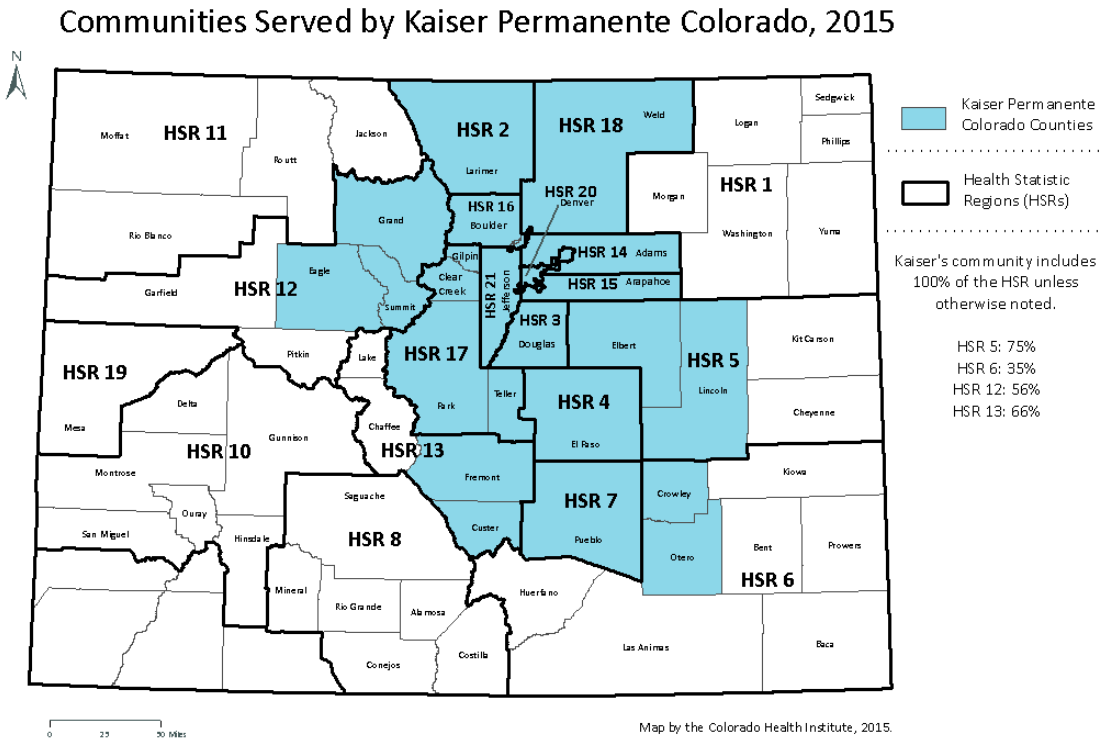
A. Kaiser Permanente's Definition of Community Served

Kaiser Permanente defines the community served as those individuals residing within its service area. A service area includes all residents in a defined geographic area surrounding its medical facilities and does not exclude low-income or underserved populations.

KPCO also included any county with one or more member living in its boundaries. Most of KPCO's membership lives in region's urban counties, or in counties adjacent, KPCO included sparsely populated counties to better understand the regional issues and needs.

Map and Description of Community Served

i. Map



ii. Geographic description of the community served (towns, counties, and/or zip codes)

KPCO's community is made up of 24 counties encompassing 11 entire Health Statistics Regions and four partial regions (see detailed map). It is a geographically diverse area with the Continental Divide bisecting the community north and south with the plains toward the east. According to the Colorado Department of Public Health and Environment, 16 counties are classified as urban, six as rural, and two as frontier. The rural counties are on the western slope of the Continental Divide and on the Eastern Plains. Two counties, Custer and Lincoln, are classified as frontier, with a population density of six or

fewer persons per square mile. Urban counties fall along the urban Front Range corridor. Major cities in the community include Aurora, Boulder, Colorado Springs, Denver, Fort Collins, Greeley and Pueblo.

iii. Demographic profile of community served

KPCO's community includes most Coloradans, with 87 percent of the population.

A majority of the individuals (83 percent) identify primarily as white. More than five percent of the community identifies as either black, some other race or multiple races. The majority of the population in this five percent reside in Adams, Arapahoe, Denver, El Paso, Pueblo, and Summit counties. Over one in five, or 21 percent, of the community identifies as Hispanic or Latino. Most of these residents live in Adams, Crowley, Denver, Eagle, Otero, Pueblo, and Weld counties.

Approximately 34 percent of the community is under the age 25, and close to 11 percent is age 65 and over. The county with the lowest median age is Adams, at 32.6 while the median age in Custer county is 54.6.

The community's population ages 24 and under is expected to grow 11.2 percent between 2015 and 2020 while the 65 and over population is projected to grow by 28 percent during the same time period.

Demographics	
Total Population	4,460,622
Race	
White	83.1%
Black	4.4%
Asian	3.1%
Native American/ Alaskan Native	0.8%
Pacific Islander/ Native Hawaiian	0.1%
Some Other Race	4.9%
Multiple Races	3.5%
Ethnicity	
Hispanic or Latino	21.0%
Non-Hispanic	79.0%

Socio-economic Data	
Living in Poverty (<200% FPL)	29.3%
Children in Poverty	17.2%
Unemployed	3.9%
Uninsured	7.0%
High School Graduation Rate	81.4%

Population Data	
Percent < 25 yrs.	34.1%
Percent 25-64 yrs.	55.0%
Percent 65+ yrs.	10.9%

IV. WHO WAS INVOLVED IN THE ASSESSMENT

A. Identity of hospitals that collaborated on the assessment

KPCO considered health needs identified in existing assessments from state and local public health agency priorities and nonprofit hospital community health needs assessments serving its communities. These assessments used secondary data as well as primary data collected through a range of methods including focus groups, community surveys and community forums.

These hospitals are:

- Boulder Community Hospital, Boulder, 2014-2016
- Colorado Children's Hospital, Aurora, 2012
- McKee Medical Center, Loveland, 2013
- Memorial Hospital, Colorado Springs, 2014

- North Colorado Medical Center, Greeley, 2013
- Parkview Medical Center, Pueblo, 2013-2015
- St. Joseph Hospital, Denver, 2012
- St. Mary-Corwin Medical Center, Pueblo, 2012
- University of Colorado Hospital, Denver, 2013
- Vail Valley Medical Center, Vail, 2013

B. Other partner organizations that collaborated on the assessment

KPCO did not directly engage external organizations in its needs assessment.

A small team of Community Benefit staff – the CHNA Core team – worked closely with the Colorado Health Institute to review initial health needs, identify and recruit CHNA Leadership Group members, and recommend health needs identification and prioritization criteria. The Core team included:

- Heather Buffington, Project Coordinator
- Cheryl Kelly, Evaluation Investigator
- Carmen Martin, Senior Community Health Specialist
- Amy Pulver, Senior Manager, Community Health
- Mia Ramirez, Senior Community Health Specialist

Twelve KPCO employees from across the organization served as the CHNA Leadership Group to identify and prioritize community health needs. These departments were selected to bring diverse perspectives to the process. CHNA participation from across KPCO's departments also increased awareness of the process and its relevance to the entire organization.

The Leadership Group met twice to determine community health needs, establish the process and criteria for prioritization, and rank the identified health needs. Members of the group are listed below.

- Tonya Bruno, Senior Outreach & Retention Specialist
- Bernadette Doherty, Senior Manager, Strategy Management
- Christopher J. Fellenz, M.D., Physician Lead for Safety Net Partnerships & Access to Care
- Bobby King, Director, Diversity & Inclusion
- Janet Lucchesi, RN, MHS, CPHQ, Director of Quality and Accreditation
- Maureen McDonald, Senior Director, Community Benefit & Relations
- Douglas Newton, MD, MPH, Regional Specialty Chief of Integrated Behavioral Health | Department Value Advisor, Child and Adolescent Psychiatry | Clinical Lead for Pediatric Behavioral Health at KP Care Management Institute
- Paula Pulliam, Workforce Health Sr. Consultant, Complete Health Solutions
- Mia Ramirez, MPH, Senior Community Health Specialist
- John F. Steiner, MD, MPH, Senior Director, Institute for Health Research
- Mary Jo Strobel, BSN, MBA, Regional Administrator, Prevention and Wellness Solutions, Complete Health Solutions
- Jason Tacha, Executive Director Operations, Northern Colorado Service Area

C. Identity and qualifications of consultants used to conduct the assessment

The Colorado Health Institute conducted the assessment on behalf of KPCO. The Colorado Health Institute also conducted Kaiser Permanente Colorado's 2013 assessment. The Colorado Health Institute is a nonprofit health policy research institute created in 2002 by Colorado's health conversion foundations to address a statewide need for independent and impartial health care data, information

and analysis. The Colorado Health Institute serves as a trusted, nonpartisan advisor to a wide range of decision-makers. Staff participating in the CHNA included Maggie Bailey, Public Interest Fellow and Sara Schmitt, Director of Community Health Policy.

V. PROCESS AND METHODS USED TO CONDUCT THE CHNA

A. Secondary data

i. Sources and dates of secondary data used in the assessment

KPCO used the Kaiser Permanente CHNA Data Platform (www.chna.org/kp) to review over 150 indicators from publicly available data sources. Data on gender and race/ethnicity breakdowns were analyzed when available. For details on specific sources and dates of the data used, please see Appendix A.

The Colorado Health Institute supplemented the resources in the CHNA Data Platform with the following sources:

- The 2015 Colorado Health Access Survey (CHAS). The CHAS is a telephone survey of approximately 10,000 Coloradans that measures health insurance coverage, access to health care and use of health care services. The CHAS has been administered biennially since 2009. Its 2015 findings are the first in-depth look at the impact of the Affordable Care Act (ACA). CHAS data used in the CHNA included uninsured rate, barriers to care such as cost, and number of specialist visits in the past year.
- The 2013 Healthy Kids Colorado Survey (HKCS). The HKCS collects health and health behavior information from Colorado public school students in middle and high school. HKCS data used in the CHNA includes mental health, bullying on school property, physical activity, and tobacco, alcohol and marijuana use. These data were analyzed for state-level racial and ethnic disparities as well as geographic differences.
- Colorado State Demography Office. Population data from the Colorado State Demography office are calculated on an annual basis. The most recent estimates are at the county level for the year 2014 and finalized in October of 2015. CHI used 2015 estimates and projections for the year 2020 in addition to population data broken down by age groups.
- Department of Labor and Employment. The Department of Labor and Employment collects data for unemployment rates on a monthly basis and wage data on a quarterly basis. Data used for the CHNA are from September 2015 at the county level for unemployment rates. Hourly wage data was collected during the first quarter of 2015 at the county level.

ii. Methodology for collection, interpretation and analysis of secondary data

The Colorado Health Institute downloaded a complete health indicator report for the communities served by KPCO from the CHNA Data Platform. Racial/ethnic and county-level data available on the Platform were also accessed. This information was supplemented with additional publicly available data sources described in Section V.A.i.

Because the communities include nearly 90 percent of the state's population, its performance on the indicators was compared with the Healthy People 2020 target, when available, and to national performance data. State-only indicators, specifically the supplemental data sources, required a community comparison to the state overall.

Several steps were taken to yield additional insights on geographic, racial and ethnic disparities within the communities served by KPCO. Data on the poorest performing county were identified, when available. If individual county-level data were not available, data by health statistics region (HSR) were used.

Boundaries for HSRs were developed by the Colorado Department of Public Health and Environment for public health planning purposes and were determined by population size and key demographic factors within each county. The communities served by KPCO included 11 complete health statistics regions and four partial health statistics regions. Data from partial health statistics regions included values from counties not within KPCO's community and were interpreted carefully.

B. Community input

i. Description of the community input process

KPCO considered community health needs prioritized in existing assessment/public health improvement plans from local public health agencies serving the 24 counties in the KPCO community. All reports were completed from 2012-2014. These reports incorporated secondary data about the health needs of the community as well as direct input from community members and stakeholders. Specific activities that public health agencies used for collecting primary data from community members included key informant interviews, surveys, town hall and neighborhood meetings, focus groups and coalition outreach.

These public health agencies are:

- Boulder County Public Health
- Broomfield Public Health and Environment
- Clear Creek County Public and Environmental Health
- Custer County Public Health Agency
- Denver Public Health Department
- Eagle County Public Health Agency
- El Paso County Public Health
- Elbert County Public Health
- Fremont County Department of Public Health and Environment
- Gilpin County Public Health Agency
- Grand County Public Health
- Jefferson County Public Health
- Larimer County Health Department
- Lincoln County Department of Public Health
- Otero County Health Department (includes Crowley county)
- Park County Public Health
- Pueblo City-County Health Department
- Summit County Public Health
- Teller County Public Health Department
- Tri-County Health Department (serving Adams, Arapahoe and Douglas counties)
- Weld County Department of Public Health and Environment

State-level health priorities were also identified from the 2015-2019 Colorado Public Health Improvement Plan and the 2016-2020 Colorado Maternal and Child Health Needs Assessment.

ii. Methodology for collection and interpretation

Information on the health needs prioritized in the two state assessments and 21 local public health agencies priority areas was accessed from Colorado Department of Public Health and Environment's website and individual public health improvement plans. Community health needs assessments from the 10 non-profit hospitals were downloaded directly from the hospital websites.

The Colorado Health Institute matched these locally-identified priority health needs with the potential health needs identified on the CHNA Data Platform. Most locally-identified priorities were

identical to the potential health needs in the data platform, such as obesity/healthy eating active living, mental health and access to care. Others required some interpretation. For example, the public health priority of clean air and clean water was matched to the potential health need of climate change.

State-level priorities were interpreted in a similar fashion. “Flagship priorities” in the Colorado Public Health Improvement Plan were matched against potential health needs.

The Colorado Health Institute tallied the number of LPHAs, non-profit hospitals and state assessments that identified each potential health need as a priority. Each priority health need could earn up to 21 points in the LPHA priority category, 10 points for non-profit hospitals and 2 for state assessments. These points were incorporated into the overall potential health need score.

Locally-identified priorities were not weighted or considered in proportion to the population served by the public health agency or non-profit hospital.

C. Written comments

As of the time of this CHNA report development, Kaiser Permanente Colorado had not received written comments about previous CHNA Reports.

Data limitations and information gaps

The Kaiser Permanente CHNA data platform includes approximately 150 secondary indicators that provide timely, comprehensive data to identify the broad health needs faced by a community. However, there are some limitations with regard to these data, as is true with any secondary data. Some data were only available at a county level, making an assessment of health needs at a neighborhood level challenging. Furthermore, disaggregated data around age, ethnicity, race and gender are not available for all data indicators, which limited the ability to examine disparities of health within the community. Lastly, data are not always collected on a yearly basis, meaning that some data are several years old.

Because the communities served by KPCO include more than 85 percent of Coloradans, comparing service region values to state values yielded limited insights. Also, the size of the region and its overall performance on indicators did not reflect the intraregional variation.

Members of the KPCO CHNA Leadership Group identified several additional data gaps that limited their understanding of health needs, including county-level maltreatment, livable wages and current youth marijuana use. They also expressed concern about limited available data that reflects the impact of health reform on the health care workforce.

VI. IDENTIFICATION AND PRIORITIZATION OF COMMUNITY’S HEALTH NEEDS

A. Identifying community health needs

i. Definition of “health need”

For the purposes of the CHNA, Kaiser Permanente defines a “health need” as a health outcome and/or the related conditions that contribute to a defined health need. Health needs are identified by the comprehensive identification, interpretation, and analysis of a robust set of primary and secondary data.

ii. Criteria and analytical methods used to identify the community health needs

The KPCO CHNA Leadership Group considered multiple criteria for identifying the health needs of the communities served by KPCO. These criteria applied to health data as well as community input.

Health data criteria included comparing the community’s performance value against a benchmark. The benchmark most often used was the national performance value; however,

state values were used for state-only data sources. Scoring methodology in the CHNA Data Platform provided an initial benchmark score. The community's performance on Healthy People 2020 targets was also assessed and factored into the health needs analysis. A poor performance against the target resulted in a score of one (1), while a zero (0) was given if the community exceeded the target associated with the potential health need.

Racial and ethnic disparities served as the third data-related criteria. The potential health need received a score of one (1) if data indicate disparities and zero (0) if none were observed in data. The Leadership Group also acknowledged that disparities were present in most of the health indicators, regardless of limitations in available data.

Community input criteria measured the priorities identified in the state and local public health improvement plans and by nonprofit hospitals. The most frequently-identified priorities among these community partners were obesity/HEAL, mental health, substance abuse/tobacco and access to care. Priorities identified by these three sectors were tallied and the total number assigned to the corresponding potential health need.

The Leadership Group reviewed data tables for each potential health need. These tables included a description of the data indicators, national benchmark value, average value for the community overall, the value for the poorest performing county in the community and whether racial/ethnic disparities were measured for the indicator. They also reviewed the community input data with the number of state and local public health agencies and nonprofit hospitals that prioritized the potential health need.

The Leadership Group selected the four highest scoring potential health needs in their initial review of the data and made several thematic revisions. They revised the top scoring potential health need (Obesity/Healthy Eating Active Living) to Healthy Eating and Active Living in order to capture the broader environmental aspects that may not be reflected in "Obesity." The group decided to make the second highest scoring need, Mental Health, a separate health need and not combine it with the third-highest scorer, substance abuse/tobacco. The group changed this health need to Substance Use to reflect the health concerns that use, not just abuse, can cause. They cited Colorado's alcohol, tobacco and retail marijuana laws and regulations as issues to consider with regard to this health need.

The group revised the fourth highest potential health need (Access to Care) to Access to Primary and Specialty Care, after reviewing additional data on cancer, maternal/infant health and CVD/stroke. The group felt the community's poor performance in many of these areas of health are connected to limited access to primary and specialty care. Members also discussed recent insurance coverage changes that eliminate patient cost-sharing for preventive services as another indication of the importance of primary care. Several group members also raised concerns they have heard from community partners about limited access to specialty care for Medicaid enrollees.

Other potential health needs that scored lower were called out for discussion. The group identified economic security as a main driver of overall health, citing its interconnection with all other identified health needs. The group selected it as a health need, labeling it Economic Stability and Vitality. Climate and health was also discussed at length as another potential health need that impacts current and future generations. The group identified Climate Change as a health need.

Violence and injury prevention were discussed during both Leadership Group meetings. The group acknowledged significant geographic disparities on several violence indicators and noted the issue was a priority among several public health agencies and nonprofit hospitals. The group felt the health drivers associated with violence and injury prevention were reflected in other identified health needs, including mental health, economic stability and vitality and substance use.

The final list of health needs are access to primary and specialty care; climate change; economic stability and vitality; healthy eating and active living; mental health; and substance use.

B. Process and criteria used for prioritization of the health needs

The KPCO CHNA Leadership Group prioritized the health needs of the communities served by KPCO using a strategy grid to plot need and feasibility. The strategy grid included four quadrants – "low need/low feasibility; high need/low feasibility; low need/high feasibility; and high need/high feasibility."

Criteria for determining need included the community's performance against a benchmark; the incidence and prevalence in the community; geographic characteristics; and age, racial, and/or ethnic disparities. The CHNA Data Platform provided data to assess performance against benchmarks including the national performance value and Healthy People 2020 targets, as well as incidence and prevalence. Some disparities data were available through the CHNA Data Platform and were supplemented by other sources identified in Section V.A.i.

Criteria for determining feasibility included community prioritization; existing resources, activities and political will focused on the health need; and opportunity for prevention. Community prioritization was determined using information from the state and local public health improvement plans and nonprofit hospital community health assessments. The Colorado Health Institute analyzed recent state legislation, local foundation funding priorities, community health alliance activities and nonprofit advocacy efforts to assess the extent to which existing resources were available and focused on addressing the need. Opportunities for prevention were assessed by identifying evidence-based strategies in the Community Guide to Preventive Services, the County Health Ranking's What Works for Health inventory, and the CDC Community Health Improvement Navigator data base of interventions.

Members of the Leadership Group received summaries of need and feasibility criteria for each health need at their second meeting. The group reviewed the summaries, providing additional information as well as insights on the analyses. The group broke up into three small groups to discuss the summaries and decide where to plot each health need on the strategy grid.

Members in each small group discussed together the information on need and feasibility. They determined need and feasibility as low, medium or high for each of the six health needs. The small groups plotted their decision for each health need on a strategy grid

The group discussed what priority to assign each of the health needs. Their guiding criteria were as follows: health needs that the majority of the small groups plotted as having low need/low feasibility would be prioritized as low. Health needs that the majority of small groups plotted as having high need/high feasibility health needs would be prioritized as high. Health needs that fell in low/high quadrants would be considered medium priorities.

The three small groups unanimously plotted healthy eating active living and mental health as having high need and feasibility. In citing mental health as a high priority, the group discussed mental health disparities, limited access to mental health professionals and the opportunity for community-based prevention to improve mental health.

Economic stability and vitality was picked as high by two groups and medium by one. The group discussed how this health need is integral to all others and the opportunities it provides for preventing disease and building healthy communities. The group decided to prioritize it as high.

Climate change and substance use were unanimously plotted and prioritized as medium. The group discussed the relatively low feasibility of addressing climate change and acknowledged the high need for addressing it. Substance use was also plotted and prioritized as a medium priority, with the majority of groups indicating it has very high need but low to medium feasibility.

Access to primary and specialty care was plotted as high by two groups and medium by one. The group discussed and agreed that there is high feasibility for addressing access to primary and specialty care but raised concerns about a lag in secondary data to measure need. The group also felt many aspects of health reform are still unfolding although their impacts on need are still unknown. The group decided to prioritize this health need as medium.

C. Prioritized description of all the community health needs identified through the CHNA

High Priority Health Needs

- **Economic Stability and Vitality**

Economic Stability and Vitality is a high priority health need for the communities served by KPCO.

Individuals and families need a strong economic foundation upon which to build healthy lives. Economic stability promotes good health and healthy communities. Essential ingredients for a stable and vital economy include educational achievement, livable wages and safe places to live, work and play.

The communities served by KPCO lag in third-grade reading proficiency and high school graduation, with achievement disparities greatest among Hispanic and black youth. Nearly one-in-three residents in communities served by KPCO live below 200 percent of the federal poverty level. Approximately 14 percent of residents experience food insecurity, or lack reliable access to sufficient, affordable and nutritious foods. Hourly wages are lower than the state average, and in some counties the unemployment rate is 50 percent higher than the state rate. Some urban counties, including Pueblo and Denver, have rates of assault and robbery that are nearly double or higher than the community overall.

Economic security is closely connected to other identified health needs, making it a high priority. Low-income families and seniors may lack financial resources to purchase fresh foods, limiting their opportunities for healthy eating. Residents in communities with high crime rates may be less likely to exercise or socialize with their neighbors. Economic security yields healthy communities and community members.

- **Healthy Eating and Active Living**

Healthy Eating and Active Living is a high priority health need for the communities served by KPCO.

A lifestyle that includes healthy foods and exercise improves a person's physical and mental health. It lowers risks for cardiovascular disease, obesity and other health problems. It reduces

anxiety and depression. Exercise can foster social connections, especially for older adults. Healthy eating and active living is best supported in communities where residents feel safe and have opportunities to make choices that promote well-being.

But a healthy lifestyle is the exception rather than the rule for many community members. More than half of adults living in the communities served by KPCO are overweight or obese, putting them at higher risk for costly and debilitating diseases such as cancer and diabetes. Nearly one-in-five young people are overweight or obese, with non-Hispanic black youth more likely to be in this category. The communities served by KPCO have fewer per capita grocery stores and WIC-authorized outlets and more fast food restaurants than the nation overall. A quarter of community residents live in food deserts, with limited access to fresh foods. Healthy eating and active living is a flagship public health priority for Colorado and a top priority of local public health agencies.

Healthy eating and active living throughout one's lifetime, beginning with breastfeeding and continuing through old age, promotes health. Communities with abundant opportunities and resources to support this health need are also often economically thriving, desirable places in which to live, raise families and grow old.

- **Mental Health**

Mental Health is a high priority health need for the communities served by KPCO.

Poor mental health impacts all areas of life, including a person's physical well-being, ability to work and perform well in school and to participate fully in family and community activities. Access to programs and services that promote social and emotional wellness for everyone is an important first step in improving the community's overall mental health.

Addressing mental health is a top priority among the majority of local public health agencies and nonprofit hospitals in the communities served by KPCO as well as statewide. The average suicide rate for the communities served by KPCO exceeds the national rate and the Healthy People 2020 target. The rate in Park County is over three times greater than the Healthy People 2020 target. More than half of middle schoolers have been bullied on school property, while one-in-five high schoolers stopped doing some usual activities due to feeling sad or hopeless. The urban county of Pueblo has the highest rates of poor mental health among adults and Medicare beneficiaries, as well as the highest rate of assault, of all communities served by KPCO.

Mental health has strong influences over other health needs, including healthy eating and active living. Mental well-being shapes individuals' and families' resources and abilities to make healthy decisions. Mental health also impacts substance use, a concern for communities served by KPCO.

Medium Priority Health Needs

- **Access to Primary and Specialty Care**

Access to Primary and Specialty Care is a medium priority health need for communities served by KPCO.

Primary and specialty health care helps individuals manage their diseases and learn skills for healthy living. Health insurance reforms led to record enrollment and eliminated patient cost-sharing for preventive services, making it more economical to obtain screenings and counseling. Expanded insurance coverage lowered one barrier to care, but placed greater demands upon a primary and specialty care workforce that is struggling to meet these needs.

Communities served by KPCO have a lower average rate of prenatal care and preventive cancer screenings when compared with the nation. However, the infant mortality rate exceeds the Healthy People 2020 target. When it comes to getting a needed appointment, individuals living in communities served by KPCO have more difficulty than people in the rest of the state. Several counties have few or no primary care providers. Access to care is the most frequently identified health need priority among nonprofit hospitals in the communities served by KPCO.

State and federal health care reforms that increase health insurance coverage create opportunities for more community members to receive primary and specialty care. Health insurance literacy, individuals' use of health care services and the supply of health care workers are important considerations for this health need.

- **Climate Change**

Climate Change is a medium priority health need for communities served by KPCO.

Climate change poses health concerns today and for future generations. Drought threatens economic stability throughout the community, from agricultural counties in the east to mountain communities in the west. Poor air quality exacerbates respiratory and cardiovascular conditions. Abundant clean air and water are necessary for good health.

Signs of a changing climate are impacting communities served by KPCO. The community experiences severe drought, exceeding the national average. Drought severity in the urban community of Pueblo is double the national rate. Lack of moisture can also contribute to Colorado's limited canopy cover and create challenges for improving this environmental factor. These are early indications of a health need with long-term implications.

- **Substance Use**

Substance Use is a medium priority health need for communities served by KPCO.

Misuse of substances such as alcohol, marijuana, prescription drugs or tobacco, harms individual and community health. Substance use among individuals of all ages can raise health risks for cancer, damage mental health and lead to poor decisions with tragic results. Legal marijuana and state alcohol laws make these substances readily available, raising concerns about access to underage youth.

Excessive alcohol consumption and expenditures surpass national rates. In Summit County, a mountain community, the rate of alcohol consumption is double the national average. Per capita access to liquor stores in the communities served by KPCO is more than double the national rate. Black and Hispanic white youths use alcohol and marijuana at higher rates than their peers. Nine local public health agencies and six nonprofit hospitals in the communities served by KPCO prioritized substance use as a health need. It is also a flagship public health priority for the state of Colorado.

D. Community resources potentially available to respond to the identified health needs

Community resources to respond to Access to Primary and Specialty Care include community health centers and community safety net clinics; health alliances in the community, including in Aurora, Boulder, Colorado Springs and Denver which have prioritized access to specialty care; foundations making investments in improving access to care for vulnerable populations; and state laws expanding access to health insurance coverage for low-income Coloradans.

Community resources to respond to Climate Change include efforts led by the Colorado Department of Public Health and Environment to promote healthier air and clean water as part of Colorado's 10 Winnable Battles; economic development strategies to promote tourism by preserving Colorado's natural resources; and advocacy efforts lead by nonprofit organizations.

Community resources to respond to Economic Stability and Vitality include Colorado Early Childhood Councils; local economic development councils; LAUNCH Together; the Colorado Family Planning Initiative; community United Ways and other private philanthropic foundations; education reform and advocacy efforts led by organizations, including the Colorado Children's Campaign and the Colorado Education Initiative; local Community Development Block Grant efforts; and anti-poverty advocacy organizations such as the Colorado Center on Law and Policy.

Community resources to respond to Healthy Eating and Active Living include LiveWell Colorado; HEAL Cities and Towns campaign participants; Hunger Free Colorado; foundations making investments in improving healthy eating and active living in communities and schools, including the Colorado Health Foundation; and advocacy efforts led by Healthier Colorado and Bike Colorado.

Community resources to respond to Mental Health include safety net partners such as community mental health centers; foundations investing in early childhood mental health initiatives; advocacy and consumer organizations, including Mental Health America of Colorado and the National Alliance on Mental Illness Colorado; and statewide initiatives to promote and expand integrated primary care and behavioral health.

Community resources to respond to Substance Use include the Colorado Department of Public Health and Environment's marijuana prevention campaigns; safety net partners, including community mental health centers and substance use treatment providers; and organizations and public health agencies receiving Colorado Amendment 35 tobacco tax funds.

VII. KAISER PERMANENTE COLORADO 2013 IMPLEMENTATION STRATEGY EVALUATION OF IMPACT

A. Purpose of 2013 Implementation Strategy evaluation of impact

KPCO's 2013 Implementation Strategy Report was developed to identify activities to address health needs identified in the 2013 CHNA. This section of the CHNA Report describes and assesses the impact of these activities. For more information on KPCO's Implementation Strategy Report, including the health needs identified in the facility's 2013 service area, the health needs the facility chose to address, and the process and criteria used for developing Implementation Strategies, please visit https://share.kaiserpermanente.org/wp-content/uploads/2013/10/KPCO_CB-Strategy-Report_101514.pdf. For reference, the list below includes the 2013 CHNA health needs that were prioritized to be addressed by KPCO in the 2013 Implementation Strategy Report.

1. Access to Care
2. Healthy Eating Active Eating

Kaiser Permanente Colorado is monitoring and evaluating progress to date on their 2013 Implementation Strategies for the purpose of tracking the implementation of those strategies as well as to document the impact of those strategies in addressing selected CHNA health needs. Tracking metrics for each prioritized health need include the number of grants made, the number of dollars spent, the number of people reached/served, collaborations and partnerships, and KFH in-kind

resources. In addition, Kaiser Permanente Colorado tracks outcomes, including behavior and health outcomes, as appropriate and where available.

As of the documentation of this CHNA Report in March 2016, Kaiser Permanente Colorado had evaluation of impact information on activities from 2014 and 2015. While not reflected in this report, Kaiser Permanente Colorado will continue to monitor impact for strategies implemented in 2016.

B. 2013 Implementation Strategy Evaluation Of Impact Overview

In the 2013 IS process, all KFH hospital facilities planned for and drew on a broad array of resources and strategies to improve the health of our communities and vulnerable populations, such as grantmaking, in-kind resources, collaborations and partnerships, as well as several internal KFH programs including, charitable health coverage programs, future health professional training programs, and research. Based on years 2014 and 2015, an overall summary of these strategies is below, followed by tables highlighting a subset of activities used to address each prioritized health need.

- **KFH Programs:** From 2014-2015, KFH supported several health care and coverage, workforce training, and research programs to increase access to appropriate and effective health care services and address a wide range of specific community health needs, particularly impacting vulnerable populations. These programs included:
    - Medicaid: Medicaid is a federal and state health coverage program for families and individuals with low incomes and limited financial resources. KFH provided services for Medicaid beneficiaries, both members and non-members.
    - Medical Financial Assistance: The Medical Financial Assistance (MFA) program provides financial assistance for emergency and medically necessary services, medications, and supplies to patients with a demonstrated financial need. Eligibility is based on prescribed levels of income and expenses.
    - Charitable Health Coverage: Charitable Health Coverage (CHC) programs provide health care coverage to low-income individuals and families who have no access to public or private health coverage programs.
- **Grantmaking:** For 70 years, Kaiser Permanente has shown its commitment to improving Total Community Health through a variety of grants for charitable and community-based organizations. Successful grant applicants fit within funding priorities with work that examines social determinants of health and/or addresses the elimination of health disparities and inequities. From 2014-2015, Kaiser Permanente Colorado awarded 38 number of grants amounting to a total of $47,303,402 in service of 2013 health needs. Additionally, Kaiser Permanente Colorado has funded significant contributions to The Denver Foundation in the interest of funding effective long-term, strategic community benefit initiatives within Colorado service area. During 2014-2015, a portion of money managed by this foundation was used to award 104 grants totaling $12,545,429 in service of 2013 health needs.
- **In-Kind Resources:** Kaiser Permanente's commitment to Total Community Health means reaching out far beyond our membership to improve the health of our communities. Volunteerism, community service, and providing technical assistance and expertise to community partners are critical components of Kaiser Permanente's approach to improving the health of all of our communities. From 2014-2015, Kaiser Permanente Colorado donated several in-kind resources in service of 2013 Implementation Strategies and health needs. For example providing workshops to both practicing

providers and student providers to increase awareness of the spectrum of poverty, KP specialty care providers and physicians provide consultations or services annually to uninsured patients at Colorado SafetyNets and Arts Integrated Resources implemented “A School Without Hate” initiative to target behavioral health and social and emotional wellness by improving the culture and climate of middle schools.

- **Collaborations and Partnerships:** Kaiser Permanente has a long legacy of sharing its most valuable resources: its knowledge and talented professionals. By working together with partners (including nonprofit organizations, government entities, and academic institutions), these collaborations and partnerships can make a difference in promoting thriving communities that produce healthier, happier, more productive people. From 2014-2015, Kaiser Permanente Colorado engaged in several partnerships and collaborations in service of 2013 Implementation Strategies and health needs, including LAUNCH Together, Hunger Free Colorado, Colorado 9 to 25 (200 youth service organizations) and Clinica Family Health Services.

C. 2013 Implementation Strategy Evaluation of Impact by Health Need

Kaiser Permanente Colorado Priority Health Need: Access to Care

Long Term Goal: Increase access to comprehensive and continuing primary medical care and primary prevention services to prevent disease, diagnose and treat disease in early stages, and reduce disease-related complications for patients in the KP Colorado service area to help them function to their highest potential and gain the social and economic resources essential to overall health.

Intermediate Goal: Increase the number of low-income individuals who enroll in, or maintain, health care coverage.

Increase the number of individuals who have access to quality health care and prevention services including mental health and substance abuse.
Increase the number of school health initiatives that support access to care and prevention services to promote health and academic success.

Access to Care KFH Administered Program Highlights

KFH Program Name	KFH Program Description	Results to Date
Medicaid/CHIP	Medicaid is a federal and state health coverage program for families and individuals with low incomes and limited financial resources. KFH provided services for Medicaid beneficiaries, both members and non-members.	Total Membership: • 2014: 55,677 • 2015: 65,122 Total Losses: • 2014: $62,386,158 • 2015: $71,134,950
Medical Financial Assistance	The Medical Financial Assistance (MFA) program provides financial assistance for emergency and medically necessary services, medications, and supplies to patients with a demonstrated financial need. Eligibility is based on prescribed levels of income and expenses.	Total Spend: • 2014: $21,221,443 • 2015: $19,207,272 Unique Patients Served: • 2014: 15,002 • 2015: 38,753
Charitable Health Coverage	Charitable Health Coverage (CHC) programs provide health care coverage to low-income individuals and families who have no access to public or private health coverage programs.	Total Spend: • 2014: $4,710,635 • 2015: $2,458,105 Number of Members: • 2014: 212 • 2015: 426

Access to Care Grantmaking Highlights

Summary of Impact: During 2014-2015, there were 10 active KFHP grants, totaling $45,039,399, addressing Access to Care in the Kaiser Permanente Colorado service area.[1] In addition, a portion of money managed by a donor advised fund at The Denver Foundation was used to award 21 grants, totaling $2,904,532, in service of Kaiser Permanente Colorado's 2013 Access to Care implementation strategies. These grants are denoted by an asterisks (*) in the table below.

Center for African American Health	$160,000	Focus on Diabetes: Diabetes Self-Management Program Expand the Center for African American Health's Diabetes	9 Diabetes self-management (DSM) trained and Stanford certified 5 new DSM host sites identified in Denver metro area 85 participants enrolled

[1] This total grant amount may include grant dollars that were accrued (i.e. awarded) in a year prior to 2014, though the grant dollars were paid in years 2014 and 2015.

		Self-Management programming using the Stanford School of Medicine evidence-based model. The Center delivers the program throughout the metro Denver area and in Colorado Springs.	72% completion rate by participants 58% response rate to participant surveys
*Colorado Community Health Network Inc.	$99,000	Specialty Care E-consult Project Continuation Funding supports 0.4 FTE of staff to serve as administrator of the eConsult platform through which primary care providers in the safety net can electronically request advice from 8 of KP's specialty care departments.	1,057 e-consults, By department: Allergy/Immunology: 16 Cardiology: 161 Dermatology: 175 Endocrinology: 157 GI: 287 Opthalmology: 115 Pulmonology: 31 Rheumatology: 115
*Saint Joseph Hospital Foundation	$42,000,000	This program would fund the delivery of hospital and outpatient care for the underserved by subsidizing the cost of care.	Through Q3, these measures were achieved: 9,638 patients enrolled in charity care (provided low or free cost health care 9% of charity care patients enrolled in coverage programs (Medicaid, Connect for Health Colorado, ec.) Clinic Examples are: 65% of patients with Diabetes seen in the Caritas clinic achieved Hemoglobin A1C levels at less than 8.0% 56.7% of all female patients in the Bruner clinic ages 50><74 were screened for breast cancer using mammography 88.5% of Seton clinic patients with abnormal results that require colposcopy received completed colposcopy within 60 days of cervical cancer screening.

Access to Care Collaboration/Partnership Highlights		
Organization/ Collaborative Name	**Collaborative/ Partnership Goal**	**Results to Date**
Early Childhood Mental Health Funders Network	The Network consists of funders that are investing in early childhood mental health. The goal of this partnership is to share learnings and work together to improve early childhood mental health.	Sr. Community Health Specialist participates in the collaboration, representing the interests of Kaiser Permanente. A key result of this partnership is a multi-funder collaboration between eight Colorado-based foundations to improve the social, emotional, behavioral, physical and cognitive outcomes for young children (prenatal through age eight) and their families in Colorado.

Colorado Prevention Alliance	The Colorado Prevention Alliance (CPA) is a collaborative of more than 30 of Colorado's leading public and private health insurers and other healthcare partners. The goal is to reduce the prevalence of the most common chronic conditions while promoting increased adherence to screening, preventive care and treatments for more than 3 million covered Coloradans.	Kaiser Permanente physician participates in a new initiative called Food is Medicine which works to address the social determents of health with food security as a priority. Additionally, work is being done to develop a statewide database and work strategy to connect Colorado residents to social resources.
LAUNCH Together Evaluation Collaboration	The LAUNCH Together initiative is a unique opportunity to partner and learn with seven other like-minded local funders to improve mental health for young children, thereby contributing to school readiness and eventual academic achievement, prevention of chronic disease, and greater success in adult and parenthood.	Kaiser Permanente evaluation staff participate in month meetings to help guide the direction of the evaluation of LAUNCH Together. The collaboration has provided feedback on evaluation questions and methods and will be involved in interpreting and dissemination results.
Access to Care In-Kind Resources Highlights		
Recipient	**Description of Contribution and Purpose/Goals**	
Community Care Providers: Clinica, MCPN, CCHN Higher Ed: UCCS, Arapahoe Community College, Colorado Community College Denver	Arts Integrated Resources staff provide Care Equity Project workshops to both practicing providers and student providers. The goal of the workshops is to increase awareness of the spectrum of poverty. Examples of sites receiving the program include: Metro Community Provider Network (100% of staff received a 2-hour Care Equity Workshop) and University of Colorado Colorado Springs College of Nursing and Health Sciences (nursing students receive a 6-hour Care Equity Class Session as part of their Community Health Course).	
Poverty Immersion Colorado Springs (PICOS)	Sr. Community Health Specialist provides content expertise and relationships for the immersion class. The purpose is to increase 3rd medical students' awareness of the spectrum of poverty.	
Clinica Family Health Services, Metro Community Provider Network, Salud Family Health Centers, Inner City Health Center, Clinica Tepeyac, Summit Community Care Clinic	Kaiser Permanente Colorado provides a unique program that allows safety net primary care providers to electronically request advice (e-consult) with select Kaiser Permanente specialists regarding their uninsured adult patients. Almost 1,300 patients have been served since the program began in 2013. The program also provides specific face to face visits to safety net patients in some cases, and offers opportunities for medical education to safety net providers.	
Impact of Regional Initiatives Addressing Access to Care		

Kaiser Permanente Colorado Priority Health Need: Healthy Eating and Active Living

Long Term Goal: Increase access to affordable, healthy foods, expand opportunities to lead physically active lifestyles and build economically vibrant communities in the KP Colorado service area.

Intermediate Goal: Increase the number of policies, community programs and social and economic resources to support and promote healthy eating. Increase the number of policies, community programs and social and economic resources that support and promote physical activity. Support school initiatives that address health factors to support learning and educational achievement.

Healthy Eating and Active Living Grantmaking Highlights

Summary of Impact: During 2014-2015, there were 28 active KFHP grants, totaling $2,264,003, addressing Healthy Eating Active Living in the Kaiser Permanente Colorado service area.[2] In addition, a portion of money managed by a donor advised fund at The Denver Foundation was used to award 84 grants, totaling $9,640,897, in service of Kaiser Permanente Colorado's 2013 Healthy Eating Active Living implementation strategies. These grants are denoted by an asterisks (*) in the table below.

Grantee	Grant Amount	Project Description	Results to Date
Walk & Wheel: Municipalities (10 grantees)	$872,000	Grants to 10 municipalities to create environments that support accessibility to daily activities via multi modal transportation. Funded activities included Education and Encouragement, Planning (Policy Development and Implementation), and Changes in the Built Environment	Results to date: 6 new bicycle master plans; 6 adopted HEAL Resolutions; 1 complete streets policy; 6 city/county funding matches; and 4 new grants (from other sources) to continue work. Education and Encouragement: 5,000 residents reached through 46 events across 10 grantees, including 8 Bike to Work Day events, 4 family/youth programs, and 1 open street event.
*Thriving Schools (27 school districts)	$3,230,095	Districts received grants to increase physical activity before, during, and after school to be in compliance with Colorado House Bill 1069 which requires they offer at least 30 minutes a day.	Year 1 results: 85 individual schools participated 76% of districts report providing at least 30 minutes a day of physical activity, reaching 44,000 students 36% of districts are providing enough physical activity opportunities for children and adolescents to meet public health recommendations (60 minutes/day)
LiveWell Colorado	$4,850,000	As part of Kaiser Permanente Community Health Initiative, LiveWell Colorado (LWC) is a place-based initiative funding local communities to implement interventions to increase healthy eating and physical activity in multiple settings and among multiple age groups.	Approximately 6% of Colorado's total population has been reached by LWC initiatives with roughly 200 community strategies, and 200 school strategies reaching 330,000 Coloradans in some way We have seen more behavior change impact in school population than community population,

[2] This total grant amount may include grant dollars that were accrued (i.e. awarded) in a year prior to 2014, though the grant dollars were paid in years 2014 and 2015.

			especially youth interventions targeting physical activity Strong promotional strategies have also contributed to strategy impact
Hunger Free Colorado	$600,000	Support End Hunger in Colorado This grant supports efforts to connect community members to federal food assistance programs, increase access to state and local food assistance programs, and advance policy to increase access to healthy food for vulnerable populations.	In year 1: 1,499,621 summer meals were served; 28,570,942 breakfasts were served; and supper sites increased by100. 1,839 SNAP applications were completed and 5,836 referrals were completed.

Healthy Eating and Active Living Collaboration/Partnership Highlights		
Organization/ Collaborative Name	**Collaborative/ Partnership Goal**	**Results to Date**
El Paso County Public Health Healthy Community Collaborative (HCC)	The purpose of the HCC is to help the region fulfill CHIP goals & objective to reduce obesity prevalence in El Paso county. The Healthy Community Collaborative (HCC) consists of individual citizens and representatives from more than 50 agencies.	Sr. Community Health Specialist participates in monthly meetings, providing HEAL content expertise. The HCC is investigating strategies to advocate better nutritional choices; increase healthy food options for both adults and children in settings such as schools, worksites, and in our neighborhoods; create changes in our community and environment to increase opportunities for physical activity; and promote other behaviors and policies that reduce risk for obesity.
Colorado 9 to 25	The purpose of the network is to provide services to youth, support positive youth development and create a web of support for youth.	Allows Kaiser Permanente's Arts Integrated Resources to partner and build relationships with 200 youth serving organizations in the state. The network hosts a yearly youth summit.
Healthy Kids Colorado Survey Advisory Board	The purpose of the Healthy Kids Advisory Board is to provide insight and direction on the types of questions that are included in the survey every other year and review interpretation and dissemination.	A Sr. Community Health Specialist participates in meetings. The survey was launched in 2013 and it addresses multiple needs for youth health data and provides both state- and region-level results. The unified HKCS was administered again fall 2015. A total of 224 randomly selected schools and 40,206 randomly selected students participated in the 2013 HKCS. Overall response rates were 63% for middle schools, 58% for high schools, and 24% for alternative high schools.

Healthy Eating and Active Living In-Kind Resources Highlights	
Recipient	**Description of Contribution and Purpose/Goals**
JeffCo School District	Arts Integrated Resources implemented "A School Without Hate" initiative yearly to target behavioral health and social and emotional wellness by improving the culture and climate of middle schools in Jeffco Public Schools. 39 schools participated with almost 10,000 students involved.
Schools across the region	Arts Integrated Resources provided the Laughaceuticals workshops (1-hour) to 64 groups of school teachers and staff.

Hunger Free Colorado	Sr. Community Health Specialist partners with Complete Health Solutions, CB&R, and Community Specialists to conduct PDSA cycles quarterly with Hunger Free Colorado Hotline Supervisor.
Impact of Regional Initiatives Addressing Insert Health Need	
Program Office CB will provide some standard language for key initiatives including ALL/PHASE, HEAL Zones, and Thriving Schools. Local staff will have the ability to add local detail to this language if desired.	

APPENDIX A. Secondary Data Sources and Dates

APPENDIX B. Health Need Profiles

APPENDIX A: Secondary Data Sources and Dates

1. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2006-2010.
2. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2006-2012.
3. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2011-2012.
4. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. US Department of Health & Human Services, Health Indicators Warehouse. 2005-2009.
5. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. US Department of Health & Human Services, Health Indicators Warehouse. 2006-2012.
6. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012.
7. Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. US Department of Health & Human Services, Health Indicators Warehouse. 2010.
8. Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. US Department of Health & Human Services, Health Indicators Warehouse. 2012.
9. Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network. 2008.
10. Centers for Disease Control and Prevention, National Vital Statistics System. Centers for Disease Control and Prevention, Wide Ranging Online Data for Epidemiologic Research. 2006-2010.
11. Centers for Disease Control and Prevention, National Vital Statistics System. Centers for Disease Control and Prevention, Wide Ranging Online Data for Epidemiologic Research. 2007-2010.
12. Centers for Disease Control and Prevention, National Vital Statistics System. Centers for Disease Control and Prevention, Wide Ranging Online Data for Epidemiologic Research. 2007-2011.
13. Centers for Disease Control and Prevention, National Vital Statistics System. University of Wisconsin Population Health Institute, County Health Rankings. 2008-2010.
14. Centers for Disease Control and Prevention, National Vital Statistics System. US Department of Health & Human Services, Health Indicators Warehouse. 2006-2012.
15. Centers for Medicare and Medicaid Services. 2012.
16. Child and Adolescent Health Measurement Initiative, National Survey of Children's Health. 2011-2012.
17. Colorado Department of Labor and Employment, Colorado Labor Statistics, LMI Gateway. 2015.
18. Colorado Department of Public Health and Environment, Colorado Department of Human Services Office of Behavioral Health, Colorado Department of Education, and University of Colorado Denver. 2013 Healthy Kids Colorado Survey, 2013.
19. Colorado Health Institute, Colorado Health Access Survey. 2015.
20. Colorado State Demography Office, Population Data. 2014.
21. Dartmouth College Institute for Health Policy & Clinical Practice. Dartmouth Atlas of Health Care. 2012.
22. Environmental Protection Agency, EPA Smart Location Database. 2011.
23. Federal Bureau of Investigation, FBI Uniform Crime Reports. 2010-2012.
24. Feeding America. 2012.
25. Multi-Resolution Land Characteristics Consortium, National Land Cover Database. 2011.
26. National Center for Education Statistics, NCES – Common Core of Data. 2012-2013.
27. National Oceanic and Atmospheric Administration, North America Land Data Assimilation System (NLDAS). 2014.
28. New America Foundation, Federal Education Budget Project. 2011.
29. Nielsen, Nielsen Site Reports. 2014.
30. State Cancer Profiles. National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. 2007-2011.
31. University of Wisconsin Population Health Institute, County Health Rankings. 2012-2013.
32. University of Wisconsin Population Health Institute, County Health Rankings. 2014.
33. US Census Bureau, American Community Survey. 2009-2013.

34. US Census Bureau, American Housing Survey. 2011, 2013.
35. US Census Bureau, County Business Patterns. 2011.
36. US Census Bureau, County Business Patterns. 2012.
37. US Census Bureau, County Business Patterns. 2013.
38. US Census Bureau, Decennial Census. 2000-2010.
39. US Census Bureau, Decennial Census, ESRI Map Gallery. 2010.
40. US Census Bureau, Small Area Income & Poverty Estimates. 2010.
41. US Department of Agriculture, Economic Research Service, USDA – Food Access Research Atlas. 2010.
42. US Department of Agriculture, Economic Research Service, USDA – Food Environment Atlas. 2011.
43. US Department of Agriculture, Economic Research Service, USDA – Child Nutrition Program. 2013.
44. US Department of Education, EDFacts. 2011-2012.
45. US Department of Health & Human Services, Administration for Children and Families. 2014.
46. US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File. June 2014.
47. US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2012.
48. US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2013.
49. US Department of Health & Human Services, Health Resources and Services Administration, Health Professional Shortage Areas. March 2015.
50. US Department of Health & Human Services, Office of Disease Prevention and Health Promotion, Healthy People 2020.
51. US Department of Housing and Urban Development. 2013.
52. US Department of Labor, Bureau of Labor Statistics. June 2015.
53. US Department of Transportation, National Highway Traffic Safety Administration, Fatality Analysis Reporting System. 2011-2013.
54. US Drought Monitor. 2012-2014.

APPENDIX B: Health Needs Profiles

Access to Primary and Specialty Care

RATIONALE	HEALTH OUTCOMES INDICATORS [REPORT AREA // BENCHMARK]	CONTRIBUTING FACTORS	Assets
Primary and specialty care services help individuals manage their diseases and learn the necessary skills to be healthy. While uninsured rates are at a new low, access to care is a telling factor of whether community members are getting the care they need. Data show a lack of prenatal care and preventive cancer screenings in the communities served by KPCO. Individuals also face barriers getting an appointment when needed.	Percent Mothers Not Receiving Prenatal Care in First Trimester • KPCO Service Area 29.4%** // 17.3% U.S. • Pueblo County 38.8% Unable to Get An Appointed As Soon As Needed • KPCO Service Area 22.4%** // 18.7% Cancer Mortality per 100,000 Population • Non-Hispanic Blacks 184.2**//145.3	• Cancer Screenings - Mammogram, Pap Test** • Shortage of Primary Care Providers • Underinsured Population	• Community health alliances in Aurora, Boulder and Denver • Safety net providers • Foundations funding initiatives to expand access to care

PRIMARY DATA:	Eight hospitals prioritized access to primary and specialty care as a health need along with four local public health agencies.
GEOGRAPHIC IMPACT:	The counties in the southeast region of Kaiser Permanente Colorado's (KPCO) service area have higher rates of limited prenatal care and perform poorly in other access indicators such as specialist visits and access to dentists. Counties in the mountain region also have limited access to medical, dental and mental health providers.

Climate Change

RATIONALE	HEALTH OUTCOMES INDICATORS [REPORT AREA // BENCHMARK]	CONTRIBUTING FACTORS	Assets
Climate change poses a threat for future generations. Clean air and water are essential for good health but may not be available with an increase in drought severity and air pollution. Drought severity in the communities served by KPCO is higher than the national average.	Percentage of Weeks in Drought (January 1, 2012-December 31, 2014) • KPCO Service Area 53.0%** // 46.09% • Pueblo County 96.7%** // 53.0% Population Weighted Percentage of Area Covered by Tree Canopy • KPCO Service Area 13.3%** // 24.7%	• Public Transit within 0.5 Miles Walkability	• Economic development that protects natural resources • Colorado Department of Public Health and Environment
PRIMARY DATA:	Two of Colorado's 10 Winnable Battles are Healthy Air and Healthy Water.		
GEOGRAPHIC IMPACT:	Rural Otero County performs poorly as compared to the community for air quality, drinking water safety, and asthma prevalence. Drought is severe in southern Colorado, specifically Pueblo County.		

Economic Stability and Vitality

RATIONALE	HEALTH OUTCOMES INDICATORS [REPORT AREA // BENCHMARK]	CONTRIBUTING FACTORS	Assets
A strong economic foundation promotes good health and is integral to thriving, healthy communities. Necessary factors for economic stability include education, a livable wage, and low rates of crime and violence. The communities served by KPCO lag in third-grade reading proficiency and high school graduation. Hourly wages are below the state benchmark. Additionally, violence and crime are more prevalent within certain counties.	High School Graduation Rate • KPCO Service Area 81.4% // 82.2% Percent of Fourth Grade Students Reading Below Proficiency • KPCO Service Area 43.1%** // 27.1% Average Hourly Wage • KPCO Service Area $22.20 // $26.78 • Crowley County $13.83 // $22.20 Poverty (Population Below 100% FPL) • Hispanic/Latino 24.2%** // 13.1%	• Head Start Program Facilities** • Violent Crime - Rape **	• Early childhood councils • Economic development councils • United Ways • LAUNCH Together
PRIMARY DATA:	Economic Stability and Vitality is not prioritized by any local public health agencies or KPCO contracted hospitals.		
GEOGRAPHIC IMPACT:	Rural and eastern plains counties perform poorly on poverty, unemployment and income.		

Healthy Eating Active Living (HEAL)

RATIONALE	HEALTH OUTCOMES INDICATORS [REPORT AREA // BENCHMARK]	CONTRIBUTING FACTORS	Assets
A healthy lifestyle is influenced by the availability of healthy foods, neighborhoods that promote activity and safety as well as one's overall physical and mental health. More than half of the adults living in communities served by KPCO and one in five youth are overweight or obese, putting them at higher risk for costly diseases, including cancer and diabetes. One in four residents live in a food desert with limited access to fresh, healthy foods.	Overweight (Adult, 18+ years old) • KPCO Service Area 35.4% // 35.8% • Broomfield County 46.6%** // 35.4% Number of Stores per 100,000 that are WIC Authorized • KPCO Service Area 7.4 // 15.6 Percentage of Population Living in Designated Food Deserts • KPCO Service Area 25.3%* // 23.6% Physically Active for 60 minutes/day for seven days (middle school) • KPCO Service Area 33.8% // 34.0% • Denver County 22.1%** // 33.8%	• Fruit and Vegetable Consumption (High Schoolers and Adults) • Breastfeeding	• LiveWell communities • HEAL Cities and Towns • Bike Colorado

PRIMARY DATA:	Highest prioritized health need with seven KPCO contracted hospitals and 17 local public health agencies choosing HEAL.
GEOGRAPHIC IMPACT:	Urban counties including Adams, Pueblo and Weld perform poorly compared to the community for rates of adult overweight, obesity and diabetes prevalence.

Mental Health

RATIONALE	HEALTH OUTCOMES INDICATORS [REPORT AREA // BENCHMARK]	CONTRIBUTING FACTORS	Assets
All areas of life are impacted by mental health including physical well-being, ability to work, educational attainment, and participation with family and among the community. Addressing access to mental health is a top priority for local public health agencies and non-profit hospitals in the community. The suicide rate is higher than the national rate and the Healthy People 2020 target rate. More than one in two students in middle school have been bullied on school property while almost one in four high schoolers have ceased regular activities due to feeling sad or hopeless.	Suicide per 100,000 population age-adjusted • KPCO Service Area 17.8** // 12.3 • Park County 34.5 // 17.8 Stopped Usual Activities Due to Feeling Sad or Hopeless (high school) • Denver County 29.1% // 24.3% Ever Bullied on School Property (middle school) • KPCO Service Area 50.4%** // 47.4%	• Depression Among Medicare Beneficiaries • Poor Mental Health Days	• Safety net providers • Mental Health America of Colorado • Foundations investing in early childhood mental health

PRIMARY DATA:	Mental health is one of the top prioritized health needs in the communities served by KPCO. 15 local public health agencies and seven of KPCO's contracted hospitals chose mental health as a need.
GEOGRAPHIC IMPACT:	Park, Pueblo, and Elbert Counties perform poorly in suicide rates, poor mental health days, and access to mental health providers, respectively.

Substance Use

RATIONALE	HEALTH OUTCOMES INDICATORS [REPORT AREA // BENCHMARK]	CONTRIBUTING FACTORS	Assets
Substance use affects individuals and members of the community around them while increasing health risks for cancer and poor mental health which may lead to impaired decisions. Consumption and access to alcohol in the communities served by KPCO is higher than the national average. This is a flagship priority for the state of Colorado along with nine local public health agencies and six non-profit hospitals.	Liquor Store Access per 100,000 population • KPCO Service Area 23.9** // 10.5 Percentage Of Adults Drinking Excessively (ages 18 and older) • KPCO Service Area 17.7% // 16.9 • Summit County 34.2%** // 17.7% Marijuana Use, 1+ times in past 30 days (high school) • KPCO Service Area 20.0% // 19.7% • Pueblo County 32.1%** // 20.0	• Alcohol Expenditures* • 1+ alcoholic drink in the past 30 days (middle & high school) • Used e-cigarettes (high school)	• Colorado Department of Public Health and Environment • Safety net providers • Organizations funded with Amendment 35 tobacco tax revenues
PRIMARY DATA:	Substance use is prioritized by nine local public health agencies and six contracted KPCO hospitals.		
GEOGRAPHIC IMPACT:	Middle school and high school students living in urban counties of Pueblo and Denver have higher rates of alcohol and marijuana use.		