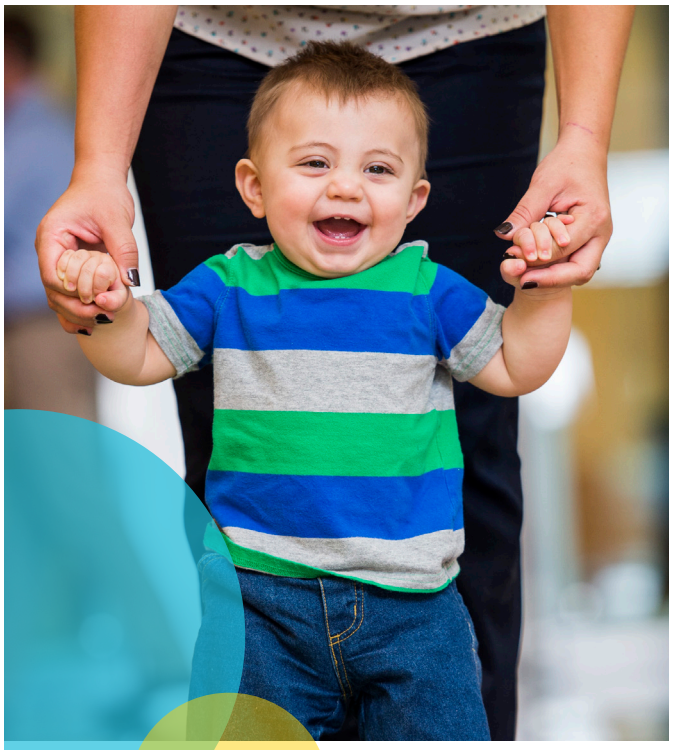


2015 Community Health Needs Assessment

Joint CHNA Children's Hospital Colorado Anschutz Medical Campus, Children's Hospital Colorado South Campus & Children's Hospital Colorado at Parker Adventist

Approved by the Children's Hospital Colorado Board of Directors, December 17, 2015

TABLE OF CONTENTS

LETTER TO THE COMMUNITY

We are proud to present the Children's Hospital Colorado 2015 Community Health Needs Assessment. This report is the result of in-depth analysis of public health and demographic data, dozens of interviews with experts in public health and child welfare, focus groups with parents, and the input of hundreds more caregivers through our online survey. We have spent the last year listening to the concerns and interests of our community and are pleased to share the results of those conversations.

Children's Hospital Colorado is committed to providing world-class health care to children in Colorado and in our seven-state region. Through this health needs assessment, we have come to better understand the health needs facing diverse populations in our community. We have also gained insight into the resources currently available to meet those needs as well as gaps that our organization may be able to fill.

This report will inform our future endeavors as we strive to continually improve the ways we both prevent and treat illness and injury in children. Following the publication of this report, we will develop an implementation plan to address the priority needs that have been identified. The implementation plan will be the roadmap for our public health, philanthropic and advocacy work for the next three years.

We sincerely thank the many contributors to this report and look forward to ongoing collaboration with our many community partners. Together, we can ensure that all Colorado kids are healthy, safe, and flourishing.

President and Chief Executive Officer
Children's Hospital Colorado

OVERVIEW AND PURPOSE

Overview of Children's Hospital Colorado

Children's Hospital Colorado is a private, not-for-profit pediatric health care network that has been serving the children of Colorado for more than 100 years. Launched in 1908, the organization has, from the start, been committed to providing outstanding pediatric care. Today, the network consists of 16 hospital, urgent care and specialty facilities. The main hospital facility, located in Aurora, provides comprehensive pediatric care to patients in metro Denver and is the only Level 1 Pediatric Trauma Center in a 7-state region. The Children's Colorado South Campus facility, located in Douglas County, also provides comprehensive care including emergency, inpatient and diagnostic care. The Children's Hospital at Parker Adventist, also located in Douglas County, offers pediatric medicine, emergency services and inpatient care inside Parker Adventist Hospital which is operated by Centura Health. Our network employs more than 2,000 pediatric specialists and more than 5,000 full-time employees. Each year, the network has more than 18,000 inpatient admissions and more than 680,000 outpatient visits. This community health needs assessment is a joint assessment for the Main Campus, South Campus and Parker Adventist locations of Children's Hospital Colorado.

Purpose of the Assessment

The purpose of the community health needs assessment (CHNA) is to better understand the current state of children's health in Colorado as well the interests and concerns of Colorado parents. Through an examination of both demographic data and community input, we can better understand how to fulfill the hospital's mission of improving the health of children.

The CHNA will help us focus our efforts on the most urgent challenges facing children in our community. Specifically, the results of this assessment will be used to:

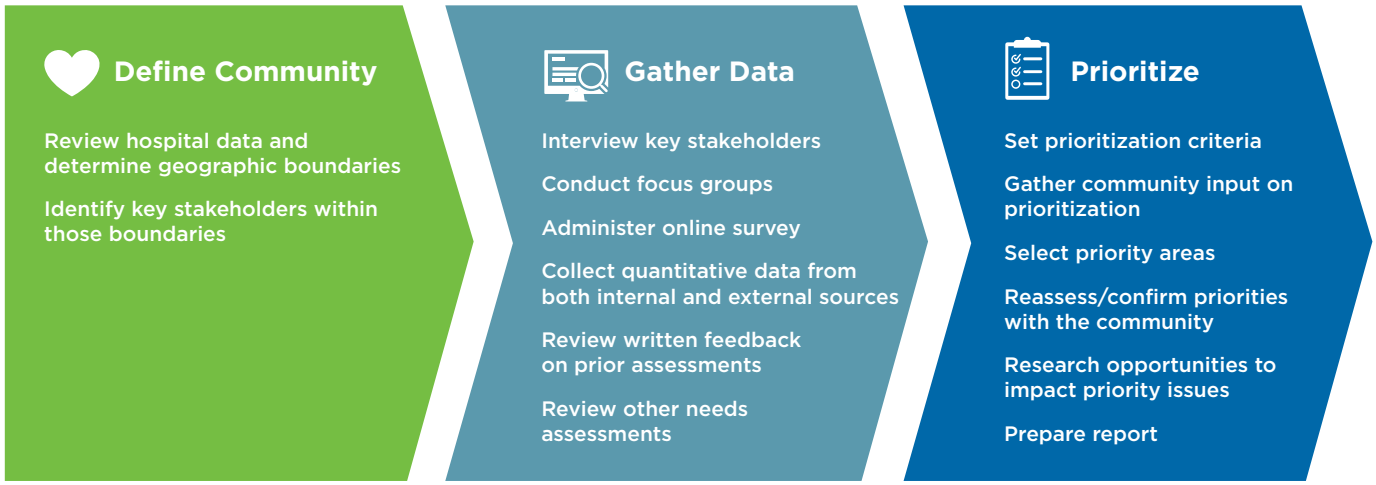
- Inform the activities of our Child Health Advocacy Institute (CHAI). CHAI is a division of Children's Colorado that works with community and public sector partners to improve the health and safety of children in Colorado.
- Influence the implementation of our strategic plan, which was adopted in 2015. The strategic plan calls for dedicated efforts in population health, and this report will serve as the foundation for the activities our hospital will pursue within population health.
- Identify key community partners. Understanding the highest priority needs in our community will lead to a better understanding of the local groups who are addressing these issues and ways that we can support and complement their efforts.

In addition, this report fulfills the requirements of the Affordable Care Act of 2010. IRS Section 501(r) requires that nonprofit community hospitals conduct a community health needs assessment every three years. This is a joint report for the Main Campus, South Campus and Parker Adventist facilities. Regulations for joint assessments are described in Treas. Reg. §§ 1.501(r)-3(b)(6)(v) and 1.501(r)-3(c)(4). The IRS allows hospital facilities to produce a joint CHNA report as long as the facilities use the same definitions of community and conduct a joint CHNA process. We have followed those requirements for this report. The last Children's Colorado CHNA was conducted in 2012. An implementation plan detailing how we will act on the findings of this report will be issued no later than May 2016.

METHODOLOGY

To prepare this report, Children's Hospital Colorado engaged in a comprehensive process of gathering data and input from nonprofit organizations, government agencies, public health departments, the business community, and individual parents and community members. The project was initiated and led by the Child Health Advocacy Institute, which is a division of the hospital, and received support and guidance from senior members of the hospital's leadership team. The analysis includes both qualitative and quantitative data and considers the perspectives of both internal and external stakeholders.

Process



Before launching the 2015 CHNA, we conducted a review of the prior health needs assessment, which was produced in 2012. The IRS requires the hospital evaluate the impact of actions taken as a result of the prior CHNAs. In addition, we wanted to ensure that the current project would build on prior efforts. To meet the IRS requirement, and to inform the current assessment, we asked both internal and external parties to read the prior report and submit written feedback. Six professionals, including representatives from public health, policy and advocacy, clinical practice and the nonprofit sector, provided feedback on the 2012 report. We also commissioned Lorann Stallones, who is a professor with the Colorado School of Public Health, to do a formal review of the prior report. Her assessment is included as Appendix D.

The next step in the 2015 process was to determine how the "community" would be defined for purposes of assessing community needs. To make this determination, the authors reviewed hospital aggregated patient data for both in-patient admissions and outpatient visits and determined the counties where a significant majority of patients reside. Based on this data, we selected eight counties for more in-depth analysis. These counties are Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Jefferson and El Paso. Fully 86 percent of all in-patient and outpatient visits for all facilities were from residents of these counties, and 84 percent of patients at the Main Campus were from these eight counties, as were 93 percent of South Campus patients and 92 percent of Parker Adventist patients. As detailed in the "Community" section below, we also looked closely at Ward 1 of the City of Aurora, where the Main Campus is located, and at Douglas County, where both the South Campus and the Parker Adventist facility are located. Because this is a joint assessment for the three campuses, we have defined "community" to be the same for all campuses and have conducted a joint process for all facilities.

Having defined the community, we then sought to identify key informants within the target area. An internal steering committee composed of CHAI staff and other hospital leaders generated an initial list of nonprofit leaders, public health officials and other informed stakeholders to be interviewed. Additional informants were identified as the first group of interviews was completed and those participants were able to suggest other potential participants.

Key informant interviews were conducted by phone and lasted approximately 30 minutes. The interview guide used for these conversations is provided in Appendix A. Respondents were asked to identify the top three health-related issues or concerns for children in their community. Responses were open-ended and interviewers provided no prompts. Once the respondent had identified the top three issues, more in-depth and probing questions were asking about each issue. While respondents were informed that they would not be directly quoted for this report, they were told that a list of participating organizations would be included in the report. A total of 42 interviews were conducted with key informants from both statewide organizations and local organizations in the target counties and cities.

Total Interviews Area Represented by Informant	
State of Colorado	10
City of Aurora	6
Adams County	2
Arapahoe County	1
El Paso County	7
Douglas County	6
Jefferson County	3
City and County of Broomfield	4
City and County of Denver	3
TOTAL	**42**

At the same time, we identified local partners in the target counties who could host focus groups. Emphasis was placed on working with partners that serve at-risk parents to participate in these groups. Host partners were asked to convene eight to 15 community representatives and to provide space for the meeting. Focus groups sessions lasted one hour and were facilitated by a hospital representative. Participants were given a $25 gift card as compensation for their time. The focus group guide is provided in Appendix B. Participants were asked a series of questions similar to those used for key informant interviews and were encouraged to speak to one another and to build on each other's thoughts and ideas. All participants were assured anonymity. A total of nine focus groups were conducted in a variety of locations. Collectively, there were 92 participants in these focus groups.

	# of Focus Groups	# of Participants
Aurora	5	48
El Paso	1	4
Douglas	1	11
Broomfield	1	10
Denver	1	19
TOTAL	**9**	**92**

Recognizing that the number of individuals who could be reached through interviews and focus groups was inherently limited, the hospital also sought to reach a significantly greater number of community members through an online survey. The survey was distributed by partner organizations that had participated in interview and focus groups, through the hospital's social media outlets, and through the organic process of individuals forwarding the survey to colleagues, friends and family. The survey was available in both English and Spanish and had a total of 346 respondents.

	English Survey Respondents	Spanish Survey Respondents	Total Respondents
Adams	27	28	55
Arapahoe	63	10	73
Boulder	12	2	14
Broomfield	4	1	5
Denver	65	20	85
Douglas	35	0	35
El Paso	22	0	22
Jefferson	30	2	32
Other	23	2	25
TOTAL	**281**	**65**	**346**

In addition to gathering qualitative data through interviews and focus groups, the authors also studied a variety of quantitative data sources. Through a partnership with the Colorado Children's Campaign, we collected state and county level data on a number of child health indicators as well as basic demographic information. The data reviewed and sources of that data included:

Demographic Data

- Age distribution by county
- Racial and ethnic breakdown of children under 18 by county
- Children (under 18) living in poverty by county
- Median household income by county
- Children (under 18) in a single-parent household
- Children (under 18) living with grandparent who is responsible for caring for them
- Residents (all ages) who are foreign-born
- Children ages 5 to 17 who speak a language other than English at home

Health Status Data

- General health status (reported by parents)
- Uninsured children (under 18)
- Children whose health care meets criteria for all five components of a medical home
- Children whose parents report their child has no place he/she usually goes when he/she is sick or when parent needs advice on child's health
- Type of place child goes to most often when he/she needs care
- Children (ages 0 to 18) enrolled in Medicaid
- Children (ages 0 to 18) enrolled in CHP+
- Children (ages 0 to 18) who did not get needed doctor care due to cost
- Children (ages 0 to 18) who did not get needed specialist care due to cost
- Children (ages 0 to 18) who did not get needed dental care due to cost
- Children (ages 0 to 18) who did not fill a prescription due to cost
- Average out of pocket medical spending for families, including prescription, dental, vision and other medical expenses

Food/Nutrition/Obesity Data

- Children in families relying on low-cost food (food scarcity)
- Households with children ages 1-14 who sometimes or often felt that the food they bought didn't last, and they didn't have money to get more (2014)
- Households with children ages 1-14 who sometimes or often felt that they couldn't afford to eat balanced meals
- Households with children ages 1-14 who sometimes or often could not afford the food they needed in the past year
- Children whose parents report their child drank 1 or more sugar-sweetened beverage per day
- Children whose parents report their child consumes at least 5 total servings of fruits and/or vegetables per day
- Children (ages 5-14) whose parents report their child is physically active for at least 60 minutes per day
- Calculated BMI percentile for children (ages 2-14)

Mental Health

- Children whose parents report their child has difficulties with one or more of the following areas: emotions, concentration, behavior, or being able to get along with other people
- Children (ages 4-14) whose parents reported their child had at least one day in the past month when their child's mental health was not good
- Children (ages 4-14) whose parents reported their child needed mental health care or counseling within the past 12 months
- Of children (ages 4-14) whose parents reported their child needed mental health care or counseling during the past 12 months, the percent that did not receive all needed care and of children (ages 4-14) who needed and did not get all needed care, reasons why child did not receive all needed mental health care
- High school students who reported feeling so sad or hopeless for at least two weeks that it interfered with their usual activities
- High school students who reported they had seriously considered attempting suicide during the past 12 months
- High school students who made a suicide attempt during the past 12 months that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse

Substance Use

- High school students who report having had at least one drink of alcohol on one or more of the past 30 days
- High school students who report having used marijuana one or more times during the past 30 days
- High school students who report having taken a prescription drug (such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax) without a doctor's prescription one or more times during their life

Sexual Health

- High school students who have ever had sexual intercourse
- Chlamydia cases (ages 13-24, rate per 100,000)
- Gonorrhea cases (ages 13-24, rate per 100,000)
- Syphilis cases (ages 13-24, rate per 100,000) (2012-2014)

Oral Health

- Children (ages 1-14) who saw a dentist for preventive dental care during the past 12 months
- Parent's rating of the condition of child's (ages 1-14) teeth

Community Environment

- How often parents report feeling their child is safe in his/her neighborhood

Health Disparities

By race/ethnicity

- General health status of child (ages 1-14, reported by parents):
  - Non-Hispanic White
  - Black
  - Hispanic white
  - Other

By income

- General health status of child (ages 1-14, reported by parents):
  - Family income below $25,000/year
  - Family income between $25,000 and $49,999 per year
  - Family income above $50,000 per year

We also reviewed internal data to better understand the needs of our patient population. The data reviewed included:

- Total inpatient admissions by county and by facility
- Total outpatient visits by county and by facility
- Total emergency department visits by county and by facility
- Insurance coverage type for all patients
- BMI percentile for all discharged patients by county
- For each of the eight counties studied
  - Top 10 inpatient admission diagnoses
  - Top 10 outpatient admission diagnoses
  - Top 10 inpatient primary diagnoses
  - Top 10 outpatient primary diagnoses

In addition to our own data collection, we sought to build on the work done by public health departments and nonprofit organizations in our community. Other reports reviewed included:

- The community health needs assessments done by each of the public health departments in our target counties
- The Colorado Department of Public Health and Education's Colorado Maternal and Child Health 2016-2020 Needs Assessment
- The 2015 Kids Count Colorado report issue by the Colorado Children's Campaign
- The 2015 Health Report Card issued by the Colorado Health Foundation
- The 2015 All Kids Covered report
- The Action for Equity report issued by the Colorado Coalition for the Medically Underserved

Another data point we reviewed was the written feedback we received on the 2012 community health needs assessment. That assessment was available to the public online, as was an online survey with questions about its strengths and weaknesses. A total of six people provided feedback on the 2012 report.

After the key informant interviews and focus groups were completed, and the quantitative data was collected, we next convened a group of hospital leaders to determine what criteria would be used to prioritize among the many issues raised and studied. The committee that selected the prioritization criteria included representatives from CHAI, hospital administration, the emergency department, human resources, and research/analytics.

The group considered a variety of criteria that could be used when selecting the issues that the hospital will focus on for the coming years. A list of criteria that were considered is provided in Appendix C. After deliberation, they determined that following four factors were most important:

Once these criteria were established, the final step in the process was to present the research findings to key stakeholders and ask them to select the issues that the hospital will prioritize.

Two different prioritization meetings were held, one with representatives from nonprofit, government and public health agencies and one with internal leadership. In both meetings, participants were presented with detailed information about the results of the interviews, focus groups and surveys as well as data from internal and external sources (see page 9 for a list of data sources). In addition, there was discussion about how the prioritization criteria were selected and how they should be applied to research results. Each participant was then given two minutes to comment on what he or she believed the hospital should select as its priority issues. Finally, participants engaged in a polling process, with each having five votes to allocate among all the issues that were surfaced through the assessment. Internal stakeholders were also given the results of the community stakeholder polling prior to casting their own votes.

The report was then published in draft form online, and the public was invited to comment for a 30 day period. This final version of the report includes minor and immaterial edits that were made in response to feedback on the draft report.

Lastly, the Community Health Needs Assessment was approved by the Children's Hospital Colorado Board of Directors on December 17, 2015.

Partner Organizations

The Colorado Children's Campaign (CCC) was an official partner in the production of this community health needs assessment. CCC is a nonprofit, nonpartisan children's advocacy organization. They produce an annual "Kids Count" report, which is a collection of data from a variety of reliable sources that paints a picture of the status of children in Colorado. They collected the majority of the quantitative data included in this report.

Data Sources

The Colorado Children's Campaign provided most of the quantitative data that was considered as part of this report. The sources of the data at the CCC provided include:

- U.S. Census Bureau, 2010 Decennial Census
- U.S. Census Bureau, 2009-2013 American Community Survey 5-Year Estimates
- U.S. Census Bureau, 2011-2013 American Community Survey 3-Year Estimates
- U.S. Census Bureau, 2009-2013 American Community Survey 5-Year Estimates
- Colorado Department of Public Health and Environment, 2012-2014 Child Health Surveys
- Colorado Department of Health Care Policy and Financing
- Colorado Health Institute and The Colorado Trust, 2013 Colorado Health Access Survey
- Colorado Department of Public Health and Environment, 2010-2013 Child Health Surveys summary
- Colorado Department of Public Health and Environment, 2012-2014 Child Health Surveys summary
- Colorado Department of Public Health and Environment, 2014 Child Health Survey
- Colorado Department of Public Health and Environment, 2013 Healthy Kids Colorado Survey
- Colorado Department of Public Health and Environment, 2012-2014 NETSS files

Internal patient data came from the hospital's patient record system, EpicCare.

Third Party Contractor

Amy Slothower, who is the principal consultant at Cause Effect Advisory Services, was retained as a third party contractor to facilitate this community health needs assessment. She conducted many of the key stakeholder interviews, facilitated the focus groups, analyzed the quantitative data, led internal and external discussion about how to prioritize the needs of the community and wrote the report.

Organizations Providing Input

The following organizations, government agencies and public health departments provided input for this report by participating in key stakeholder interviews, hosting focus groups, and/or sharing data and information:

2040 Partners for Health

Alliance for Kid/El Paso County's Early Childhood Council

Aurora Health Access

Aurora Public Schools

Boys and Girls Clubs of Metro Denver

Boys and Girls Club of the Pikes Peak Region

Broomfield Public Library

Campus Community Partnership

City Council of Aurora

City and County of Broomfield

City of Colorado Springs Parks & Recreation

Colorado Access

Colorado Association for School Based Health Care

Colorado Black Health Collaborative

Colorado Children's Campaign

Colorado Coalition for the Medically Underserved

Colorado Consumer Health Initiative

Colorado Health Foundation

Comitis Crisis Center

Colorado School of Public Health at the University of Colorado

Community Reach Center

Dawn Clinic

Denver Public Schools

Douglas County School District

Emergency Medical Services of El Paso County

Family Voices Colorado

Fields Foundation

Gary Community Investment Fund

Highlands Ranch Chamber of Commerce

Hoffman Youth Center

Jefferson County Public Health

Littleton Fire Rescue

Lowry Family Center

Mamie Dobb Eisenhower Public Library

Meadow Parks Preschool

Metro Community Provider Network

Mile High Behavioral Health Care

Northwest Douglas County Economic Development Corporation

Parenting Matters

Promotora de Saluds

Rocky Mountain Youth Clinic

South Metro Fire Rescue

Street Smart

TriCounty Health Department

Wal-Mart

Underserved Population Input

Special effort was made to solicit input for this report from underserved populations. Outreach to underserved populations included:

- Contacting nonprofit organizations that represent the interests of underserved groups and including them in stakeholder interviews. Key organizations included:
  - Colorado Coalition for the Medically Underserved
  - Colorado Black Health Collaborative
  - Comitis Crisis Center
  - The Fields Foundation
  - Promotoras de Salud
  - Rocky Mountain Youth Clinic
  - Street Smart
- Conducting focus groups in low-income areas of the community and with underserved groups. Focus groups included:
  - Two sessions at the Hoffman Youth Center in Ward 1 of Aurora. One session was conducted in English and one session was conducted in Spanish.
  - One session at the Epworth United Methodist Church in central Denver in a predominantly African American neighborhood.
  - One session at the Fields Opportunity Center with pregnant and parenting teens.
  - Two sessions at the Comitis Crisis Center with homeless families that were temporarily residing at the center. One of the two sessions specifically targeted veterans.
- Widely distributing the needs assessment survey to ensure the participation of diverse audiences. To compensate for lack of Internet access among some populations, a paper version of the survey was distributed in health clinics, at a mobile home community and at a child care center. Responses were then entered into the same database as the online version of the survey for analysis. Overall, 42 percent of respondents were ethnic minorities and close to one third of respondents had household incomes of less than $50,000 per year.

Survey Respondents	Total	Percentage
African American/Black	25	7%
Caucasian/White	207	58%
Asian	8	2%
American Indian/ Alaska Native Hawaiian/ Pacific Islander	13	4%
Hispanic/Latino	80	23%
Other (please specify)	21	6%
Total	**354**	

Survey Respondents	Total	Percentage
$0 - $24,999	53	16%
$25,000 - $49,999	57	17%
$50,000 - $74,999	43	13%
$75,000 - $99,999	38	12%
$100,000 or more	108	33%
Prefer not to answer	29	9%
Total	**328**	

(Note that questions about race and income were optional so total responses to these questions are not equal to the total number of responses received.)

Information Gaps/Limitations

As with any study that relies heavily on the opinions of individuals, this needs assessment does have some limitations. Some of the gaps in information that we were unable to overcome include:

- Much of the secondary data that was analyzed is only available at a state level. While it would be preferable to have data on indicators such as health status of children by income level at the county or even neighborhood level, this data was simply not available.
- The opinions gathered from key stakeholder interviews and focus groups may or may not be representative of those of the broader population. While every effort was made to recruit a diverse group of participants and to speak to a large number of individuals, the respondents are not representative in a statistical sense, and there is no way to guarantee that their opinions are identical to those of the entire eight-county region considered in this analysis.
- We faced a particular challenge with recruiting immigrant populations for our focus groups and we did not ask survey respondents to indicate their country of origin. We believe, therefore, that this population is underrepresented in our findings. This is noteworthy because Ward 1 of Aurora, where the hospital's Main Campus is located, has a particularly high percentage of residents who are foreign-born.

COMMUNITY

For the purposes of this report, "community" is defined as the eight-county region surrounding the Main Campus, South Campus and Parker Adventist locations of Children's Hospital. Particular attention is paid to the neighborhoods immediately surrounding these facilities. While the needs of children statewide are considered, the focus is on those counties and neighborhoods where the hospital has the greatest influence.

How the Community was Determined

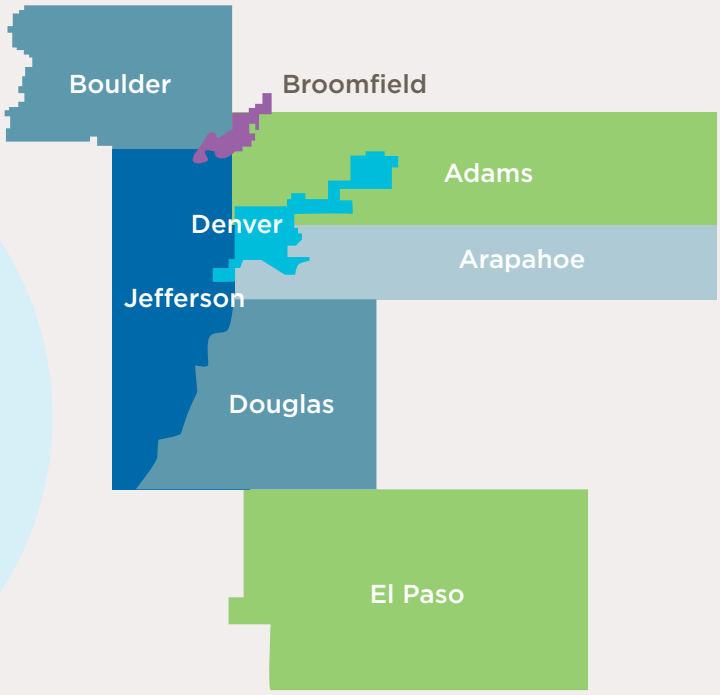
Children's Colorado considered three factors when defining this "community":

- The mission of the organization
- The geographic area served by the hospital facilities
- The physical location of the hospital facilities

The mission of Children's Hospital Colorado is "to improve the health of children through the provision of high-quality, coordinated programs of patient care, education, research and advocacy." Contained in this mission statement is a commitment to children statewide and beyond.

Children's Colorado serves a seven-state region; however, the majority of our patients come from Colorado and, specifically, the Denver metro area. In 2014, for all facilities, we had 18,332 total inpatient admissions, 138,523 emergency department visits and 557,275 total outpatient visits. A total of 86 percent of those admissions and visits were from residents of the eight counties selected for this needs assessment.

For our Main Campus, **we had a total of 382,057 patient visits;** the majority of these patients came from the following 8 counties.



The distribution of patients among those counties is as follows:

2014 Patient Visits: Children's Hospital Colorado Main Campus

County	Inpatient Admissions	Outpatient Visits	Emergency Department Visits	Total Visits	% of Total
Adams	2,235	55,762	14,800	72,797	19%
Arapahoe	2,731	83,622	23,539	109,892	29%
Boulder	448	9,418	333	10,199	3%
Broomfield	153	3,099	168	3,420	1%
Denver	1,815	52,245	15,718	69,778	18%
Douglas	747	13,697	765	15,209	4%
Jefferson	1,231	23,330	2,207	26,768	7%
El Paso	691	10,956	218	11,865	3%
Other Counties	4,097	55,788	2,244	62,129	16%
TOTAL	**14,148**	**307,917**	**59,992**	**382,057**	

The Main Campus of the hospital is located in Arapahoe County at 13123 East 16th Avenue in the City of Aurora. The neighborhoods immediately surrounding the hospital are in Ward 1 of Aurora in Arapahoe County. This Ward faces significant economic challenges and is home to a predominantly low-income population. Because the hospital is committed to both being a good steward of the community surrounding its facilities and reaching out to the families of children who are particularly vulnerable, extra effort was made to engage Ward 1 citizens and their representatives in our research. Specifically, we conducted four out of our eight focus groups in this neighborhood and eight out of our 42 stakeholder interviews were with professionals who represent Aurora and/or Arapahoe County.

Our South Campus, which is located at 1811 Plaza Drive in Highlands Ranch in Douglas County, also draws patients primarily from the eight-county region that is included in this needs assessment. The South Campus had a total of 49,987 patient visits, 93 percent of who came from the eight counties considered in this study.

2014 Patient Visits: Children's Hospital Colorado South Campus

County	Inpatient Admissions	Outpatient Visits	Emergency Department Visits	Total Visits	% of Total
Adams	3	1,028	74	1,105	2%
Arapahoe	79	8,084	2,826	10,989	22%
Boulder		305	14	319	1%
Broomfield	1	147	7	155	0%
Denver	57	3,833	1,186	5,076	10%
Douglas	160	12,154	5,802	18,116	36%
Jefferson	136	6,457	2,619	9,212	18%
El Paso	1	1,602	47	1,650	3%
Other Counties	22	2,865	478	3,365	7%
TOTAL	**459**	**36,475**	**13,053**	**49,987**	

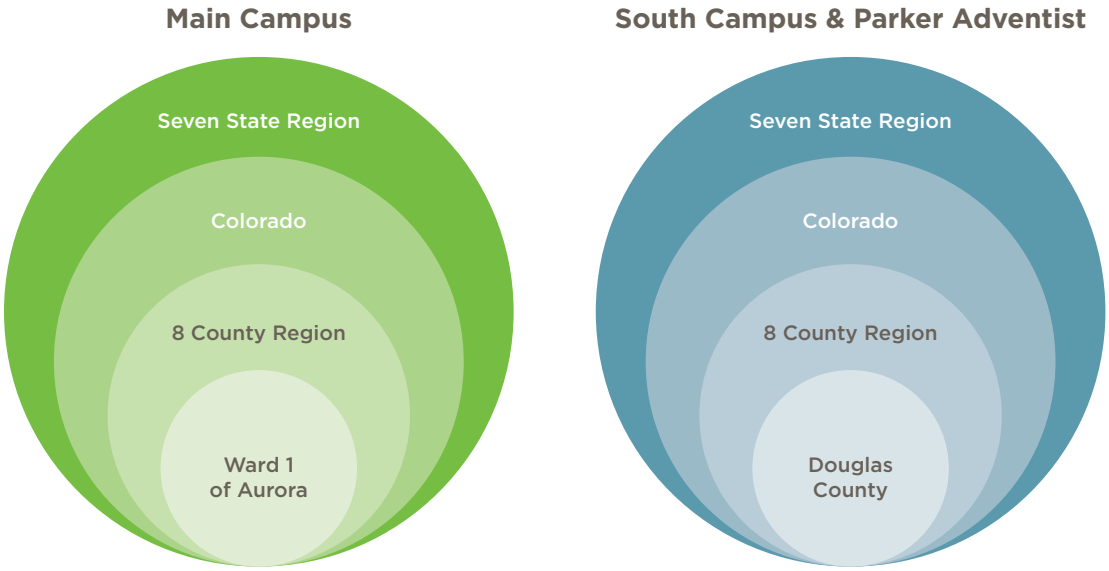
The South Campus and Parker Adventist locations are in a more affluent part of the state than the Main Campus. The median household income in Douglas County is over $100,000. Because we believe that Douglas County residents are more likely to have Internet access than those in the neighborhood near our Main Campus, and because we believe that there are fewer at-risk children in this area, we chose to rely more on online surveys to gather input from this community. We conducted one focus group and six interviews in this county. We had 35 survey responses from Douglas County residents. We also had 85 responses from Denver residents and 32 responses from Jefferson County residents. A total of 64 percent of the South Campus patients and 41 percent of Parker Adventist patients come from these three counties, and 44 percent of our survey responses were from these counties.

2014 Patient Visits: Children's Hospital Colorado at Parker Adventist Hospital

County	Inpatient Admissions	Outpatient Visits	Emergency Department Visits	Total Visits	% of Total
Adams	2	282	162	446	2%
Arapahoe	147	3,371	5,589	9,107	47%
Boulder	1	35	1	37	0%
Broomfield		19	5	24	0%
Denver	5	330	198	533	3%
Douglas	96	3,188	3,962	7,246	37%
Jefferson		252	32	284	1%
El Paso		282	38	320	2%
Other Counties	20	767	688	1,475	8%
TOTAL	**271**	**8,526**	**10,675**	**19,472**	

Our Parker Adventist location, which is inside Parker Adventist Hospital at 9395 Crown Crest Boulevard, Parker, CO 80138 draws 92 percent of its patients from the eight-county region considered in this report. The Parker Adventist location had a total of 19,472 patient visits in 2014.

CHILDREN'S HOSPITAL COLORADO COMMUNITY



DESCRIPTION OF THE COMMUNITY SERVED

Age

About 25 percent of the population in Colorado is under the age of 18. In the counties we considered, the percentage of the population under 18 ranges from 22 percent to 31 percent.[1]

Age Distribution	Under 5	5 to 9	10 to 14	15 to 17	Total under 18
Adams	9%	8%	8%	4%	29%
Arapahoe	7%	7%	7%	4%	25%
Boulder	6%	6%	6%	4%	22%
Broomfield	7%	8%	7%	4%	26%
Denver	7%	6%	5%	3%	21%
Douglas	8%	9%	9%	5%	31%
Jefferson	6%	6%	6%	4%	22%
El Paso	7%	7%	7%	4%	25%
State	**7%**	**7%**	**7%**	**4%**	**25%**

In Ward 1, the community surrounding the main hospital, the median age is 29.72 years.[2] This compares to a median age of 33.2 years for the City of Aurora and 33.7 for the state, meaning Ward 1 has a significantly younger population than the city or state.

Douglas County, where our South Campus and Parker Adventist facility are located, also has a higher-than-average youth population. About 31 percent of the county residents are under the age of 18, compared to 25 percent of the state's population.

Race and Ethnicity

While Colorado, as a state, has a population that is just over 40 percent minority, the racial and ethnic composition of the counties in our community varies widely. Arapahoe County, where the main hospital campus is located, and Adams and Denver Counties, which are the nearest other counties, have higher minority populations than the state. In all counties, Hispanics and Latinos are the largest minority population by a wide margin.[3]

Race and Ethnicity	Hispanic/ Latino	White	Black/ African American	American Indian or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Other	Two or more
Adams	50.0%	40.0%	3.0%	0.5%	3.0%	0.1%	0.2%	3.0%
Arapahoe	27.0%	50.0%	11.0%	0.4%	5.0%	0.2%	0.3%	6.0%
Boulder	22.0%	68.0%	1.0%	0.4%	6.0%	0.1%	0.2%	4.0%
Broomfield	16.0%	72.0%	1.0%	0.4%	6.0%	0.1%	0.2%	4.0%
Denver	51.0%	30.0%	11.0%	0.6%	3.0%	0.1%	0.3%	4.0%
Douglas	10.0%	81.0%	1.0%	0.2%	4.0%	0.1%	0.2%	4.0%
Jefferson	22.0%	70.0%	1.0%	0.5%	3.0%	0.1%	0.2%	3.0%
El Paso	22.0%	62.0%	6.0%	0.6%	2.0%	0.3%	0.3%	7.0%
State	**31.0%**	**58.0%**	**4.0%**	**0.6%**	**3.0%**	**0.1%**	**0.2%**	**4.0%**

Aurora's Ward 1 has a much higher than average minority population. The Black/African American population is 14.6 percent and the Hispanic population is 53 percent.[4] In contrast, Douglas County has a relatively low minority population. A total of 81 percent of Douglas County residents are white, compared to 58 percent statewide.

In Colorado, 10 percent of residents are foreign-born, with higher percentages in Adams and Arapahoe Counties (15 percent each) and Denver County (16 percent.) The more suburban counties included in this study had lower foreign-born populations, such as 6 percent in Douglas County and Jefferson County.[5] The percentage of children who speak a language other than English in the home closely parallels the percentage of foreign-born residents.[6]

	Residents (all ages) who are foreign-born	Children ages 5 to 17 who speak a language other than English at home
Adams	15%	33%
Arapahoe	15%	25%
Boulder	11%	22%
Broomfield	9%	15%
Denver	16%	39%
Douglas	6%	7%
Jefferson	6%	11%
El Paso	7%	11%
State	**10%**	**19%**

Ward 1 has a much higher than average foreign born population of nearly 35 percent, and more than 40 percent of the residents speak Spanish in the home.

Socio-economic Status

Nearly one out of five children in Colorado is living in poverty. In the County of Denver, close to one third of all children are living in poverty. The median household income in the state is $57,892[7], which compares favorably to the national median income of $53,046. However, as with the race and ethnic distribution of the population, poverty rates and median incomes vary significantly by county.

County	Children living in poverty	Median Household Income
Adams	20%	$55,223
Arapahoe	17%	$60,283
Boulder	13%	$69,260
Broomfield	8%	$78,745
Denver	29%	$50,728
Douglas	4%	$100,260
Jefferson	12%	$67,952
El Paso	17%	$57,001
State	**18%**	**$57,892**

Again, for Ward 1 of Aurora, family income levels are lower than both the state and the national average. Median household income is just over $30,000.[8] Douglas County, on the other hand, has the highest median household income of any county in the state at over $100,000.

In Colorado, 29 percent of children live in single-parent households, and three percent live with grandparents who are responsible for caring for them. As with other socio-economic indicators, the percentages vary significantly between counties, and those counties with lower median household incomes also have higher rates of single-parent families.[9]

	Children living in a single-parent household	Children living with a grandparent who is responsible for caring for them
Adams	32%	4%
Arapahoe	32%	3%
Boulder	25%	2%
Broomfield	22%	2%
Denver	40%	3%
Douglas	15%	1%
Jefferson	28%	2%
El Paso	29%	2%
State	**29%**	**3%**

Health Status

While it is difficult to use any single measure to determine the health status of children in a given community, Colorado parents in general feel positive about the health of their children, with fewer than three percent of parents reporting that their children's health is either "fair" or "poor." The ratings that parents give to their children's health are also fairly consistent across counties with the interesting exception of Adams County, where ratings are slightly lower.[10]

Health Status	Excellent	Very good	Good	Fair	Poor
Adams	53%	26%	16%	4%	1%
Arapahoe	63%	24%	11%	2%	0.4%
Boulder	61%*	23%*	13%*	2%*	0.4%*
Broomfield	61%*	23%*	13%*	2%*	0.4%*
Denver	63%	23%	9%	5%	--
Douglas	67%	25%	7%	1%	--
Jefferson	64%	24%	10%	1%	--
El Paso	60%	24%	13%	2%	0.2%
State	**61%**	**26%**	**11%**	**2%**	**0.3%**

*Denotes regional data. Boulder and Broomfield make up Health Statistics Region 16. Elbert County is part of Health Statistics Region 5, which also includes Lincoln, Kit Carson and Cheyenne counties.

It is noteworthy that there are disparities among different racial and ethnic groups in the ratings they give to their children's health, with Hispanic families being far less likely to believe that their children's health is "excellent."[11] (Note that this data is not available at the county level.)

Health Status	Excellent	Very Good	Good	Fair	Poor
Non-Hispanic White	66%	25%	8%	1%	0.2%
Black	66%	19%	13%	2%	0.5%
Hispanic White	50%	27%	19%	4%	0.4%
Other	**56%**	**24%**	**16%**	**3%**	**0.5%**

Similarly, there is a notable difference between the health ratings that low-income parents, in contrast to higher income parents, give to their children's health.[12] Parents from the lowest-income group are least likely to rate their children's health status as excellent.

Health Status	Excellent	Very Good	Good	Fair	Poor
Family income below $25,000	43%	28%	22%	6%	0.6%
Family income between $25,000 and $49,999	55%	25%	16%	3%	0.7%
Family income above $50,000	67%	25%	7%	1%	0.06%

Health Access

On a positive note, Colorado children are increasingly getting access to health insurance. However, the rates of coverage vary significantly across counties. Using a five-year average from 2009-2013, the rate of uninsured children under the age of 18 ranged from four percent to 13 percent in the counties considered.[13] Newly released data for 2014 indicates that the state-level uninsured rate for children has dropped to 5.6 percent, down significantly from 9 percent the previous year. While 2014 data is not yet available at the county level, it is reasonable to assume that there is still significant variation by county.

A substantial number of children are receiving coverage from public sources, including Medicaid and CHP+ and, again, rates of enrollment in public programs vary significantly across counties. As expected, higher income counties have lower rates of enrollment in public insurance programs.[14]

County	Uninsured Children (Under 18) (2009-13)	Children (ages 0 to 18) enrolled in Medicaid at least some point during FY13-14	Children (ages 0 to 18) enrolled in CHP+ at least some point during FY13-14
Adams	13%	47%	11%
Arapahoe	10%	37%	9%
Boulder	7%	26%	7%
Broomfield	5%	17%	6%
Denver	10%	52%	10%
Douglas	4%	10%	3%
Jefferson	8%	28%	7%
El Paso	7%	35%	7%
State	**9%**	**38%**	**9%**

However, increased health insurance coverage does not necessarily mean that children are finding medical homes or getting the medical care they need. While only about two percent of parents report that their child has no place to go when the child is sick,[15] five percent did not get needed medical care due to cost, and 10 percent did not get needed dental care due to cost. Again, rates vary by county with lower income counties having higher rates of children unable to access care due to cost.[16]

	Children (ages 1-14) whose parents report their child has no place he/she usually goes when he/she is sick or when parent needs advice on child's health (2012-2014)	Children (ages 0 to 18) who did not get needed doctor care due to cost (2013)	Children (ages 0 to 18) who did not get needed specialist care due to cost (2013)	Children (ages 0 to 18) who did not get needed dental care due to cost (2013)	Children (ages 0 to 18) who did not fill a prescription due to cost (2013)
Adams	2%	7%	8%	12%	5%
Arapahoe	6%	9%	7%	10%	13%
Boulder	2%*	4%*	2%*	7%*	4%*
Broomfield	2%*	4%*	2%*	7%*	4%*
Denver	3%	9%	10%	15%	9%
Douglas	1%	3%	3%	6%	7%
Jefferson	1%	2%	1%	4%	1%
El Paso	2%	4%	5%	13%	7%
State	**2%**	**5%**	**5%**	**10%**	**6%**

*Denotes regional data. Boulder and Broomfield make up Health Statistics Region 16. Elbert County is part of Health Statistics Region 5, which also includes Lincoln, Kit Carson and Cheyenne counties.

Another important indicator of health care access is the percentage of children who have a medical home. The Colorado Department of Public Health and Environment defines a medical home as a practice that is patient-centered, comprehensive, coordinated, accessible and committed to quality and safety. Essentially, this means that a child has a regular doctor who understands the whole needs of the child and helps to coordinate any care the patient may receive in addition to the child's primary care. Only 64 percent of children statewide have health care that meets these criteria, and the rate varies greatly both by county and by income and race,[17] with minority and low-income children being far less likely to have a medical home than their peers:

Children (ages 1-14) whose health care meets criteria for all five components of a medical home (2012-2014)

Non-Hispanic white	70%
Black	43%
Hispanic white	57%
Other	52%

Family income below $25,000 per year	46%
Family income between $25,000 and $49,999 per year	55%
Family income above $50,000 per year	71%

Health Conditions

Looking more closely at specific medical conditions yields deeper insight into the health status of children in our community. One area of particular concern is childhood obesity and the related issues of nutrition and physical activity. In Colorado, 28 percent of children are overweight or obese, and in Denver, that figure is 34 percent. Those counties with lower median incomes have slightly higher rates of obesity than the state average, and counties with higher median incomes have slightly lower rates.[18]

	Underweight	Healthy Weight	Overweight	Obese
Adams	10%	58%	14%	18%
Arapahoe	9%	64%	10%	16%
Boulder	9%*	65%*	13%*	13%*
Broomfield	9%*	65%*	13%*	13%*
Denver	10%	56%	15%	19%
Douglas	15%	67%	9%	10%
Jefferson	8%	71%	12%	9%
El Paso	13%	59%	14%	13%
State	**11%**	**62%**	**13%**	**15%**

*Denotes regional data. Boulder and Broomfield make up Health Statistics Region 16.

Not surprisingly, many children in Colorado are also not meeting minimum daily-suggested consumption of fruits and vegetables or getting the minimum suggested daily physical activity. Again, rates vary by county and poorer habits are, on average, correlated with lower average incomes.

	Children (ages 1-14) whose parents report their child consumes at least 5 total servings of fruits and/or vegetables per day (2012-2014)	Children (ages 5-14) whose parents report their child is physically active for at least 60 minutes per day (2012-2014)
Adams	21%	44%
Arapahoe	19%	44%
Boulder	19%*	47%*
Broomfield	19%*	47%*
Denver	21%	44%
Douglas	16%	44%
Jefferson*	16%	41%
El Paso	16%	42%
State	**19%**	**45%**

*Denotes regional data. Boulder and Broomfield make up Health Statistics Region 16.

Closely related to concerns about obesity and poor nutrition and exercise habits are issues around food scarcity and dependence on low-cost food. More than one in five families in Colorado struggles with paying for food.[19]

Households with children ages 1-14 who sometimes or often felt that the food they bought didn't last, and they didn't have money to get more (2014)	24%
Households with children ages 1-14 who sometimes or often felt that they couldn't afford to eat balanced meals (2014)	21%
Households with children ages 1-14 who sometimes or often could not afford the food they needed in the past year (2014)	28%

Another area of concern is the mental health status of children in our community. Nearly one fourth of all parents statewide report challenges with their children's emotional and behavioral health, and, in some counties, it is closer to one third of all parents. Of note, mental health concerns are almost nearly as high for children between the ages of one and four as they are for children between four and 14.[20]

	Children (ages 1-14) whose parents report their child has difficulties with one or more of the following areas: emotions, concentration, behavior, or being able to get along with other people (2012-2014)	Children (ages 4-14) whose parents reported their child had at least one day in the past month when their child's mental health was not good (2012-2014)	Children (ages 4-14) whose parents reported their child needed mental health care or counseling within the past 12 months (2012-2014)
Adams	25%	23%	10%
Arapahoe	25%	25%	16%
Boulder	23%	30%	14%
Broomfield	23%	30%	14%
Denver	24%	22%	14%
Douglas	20%	21%	11%
Jefferson	21%	26%	14%
El Paso	18%	27%	14%
State	**22%**	**25%**	**13%**

Significantly, 24 percent of parents statewide who reported that their child needed mental health care or counseling during the past 12 months did not receive all needed care.[21] The reasons that children did not receive the care they needed are difficult to discern with available data:

Of children (ages 4-14) who needed and did not get all needed care, reasons why child did not receive all needed mental health care (2012-2014)

Cost too much	10%
No health insurance	7%
Health plan problem	6%
Not available in area	4%
Transportation problems	2%
No convenient times	2%
Doctor did not know how to treat or provide care	7%
Other	60%

Looking specifically at the mental health needs of teens, the data is even more discouraging. Nearly one in four students statewide reported symptoms of depression in 2013 (the last year for which data is available) and nearly one in six seriously considered attempting suicide. These rates are fairly consistent across the state, but are slightly higher in lower-income counties.[22]

	High school students who reported feeling so sad or hopeless for at least two weeks that it interfered with their usual activities (2013)	High school students who reported they had seriously considered attempting suicide during the past 12 months (2013)	High school students who made a suicide attempt during the past 12 months that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse (2013)
Adams	28%	17%	4%
Arapahoe	26%	16%	2%
Boulder	22%*	14%*	2%*
Broomfield	22%*	14%*	2%*
Denver	29%	13%	3%
Douglas	22%	14%	2%
Jefferson*			
El Paso	21%	15%	2%
State	**24%**	**15%**	**2%**

*Denotes regional data. Boulder and Broomfield make up Health Statistics Region 16. Elbert County is part of Health Statistics Region 5, which also includes Lincoln, Kit Carson and Cheyenne counties. Jefferson County Public Schools elected not to participate in this survey

Oral health is another issue that has emerged as an area of interest for the community. While most children in Colorado do a see a dentist on a regular basis, fewer than half of parents in the state report that the condition of the their children's teeth is "excellent." Again, there are variances between counties.[23]

	Children (ages 1-14) who saw a dentist for preventative dental care during the past 12 months (2012-2014)	Parent's rating of the condition of child's (ages 1-14) teeth (2012-2014)				
		Excellent	Very good	Good	Fair	Poor
Colorado	84%	43%	31%	19%	6%	1%
Adams	84%	40%	29%	22%	7%	1%
Arapahoe	85%	43%	28%	21%	7%	0.9%
Boulder	87%*	50%*	27%*	18%*	5%*	0.4%*
Broomfield	87%*	50%*	27%*	18%*	5%*	0.4%*
Denver	84%	41%	27%	23%	6%	2%
Douglas	89%	54%	34%	10%	2%	0.6%
Jefferson	88%	47%	32%	16%	5%	0.3%
El Paso	82%	48%	32%	15%	4%	0.8%

*Denotes regional data. Boulder and Broomfield make up Health Statistics Region 16. Elbert County is part of Health Statistics Region 5, which also includes Lincoln, Kit Carson and Cheyenne counties.

SUMMARY FINDING

Community Input

Different analytical methods were used to review and understand the input provided by different data sources. For the key informant interviews, interviewers took detailed notes during the conversations. Then, interview notes were analyzed and the issues identified as needs or concerns were tabulated. The data was then organized by the frequency with which an issue was cited, yielding the following results:

Top Issues Identified through Key Informant Interviews

Issue	TOTAL MENTIONS
Mental/Behavioral Health/Toxic Stress	22
Nutrition	17
Obesity	10
Parent Education	5
Care Coordination	4
Physical Activity	4
Substance Abuse	4
Vaccinations	3
Special Needs care	3
Oral Health	3
Access/Wait times for appointments	3
Disparities	3
Medical Home	3
Accidental Injury	3
Early Intervention	3

Similarly, detailed notes were taken during the focus groups and then analyzed and tabulated:

Top Issues Identified through Focus Groups

Issue	Total Mentions
Mental/Behavioral Health/Toxic Stress	28
Nutrition	26
Oral Health	26
Access/Wait times for appointments	25
Affordability	21
Physical Activity	19
Insurance	18
Asthma/Respiratory Illness	18
Violence	17
Obesity	15
Diabetes	15
Housing	14
Substance Abuse	13
Accidental Injury	13
Vaccinations	11
Hunger	10
Prenatal Care	8

It is noteworthy that the key informant interviews and focus groups yielded slightly different lists of key concerns.

Because the key informants were generally professionals who work either in the public health arena or with nonprofit organizations that serve populations similar to those of the hospital, their perspectives tended to be more global and they highlighted issues that were more systemic. Focus groups, on the other hand, were composed of parents who live in the communities the hospital serves. Their perspectives were more informed by the needs of their own children. While mental health, nutrition, physical activity and obesity were top concerns for both groups, the focus groups discussed oral health more frequently and were also much more concerned about the difficulty of accessing providers, either because of long wait times at emergency departments or because of long delays in scheduling appointments with providers.

Because more demographic data was collected for the online survey, we were able to analyze the results in more meaningful ways. First, a simple analysis of the top rated issues/concerns was performed, with differences noted between the responses to the English language and Spanish language versions:

Top 10 Issues Identified through the Parent Survey

Issue	Count
Cost of health care	121
Mental or behavioral health	111
Nutrition	98
Physical activity	82
Obesity	71
Parent Education (child development, parenting skills, etc.)	70
Dental care	61
Safe neighborhoods/places for children to play	59
Care for children with special needs	58
Child care	57

Top 10 Issues Identified through the English Language Parent Survey

Issue	Count
Mental or behavioral health	102
Cost of health care	97
Nutrition	79
Parent Education (child development, parenting skills, etc.)	62
Physical activity	61
Child care	52
Obesity	51
Safe neighborhoods/places for children to play	50
Immunizations (vaccinations)	50
Care for children with special needs	48

Top 10 Issues Identified through the Spanish Language Survey

Issue	Count
Costo de la atención médica (Cost of health care)	24
Actividad física (Physical activity)	21
Obesidad (Obesity)	20
Nutrición (Nutrition)	19
Cuidados dentales (Dental care)	14
Acceso a atención médica (para poder ver a un médico) (Access to medical care)	13
Diabetes	11
Atención médica para niños con necesidades especiales (Care for children with special needs)	10
Atención médica regular/de rutina (Routine/regular care)	10
Diferencias en la atención médica entre las comunidades y culturas (Difference in medical care among cultures/communities)	10

Some of the notable differences between the English language and Spanish language survey responses include:

- Mental health was the most frequently selected issue in the English survey and did not appear in the top 10 issues in the Spanish-language survey
- Dental Care is a top priority in the Spanish survey
- Cost of care is a top priority for both groups
- Physical activity, nutrition and obesity are top concerns for both groups and, if considered together as a related set of issues, are the highest priority for both groups

Next, we sorted the data by county as well as by income levels to determine if there were significant variations in the issues identified as top concerns:

Top Priorities by County

	Issue #1	Issue #2	Issue #3	Issue #4	Issue #5
All	Mental Health	Cost of care	Nutrition	Parent Education	Physical Activity
Adams	Mental Health	Nutrition	Cost of Care	Physical Activity	Dental care
Arapahoe	Mental health	Nutrition	Cost of Care	Safe Neighborhoods	Physical Activity
Boulder	Immunizations	Mental health	Parent education	Child care	Cost of care
Broomfield	Dental care	Parent education	Access to care	Cost of care	Cultural differences
Denver	Nutrition	Mental health	Child care	Cost of care	Physical Activity
Douglas	Cost of care	Sports Injuries	Injuries cause by accidents	Mental health	Special needs care
Jefferson	Special needs care	Parent education	Cost of care	Immunizations	Mental health
El Paso	Cost of care	Dental care	Access to care	Insurance coverage	Mental health

Significant findings from the county-level analysis include:

- Cost of care is a top-five issue in all counties, and is a higher priority in higher income counties. Most likely, this can be attributed to a greater percentage of residents in high income communities utilizing private insurance and therefore having higher premiums, co-pays and deductibles than residents in lower-income communities who are more likely to have public insurance.
- Mental health is a top five issue in all counties except Broomfield, where the small sample size may be too small to be meaningful.
- Physical activity and nutrition are priorities in more urban counties, including Adams, Arapahoe, and Denver.
- Parent education is a priority in relatively affluent counties including Boulder, Broomfield, and Jefferson.
- In Douglas County, where the South campus and the Parker Adventist facility are located, sports injuries and injuries caused by accidents are top concerns.

Top Priorities by Income

	Issue #1	Issue #2	Issue #3	Issue #4	Issue #5
$0 - $24,999	Dental care	Housing	Child care	Mental Health	Nutrition
$25,000 - $49,999	Nutrition	Cost of Care	Dental care	Mental Health	Insurance coverage
$50,000 - $74,999	Cost of Care	Parent Education	Mental Health	Obesity	Access to care
$75,000 - $99,999	Mental Health	Cost of Care	Nutrition	Physical Activity	Special needs
$100,000 or more	Mental Health	Cost of Care	Nutrition	Parent Education	Sports Injuries

Observations on responses parsed by income include:

- Mental health is a high-priority issue in all income bands, but is ranked higher for higher income levels.
- Cost of care is a concern in all but the lowest income brackets, again most likely for reasons related to the type of coverage those respondents are most likely to have (public vs. private). The income level where cost of care is the highest priority is $50,000 to $74,999, which is likely the group whose income is just high enough that they do not qualify for public insurance.
- Nutrition is a top concern in both-high income and low-income brackets.

Admissions and Mortality data:

In addition to reviewing the information gleaned from interviews, focus groups and surveys, the needs assessment took into consideration admissions data from the hospital. We were interested in comparing the concerns of the community with the reasons that children are treated in our facilities. We considered the top 10 primary diagnoses for both inpatient and outpatient visits:

Top 10 Inpatient Primary Diagnoses (37% of all admissions)

- Acute Bronchitis 8%
- Asthma 6%
- Epilepsy 4%
- Viral Pneumonia 4%
- Affective Psychoses 4%
- Pneumonia, Organism Nos 3%
- Aftercare 3%
- Diabetes Mellitus 2%
- General Symptoms 2%
- Short Gest/Low Birth WT 2%

Top 10 Outpatient Primary Diagnoses (36% of all visits)

- Rehabilitation Procedure 19%
- Joint Disorder 3%
- Nutrition/Metabolic/Developmental Symptoms 2%
- Health Supervision 2%
- Specific Developmental Delays 2%
- General Symptoms 2%
- Hearing Loss 2%
- Aftercare 2%
- Respiratory Symptoms/Other Chest Symptoms 1%
- Epilepsy 1%

General observations from the comparison of admissions data with the community input include:

- There is relatively little overlap between the concerns raised by the community and the reasons that children are actually coming to the hospital's facilities.
- A number of the primary diagnoses, both for inpatient and outpatient care, are respiratory issues. Yet the community generally expressed little concern about these issues.
- The top 10admission diagnoses combined account for just over one third of all admission diagnoses, indicating that the reasons for which children visit the hospital are very diverse.
- The only top 10 diagnosis that has significant overlap with the community's concerns is mental health/ affective psychoses.

We also reviewed the mortality data for children in Colorado as reported by the Centers for Disease Control and Prevention (CDC). Keeping in mind the prioritization criteria that our committee selected (scale, impact, community importance and sustainability) we wanted to ensure that we were considering those issues that have the most harmful consequences for children. While most of the other data we analyzed was used to determine which issues might be affecting large numbers of children (scale) we felt that mortality data would inform our understanding of impact.

Top Cause of Mortality for Children in Colorado age 0-14

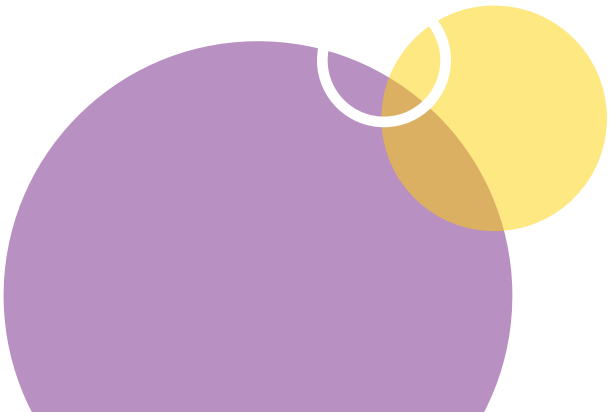
- Congenital abnormalities
- Low birth weight
- Other injuries
- Birth trauma
- Suicide
- Road traffic injuries

Top Cause of Mortality for Children in Colorado age 15-24

- Suicide
- Road traffic accidents
- Poisoning
- Homicide
- Other injuries
- Drowning

Insights gleaned from mortality data include:

- Suicide is a leading cause of death, ages 15-18, and is closely related to the concerns raised by the community about mental health.
- Injuries and accidents are also leading causes of death but were not top priority issues for the community.
- Fatalities for very young children are often triggered by congenital abnormalities and low birth weight, issues that are closely related to premature birth. Again, these were not issues that were priorities for the community.

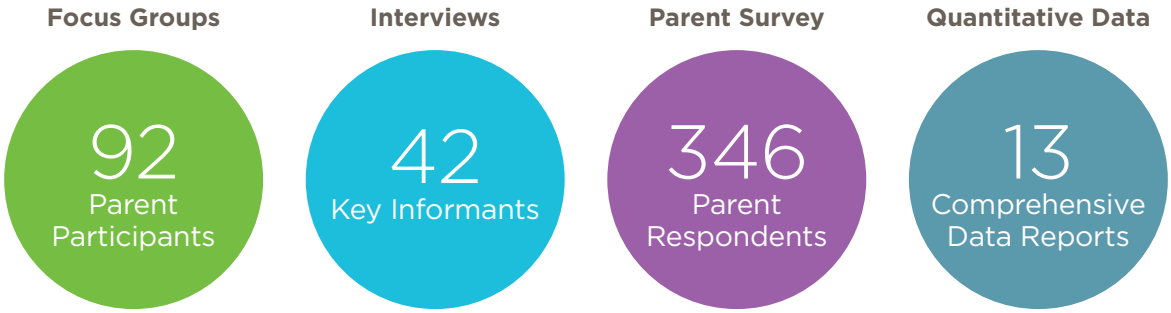


PRIORITY NEEDS ASSESSMENT

Prioritzation Process

Finally, we presented the research findings first to a group of community stakeholders and then to an internal leadership team and asked them how they would prioritize the issues that were identified through interviews, focus groups, surveys and data analysis.

CHNA DATA



The outcomes of those discussions were as follows:

Community ranking of priorities (from highest to lowest)

- Mental/Behavioral Health/Toxic Stress
- Oral Health
- Early Intervention
- Obesity/Nutrition
- Parent Education
- Health Literacy
- Access/Wait times for appointments
- Care Coordination
- Disparities
- Physical Activity

Internal leadership ranking of priorities (from highest to lowest)

- Mental/Behavioral Health/Toxic Stress
- Disparities
- Medical Home
- Parent Education
- Obesity/Nutrition
- Oral Health
- Accidental Injury
- Physical Activity
- Early Intervention
- Infant Care

There was clear consensus between both groups that mental health, obesity/nutrition and oral health are high priorities. Also, further discussion with hospital leadership led to the conclusion that some items that were prioritized by the internal team are actually strategies for addressing key issues. These include medical homes and parent education. While these strategies will be considered as part of the implementation plan, for the purposes of the needs assessment, they will not be included in the list of top priorities.

COMMUNITY BENEFIT PRIORITIES

After careful consideration of all available data, Children's Hospital Colorado has determined that the issues that both are of greatest importance to the community and which the hospital can most effectively address are:

- Mental health
- Nutrition, physical activity and obesity
- Oral health

We acknowledge that the community raised numerous other concerns and that the data supports the need to address a wide range of issues. However, we believe that concentrating our efforts in these three key areas will have the most meaningful and lasting impact. It should be noted that mental health and obesity were also identified as priorities in the 2012 community health needs assessment, and the hospital has launched and continues to support programs to address these needs. As detailed below, each of these three issues meets our prioritization criteria:

Scale – these issues touch a large number of children

Impact – these issues have a significant effect on children

Community Interest – community members expressed concern about these issues through the various channels we used to gather input

Sustainability – Children's Hospital Colorado has the resources needed to address these issues

It is also important to point out that, in addition to these priority needs, the hospital will sustain our current work on three issues that are critical to the long-term health and wellness of children in our community:

- Injury
- Prematurity
- Respiratory illness/disease

COMMUNITY IDENTIFIED PRIORITIES

DATA DRIVEN PRIORITIES

DESCRIPTION OF PRIORITY NEEDS

Mental Health

Mental Health is clearly one of the most pressing issues facing our community. Nearly one in four parents in Colorado report that their young child (ages 1 to 14) has difficulties with emotions, concentration, behavior or being able to get along with other people.[24] Similar numbers, 25 percent, reported that their child had at least one day in the past month when his or her mental health was not good, and 13 percent reported that their child needed mental health care or counseling within the past 12 months.

The numbers are equally alarming for teens. About 24 percent of high school students in Colorado report feeling so sad or hopeless for at least two weeks in the past year that it interfered with their normal activities, and 15 percent have seriously considered attempting suicide in the past 12 months.[25]

The need for improved mental health care was also evident in our conversations with community members. Fully 23 out of the 42 stakeholders who were interviewed for this assessment chose mental health as one their top three issues or concerns. The issue was raised 28 times during our 8 focus groups and was selected as a top priority by 111 out of 374 people who responded to our online survey. Mental health also ranked highest in both our community and our internal prioritization meetings.

Public health departments have also identified mental health as a top priority. Half of the eight counties in our community selected mental health as a top issue area in their own community health needs assessments. These include Tri-County Health, which represents Adams, Arapahoe and Douglas Counties, and Boulder County.

The impact of poor mental health is significant for children at any age. Over the past two decades, valuable research in the field of early childhood development has established the importance of relationships and experiences in the first years of life. It has become clear that early exposure to "toxic stress" can have an overwhelming effect on life-long health and wellbeing. According to the Harvard Center for the Developing Child, "scientists now know that chronic, unrelenting stress in early childhood, perhaps caused by extreme poverty, neglect, repeated abuse, or severe maternal depression, for example, can be toxic to the developing brain."[26] Emotional wellbeing in early childhood lays the groundwork for cognitive, social, emotional and physical development. Fostering early childhood mental wellness therefor has long-lasting implications for the future prosperity of our community.

For older children, poor mental health begins to impact school performance, social relationships and family connections. Without treatment, children who are experiencing mental health issues may also make unhealthy lifestyle decisions. We know that 31 percent of high school students in our state are using alcohol and 33 percent have had sexual intercourse.[27] While certainly not all of those risky behaviors can be directly attributed to poor mental health, there is likely some connection between improved mental health and better lifestyle choices.

And, of course, the ultimate and most devastating impact of poor mental health can occur when a child takes his or her own life. A 2013 survey found that two percent of high school students in Colorado made a suicide attempt during the past 12 months that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse.[28] Sadly, on average more than 30 Colorado teens and young adults die each year as a result of suicide.[29]

Children's Hospital Colorado has existing resources and capacity to address the issue of childhood mental health. Our psychology and psychiatry department offers outpatient, day treatment and inpatient care for children and adolescents ages three to 17. Services offered include diagnostic evaluations, individual and family therapy, and parent counseling and education. We also offer educational programs for medical and child care professionals. Each year, this department treats more than 3,800 patients. Specific conditions treated include:

- Attention Deficit Hyperactivity Disorder (ADHD)
- Autism spectrum disorders
- Anxiety disorders
- Bipolar disorders
- Coping with medical illness
- Depression
- Developmental and other learning disorders
- Disruptive behavior disorders
- Eating disorders
- Elimination problems
- Impulse control disorders, such as nail biting and hair pulling
- Mood and thought disorders
- Obsessive-Compulsive Disorder (OCD)
- Oppositional Defiant Disorder (ODD)
- Perinatal (pregnancy and postpartum) mental health
- Psychotic disorders
- School refusal
- Tourette's and other tic disorders

The hospital has also been a leader in integrating mental and behavioral health services with primary care. Project CLIMB, a mental health program in the Child Health Clinic (our primary care clinic), provides teaching, consultation and interventions as part of regular well-child pediatric visits. Clinicians can coordinate admissions to the Outpatient Specialty Clinics, Intensive Outpatient Program, Day Treatment Programs, and Intensive Services Program if needed, and can also offer immediate interventions for families during visits.

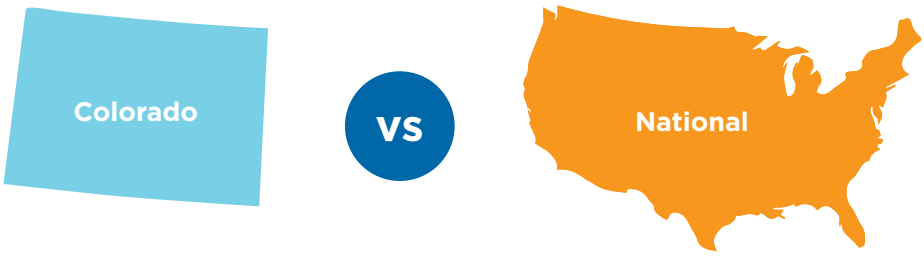
In addition, the hospital has recently announced a new "First 1,000 Days" initiative aimed at improving the health and wellbeing of children under the age of two with a particular focus on mental health. While still in its nascent stages, this new project aims to better identify vulnerable children who may be experiencing toxic stress and to provide targeted interventions to enhance their early development.

Beyond the clinical services that the hospital provides, we have taken a proactive stance on many policy issues that impact childhood mental and behavioral health. We recently co-authored a study with the Colorado Children' Campaign titled "Young Minds Matter: Supporting Children's Mental Health Through Policy Change." This publication offers a roadmap for strengthening mental health services for children in Colorado, and we are now working with state and local leaders to urge adoption of many of the policies that were recommended.

Children's Colorado is also aware of many state and local organizations doing innovative work in the field of childhood mental health. These include:

- **Mental Health Corporation of Denver and the Aurora Mental Health Center** – these private, nonprofit community mental health providers that treat children and adults of all ages and address a wide range of mental and behavioral health issues.
- **Children First** – a program of the Maria Droste Counseling Center that provides on-site counseling services at 21 elementary schools.
- **Community Reach Center** – serves more than 10,000 clients of all ages at five outpatient locations throughout Adams County, as well as in schools, nursing homes, its own residential treatment homes, physicians' offices, emergency rooms, private residences, and jail facilities.

We look forward to working with these and other key organizations as we develop our implementation plan for better addressing the mental health needs of children.



Mental Health

Colorado		National
13%	Children ages 0-14 needed care in the last year	8%
24%	Teens felt sad or hopeless at least two weeks in last year	28%
60	Teens lost their lives due to suicide	4600

Nutrition, physical activity and obesity

While Colorado has long enjoyed one of the lowest childhood obesity rates in the nation, we are unfortunately losing ground in the battle against the epidemic, with 28 percent of children in the state now overweight or obese. In some counties in our community that figure is even higher. For instance, 32 percent of children in Adams County and 34 percent of children in Denver are overweight or obese.[30]

While nutrition and physical activity are distinct issues, they are closely related to obesity and we have chosen to group them together for the purposes of this needs assessment. Lack of physical activity and poor nutrition also impact large numbers of children in our state. In Colorado, 31 percent of families report that they "rely on only a few kinds of low-cost foods to feed their children because they did not have money to buy food."[31] In some of the counties in our community that figure is even higher: 43 percent of families in Adams County and 39 percent of families in Denver rely on low-cost food. While this does not necessarily mean that those families are unable to provide healthy meals for their children, there may be some correlation between dependence on low-cost food and poor nutrition. Similarly, fewer than 20 percent of parents statewide report that their children consume at least five servings of fruits and vegetables per day.[32]

Regular physical activity not only reduces the occurrence of childhood obesity, it has also been shown to prevent a wide range of chronic diseases. The CDC and many health organizations recommend that all children ages 6 to 17 get at least 60 minutes per day of physical activity,[33] yet most children fail to meet this guideline. Just 45 percent of parents in Colorado report this level of activity for their children, and that figure is fairly consistent across counties.

Obesity has significant impacts at the both the individual and the community level. A 2005 study showed that an overweight adolescent has a 70 percent chance of becoming an overweight or obese adult, and that obese six- to eight-year-olds are approximately 10 times more likely to become obese adults than their average-weight peers.[34] Overweight children also experience health problems and challenges in school. They are at greater risk for a range of diseases including asthma, Type 2 diabetes, high blood pressure and high cholesterol, sleep apnea, and joint problems.[35] They are also more likely to miss school and have poorer academic outcomes than their normal-weight peers in every grade level.[36]

The community also pays a price for obesity. LiveWell Colorado, a nonprofit organization dedicated to ending childhood obesity, estimates that Colorado spends $1.6 billion each year treating diseases and conditions related to obesity. At a national level, it is estimated that childhood obesity costs Americans $14.1 billion per year in direct medical expenses,[37] in addition to indirect costs.

Our research also revealed that community members are very concerned about this issue. The combined topics of obesity, physical activity and nutrition were selected as top priorities a total of 34 times in our 42 stakeholder interviews. These topics were mentioned 60 times in our focus groups and were selected as key concerns 251 times in our online survey. Both the internal and the community prioritization groups ranked this issue 4th on their list of concerns. Five of the county public health departments in our community, including Boulder, Broomfield, Denver, El Paso and Jefferson, have also made this one of their top priorities.

Children's Hospital Colorado does have clinical resources in place to help address this issue. We have treated children with weight management issues for more than 20 years through our Weight Management Program and are the only regional specialty care center to treat obese pediatric patients and focus on obesity treatment for the special-needs population. We offer a range of treatments, serving about 300 children a year, and our goal is to provide a tailored program for each individual. Specific options include:

- Medical and lifestyle evaluations with a team of providers, including a dietitian and an exercise physiologist to address the individual needs of each child and/or family.
- The SHAPEDOWN® Program which is a 10-week group participation program run by social workers, therapeutic recreation specialists and a registered dietitians
- Free weekly exercise classes on Tuesdays, Wednesdays and Thursdays
- Access to the Wellness Center, which includes a yoga room and fitness room
- Outpatient nutrition counseling by a registered dietitian is available through Clinical Nutrition Services.
- Clinical research and trials for patients who meet criteria
- Radiologic studies, sleep studies and blood tests

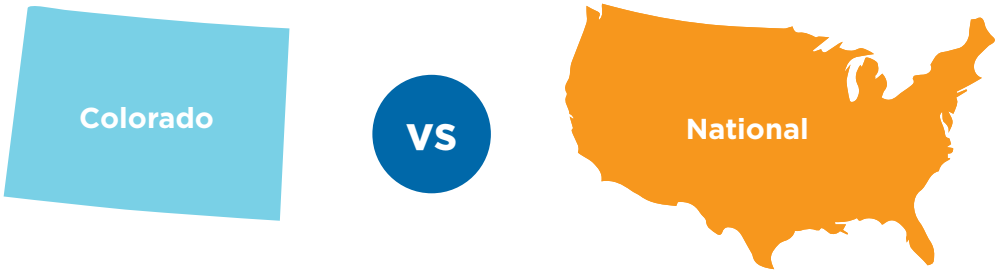
We also offer a Weight Management Specialty Clinic, which treats children ages 10 and older who need special care for obesity-related health problems. These problems might include Type 2 diabetes, high blood pressure, high cholesterol, sleep apnea or polycystic ovary syndrome. Treatments offered in this clinic include both weight management plans and, if necessary, medications as prescribed by our endocrinologists and cardiologists.

We also have a number of community outreach programs designed to encourage children to develop healthy habits. These include:

- **Bikes for Life** – launched in 2011, this program provides bikes and safety training to more than 300 children in the Denver-Metro area. The goal of the program is to create life-long healthy habits through cycling.
- **Share Our Strength's Cooking Matters** – this program helps families to shop for and cook healthy meals on a budget, and is part of Share Our Strength's No Kid Hungry campaign. Children's Colorado helps to coordinate Cooking Matters courses in communities throughout Colorado.
- **Safe Routes to School** - Children's helps lead the Colorado Safe Routes to School Network. The goal of this program is to increase the number of students safely walking and biking to and from school in every Colorado community.

There are a number of other organizations that are also doing important work in this field and who are potential partners for our ongoing work. These include:

- **LiveWell Colorado** - a nonprofit organization committed to reducing obesity in Colorado by promoting healthy eating and active living. In addition to educating and inspiring people to make healthy choices, LiveWell Colorado focuses on policy, environmental and lifestyle changes that remove barriers and increase access to healthy behaviors. LiveWell also leads the Healthy Eating Active Living (HEAL) Cities & Towns Campaign, which provides training and technical assistance to help municipal officials adopt policies that improve access to physical activity and healthy food in their communities.
- **Hunger Free Colorado** – the state's leading anti-hunger organization connects families to food and nutrition resources and advocates for policies and practices that promote access to healthy food.
- **Metro Caring** - the largest hunger-relief organization in Denver directly serving families and individuals.



Obesity – Nutrition – Physical Activity

Colorado		National
28%	Kids are overweight	21%
14%	Families experience food insecurity	19%
<20%	Kids get 3 servings of fruits/veggies	<15%

Oral Health

The third issue that we have chosen to prioritize is oral health. The data collected for this assessment indicates that poor oral health disproportionately impacts low-income children, often with distressing consequences.

About 10 percent of children in Colorado do not get the dental care they need due to cost[38]. This equates to nearly 125,000 children in our state with untreated dental conditions. In the City and County of Denver alone, 15 percent of children, nearly 19,000 total, do not get the dental care they need due to cost. While 70 percent of parents report that their children's teeth are in "good" or "excellent" condition, about 22 percent of children statewide did not receive preventive dental care in the past year.[39] According to a 2012 study, almost 40 percent of kindergarteners in the state have tooth decay, and 13.8 percent have untreated decay.[40]

Although oral health is considered by some to be less imperative than physical health, the effects of inadequate dental care can be severe. Tooth decay can cause pain and discomfort in children, which can, in turn, impact a child's ability to eat, sleep and perform well at school. There can also be social and emotional consequences for children whose untreated dental conditions lead to tooth loss and other aesthetic problems.

Oral health care was not identified as a key issue in our stakeholder interviews, but it was mentioned 26 times in our focus groups. We believe this indicates a gap in awareness among the professionals we interviewed. Focus group participants, who were predominantly low-income community members, clearly felt that lack of access to dental care was a major concern for their children. Our online survey also revealed notable difference in how this issue was prioritized among different socio-economic groups. Those respondents with the lowest income levels ($0-24,999) ranked oral health as the highest priority health issue for their children, and those in the second-lowest income level ($25,000-49,999) ranked it third. No other income levels placed oral care in their top five priorities. After reviewing this information, the community prioritization group ranked this issue second among all issues considered. While the internal prioritization group initially ranked this issue as a lower priority, ultimately the hospital decided that it can and must dedicate resources to improve oral care for the children in our community.

The Children's Hospital Colorado Dental Center sees more than 35,000 unique patients each year. Treatments range from routine preventive care to complex treatments. We also offer a walk-in emergency clinic for severe toothaches, physical injuries and other traumas. And, unlike most other dental practices, we are devoted entirely to pediatric care. We accept almost all insurance plans and also work with uninsured patients to try to minimize cost to families.

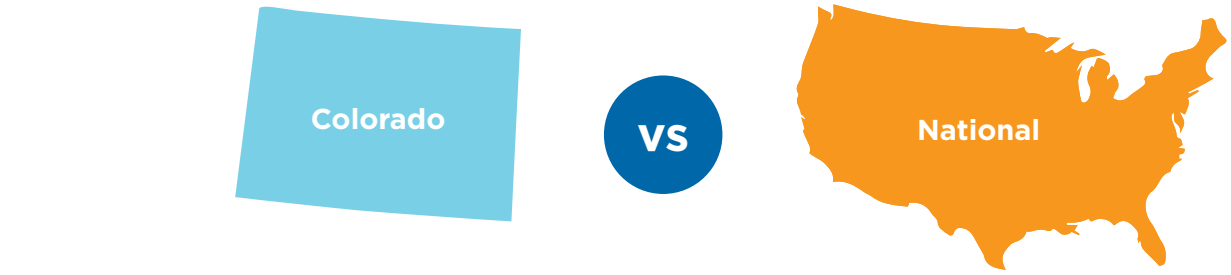
We also participate in two key community-based programs that specifically target low-income and at-risk families:

- Cavity-Free at Three (CFAT) is a training program for health care providers. It seeks to teach providers how to improve their outreach, education and service delivery to families with the goal of preventing dental disease early in life. Children's offers a Cavity Free at Three clinic that provides preventive dental care to children under three.
- The Healthy Smiles Clinic is a regional pediatric dental clinic offered in partnership with the University of Colorado School of Dental Medicine. This low-cost clinic serves school-aged children and adolescents and provides teeth cleaning, fillings, treatment for gum disease, and referrals to specialists.

While we are proud of the work of our own Dental Center, we also understand that there are many other community organizations that are focused on improving oral health for Colorado's children who may be partners for future work. These include:

- **Give Kids a Smile Day** – organized by the Colorado Dental Association on the first Friday in February, this is day when dentists statewide offer free care to low-income families and children
- **Clinica Family Health Services** - provides comprehensive primary care, including dental care, to low-income residents of southern Boulder, Broomfield and western Adams Counties
- **Metro Community Provider Network** – provides low-cost care in 23 centers in metro Denver. Services include preventative, restorative and emergency dental services for patients of all ages.
- **Rocky Mountain Youth Clinics** – a nonprofit network of clinics that provides comprehensive care, including dental care, to children across metro Denver

A more detailed list of other potential community partners that were identified through our community outreach for is provided as Appendix E.



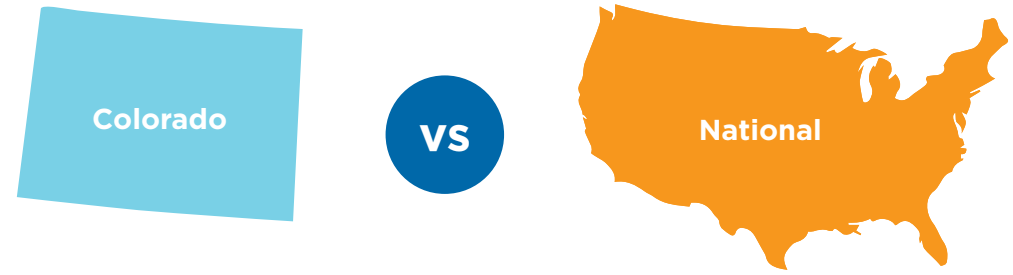
Oral Health

14% Third graders untreated dental caries 18%

70% Hispanic third graders untreated dental caries

Injury Prevention

Injury prevention has been, and will continue to be, a major area of focus for the hospital. Unintentional injury is the leading cause of death nationwide for children and youth between the ages of 1 and 24.[41] Children's Colorado has many important initiatives in place to help prevent accidental injury including passenger safety programs, projects to encourage children to safely walk and bike to school, and public education campaigns aimed at preventing abuse. These efforts will continue in full force.

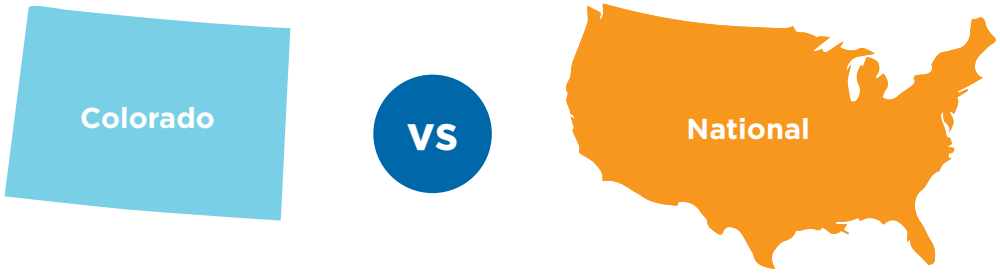


Injury

Colorado		National
#1	Leading cause of death for kids under 19	#1
213	Children died from injuries	12,174

Prematurity Prevention

Prematurity prevention will also continue to be one of our top priorities. Short gestation is the second leading cause of death for children under the age of 1, just behind congenital abnormalities.[42] Children's Colorado is a partner in the Colorado Institute for Maternal Fetal Health and offers comprehensive care and treatment both before and after birth for high-risk pregnancies. We also collaborate with organizations like the March of Dimes to increase public awareness of prematurity, support research to understand the underlying causes, and provide long-term care for children who suffer complications from premature birth.

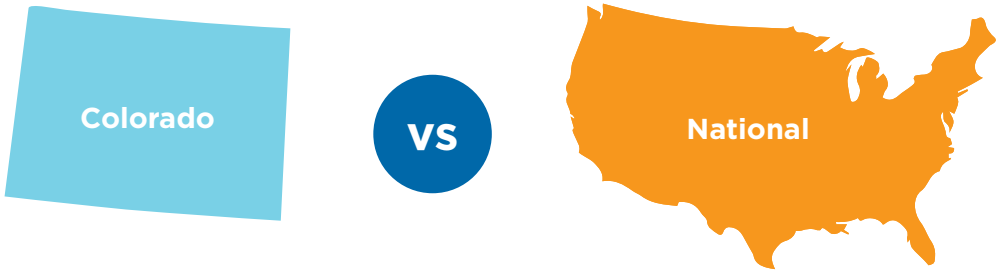


Prematurity

8%	Premature birth rate	10%
15%	African American women	13%

Respiratory Illness

Because respiratory illness is one of the leading causes of inpatient and outpatient visits for all of our facilities, we are also committed to improving respiratory care for Colorado kids. Our Breathing Institute provides cutting edge research and professional development for pulmonary care providers. In addition, we offer comprehensive clinical care, family support services, and outreach with schools and other groups that are responsible for helping children manage their respiratory conditions.



Respiratory Illnesses

9%	Kids with asthma	9%

Other Needs

While the hospital is genuinely concerned about the wide range of issues raised through this assessment, we acknowledge that some of the topics that are important to community members are not on our list of priority needs. Specifically:

- The cost of health care is an important issue that impacts all members of our community. Children's Colorado has been and will continue to be a strong advocate for policy changes that make health care more affordable. We will also continue to offer charity care when and where appropriate and will work with all of our patients and families to do what we can to make the care we offer affordable.
- Parent education is another area where we have significant efforts under way. We offer a resource-rich website, conduct regular parenting seminars, and work with the local media to inform parents about important health matters. All of this work will continue.
- Safe neighborhoods and places to play ranked as one of the top issues in our online survey. We believe that concerns about safe play spaces are closely related to concerns about physical activity. While we feel that we don't have adequate resources to address the numerous economic and social reasons that children may be living in unsafe neighborhoods, we will be cognizant of the need to include low-income children in our efforts to increase physical activity.
- Childcare is an issue that deeply impacts child health and wellbeing. While we vigorously support any and all efforts to make childcare more affordable, more available and better quality, we feel that we are not the best organization to be on the forefront of this issue. We are, however, participating with partner organizations in legislative and regulatory efforts to make quality childcare more affordable and accessible.

Conclusion

The findings of this community health needs assessment will have important implications for our organization for years to come. We are grateful to the more than 470 individuals who have contributed to this report through interviews, focus groups and surveys. We believe that we have heard from a representative group of community members and we take seriously all of the issues, ideas, and concerns that have surfaced through our conversations.

The next step in this process will be to develop an implementation plan that will spell out in detail the ways that we plan to address the priority needs of mental health, obesity/nutrition/physical activity, and oral health. The implementation plan will be available by May 2016 and will provide a three-year roadmap for our work. We look forward to working with our many community partners to develop effective and innovative approaches to addressing these entrenched issues.

We hope to continue to hear from the community about concerns and ideas, and we welcome additional feedback and comments on our needs assessment process, the contents of this report, and our implementation plan. We have created an online forum for reactions to this report and for general input about our community work. We invite interested parties to view this report online at **childrenscolorado.org/events-community/community/community-health-needs** and to leave responses at **communitybenefit@childrenscolorado.org**.

Children's Hospital Colorado is committed to making Colorado a healthier place for all kids. Together with our partners, we know that we can improve the mental, emotional, physical and oral health of children in our state. We recognize that the challenge before us is significant, but we look forward to the work ahead.

APPENDIX A – KEY INFORMANT INTERVIEW GUIDE

Name: _____

Date of Interview: _____

Organization: _____

Title: _____

Organization

I would like to confirm that your organization's primary business is _____?

What target population (s) do you primarily serve? (**Prompt:** age range and type of population)

What geographic area do you primarily serve?

Approximately how many individuals do you serve annually?

Health Needs

In thinking specifically about children (birth to 17) in the geographic area that you serve, in your opinion, what do you think are the (3) most critical health needs or concerns for children?

- Critical Health Need #1_____
- Critical Health Need #2 _____
- Critical Health Need #3 _____

Prompt: I will now ask a series of questions for each of the critical health needs you identified

Critical Health Need # 1

Why do you consider this a high priority need or concern?

Are there specific age groups or other subgroups of children who are most vulnerable?

(**Prompt:** Infants (0-1), Toddlers (1-3), Preschoolers (3-5), Middle Childhood (6-11), and Young Teens (12-17), low-income children, minority children, immigrant children)

Based on your experience and expertise, what kinds of family or community circumstances typically create barriers to addressing this critical health need?

Does your organization have programs designed specifically to address this need?

Are there "other" efforts in the community that are specifically addressing this need?

What is your perception of the role that Children's Hospital plays in addressing this need?

What is your vision of how a hospital, or a hospital in partnership with a community organization, could best address this need?

Critical Health Need # 2

Why do you consider this a high priority need or concern?

Are there specific age groups or other subgroups of children who are most vulnerable?

(**Prompt:** Infants (0-1), Toddlers (1-3), Preschoolers (3-5), Middle Childhood (6-11), and Young Teens (12-17), low-income children, minority children, immigrant children)

Based on your experience and expertise, what kinds of family or community circumstances typically create barriers to addressing this critical health need?

Does your organization have programs designed specifically to address this need?

Are there "other" efforts in the community that are specifically addressing this need?

What is your perception of the role that Children's Hospital plays in addressing this need?

What is your vision of how a hospital, or a hospital in partnership with a community organization, could best address this need?

Critical Health Need # 3

Why do you consider this a high priority need or concern?

Are there specific age groups or other subgroups of children who are most vulnerable?

(**Prompt:** Infants (0-1), Toddlers (1-3), Preschoolers (3-5), Middle Childhood (6-11), and Young Teens (12-17), low-income children, minority children, immigrant children)

Based on your experience and expertise, what kinds of family or community circumstances typically create barriers to addressing this critical health need?

Does your organization have programs designed specifically to address this need?

Are there "other" efforts in the community that are specifically addressing this need?

What is your perception of the role that Children's Hospital plays in addressing this need?

What is your vision of how a hospital, or a hospital in partnership with a community organization, could best address this need?

Conclusion

We are looking for additional input for our community health needs assessment. Would your organization be interested in helping us with any of the following:

- Referring individuals to focus groups
- Providing lists of individuals we could include in an online survey
- Providing written feedback on the previous assessment, which was conducted in 2012
- Providing input on how to prioritize the current needs once we have completed our data collection?

Are there any other resources we should consider as part of this assessment?

APPENDIX B – FOCUS GROUP GUIDE

Topic	Time	Notes
Arrival	5 minutes	Check-in with greeter
Welcome	5 minutes	Overview of the process Assurances of anonymity Introduction of other team members Norms and expectations – talk to one another not to the facilitator, the facilitator will jump in if we get off topic or if we need further explanation and will give a time warning when we are nearing the end of time for one question and need to move on to the next question
Introductions/ Warm-up	5 minutes	First Names Number and ages of children in the home
Health Needs	15 minutes	Thinking specifically about children, what would you say are the biggest health needs or problems in the community?
Resources	15 minutes	Do you feel that people in the community are aware of the health care services that are available to them? Where do people in your community go to get information about the health care services that are available to them?
Role of Children's Colorado	10 minutes	What are some things that come to mind when you think about Children's Hospital Colorado? What are some things that a hospital could do to help address the needs that we identified at the start of this discussion?
Paperwork	5 minutes	Complete forms for gift cards Complete written survey

APPENDIX C – PRIORITIZATION CRITERIA

Prioritization criteria considered:

- **Scale** – how many children are impacted by the issue?
- **Impact** – how significantly does the issue impact the lives of those touched by it?
- **Growth** – are more children impacted by the issue now than in the past?
- **Community importance** – how important is this issue to the community members who have been part of the assessment?
- **Vulnerable populations** – does this issue disproportionately impact low income and/or other vulnerable populations?
- **Mission alignment** – would addressing this issue be in alignment with the mission of the hospital?
- **Existing resources** – are there already other resources in the community that are adequately addressing this issue?
- **Capacity** – does the hospital have the skills and resources to address this issue?
- **Viability** – is it likely that putting resources and effort into addressing this issue will lead to substantive change?
- **Sustainability** – are resources available (either currently or in the future) to support the work over the long term?

Prioritization criteria selected:

- **Scale** – how many children are impacted by the issue?
- **Impact** – how significantly does the issue impact the lives of those touched by it?
- **Community importance** – how important is this issue to the community members who have been part of the assessment?
- **Sustainability** – are resources available (either currently or in the future) to support the work over the long term?

APPENDIX D - 2013-2015 CHNA REVIEW

Children's Hospital Colorado

Overview of 2013-2015 Community Health Needs Assessment Implementation Strategy

Author: Lorann Stallones, MPH, PhD

COMMUNITY PARTNERSHIP GOAL: Increase the level of engagement with community partners specific to the 4 priority health needs identified in the 2012 CHNA.

Overall considerable effort has gone into developing and maintaining partnerships with a number of organizations that address the 4 priority health needs (access to health care, obesity, injury and mental health). However, the specific strategies that were proposed have not been implemented and there is a need to tie the development of partnerships more directly to the 4 priority areas. This goal has been met.

COMMUNITY CAPACITY GOAL: Help build community capacity to advance community health improvement efforts.

Several specific activities that have been conducted directly address building community capacity to advance community health efforts through training of community members which is described under the Family Leadership Training Institute and the Advocacy Boot Camp. Following the activities of those trained in these programs will help establish the utility of these programs to accomplish stated goals and provide valuable information to determine if these programs can be expanded to meet this goal in other communities. This goal has been addressed.

HEALTH LITERACY GOAL: Improve the health literacy of Colorado Children

This is a cross cutting goal that has the potential to impact all 4 priority areas. The increase in availability of the Health Teacher resource clearly addresses this overall goal. To be useful in assessing progress toward meeting goals within the 4 priority areas, the aspects of the program that address those topics could be reviewed as well as the adoption of those in the schools where access was provided. This goal has been addressed.

PUBLIC POLICY GOAL: Lead and support policy efforts that have the potential to improve the health and safety of Colorado Children.

This goal has been met through the identification and support of legislative activities that impact access to care, child care facility oversight, addressing unmet needs in behavioral health care, and other topics related to issues identified in the Community Health Assessment Report 2012.

ACCESS TO CARE GOAL: In partnership with others, increase the number of Colorado children with access to health services by 2020.

Significant activities have targeted this goal. While the goal has not been met because the target end date in 2020, there is evidence that these activities are likely to result in meeting the target. Monitoring of the changes in the number of children covered will be needed to measure successful completion.

OBESITY GOAL: In partnership with others, work to achieve the Healthy People 2020 goal to reduce childhood obesity in Colorado by 10 percent by the year 2020.

Activities that have been underway during this period of time address changes that will need to be in place in order to accomplish this goal. However, it might be more useful to set a target that is more specific for the areas where the activities are taking place since a statewide goal may not be achieved while local areas may achieve the target reduction. Data for the local areas may be needed to monitor the success of this target.

INJURY PREVENTION GOAL #1: In collaboration with statewide partners, work to achieve the Healthy People 2020 goal of increasing age-appropriate vehicle restraint system use in children aged birth to 8 years.

Significant efforts have been focused on addressing this goal and it is likely that it can be met but there needs to be a baseline number from which to assess the success of the activities.

INJURY PREVENTION GOAL #2: In collaboration with statewide partners, work to achieve the Healthy People 2020 target setting method of reducing nonfatal child maltreatment among children aged 0-4 years by 10 percent.

Significant activities address this goal and for the period involved this goal has been met, but it will not be possible to determine whether the goal for 2020 is met unless there is an established baseline.

MENTAL HEALTH GOAL: Improve access to mental health services for Colorado children.

Activities related to this goal indicate that progress is being made to improve access to mental health services. Based on the qualitative data from the community health assessment it might be useful to consider the language being used. Since life skills training and coaching were suggested by the community group, it would be useful to assess these activities in the community and ensure they have been incorporated into the strategy to meet this goal.

Overall there is evidence of good progress in meeting most of the goals set. Improvements could be made in expanding the mapping exercise related to motor vehicles to incorporate other aspects of the overall plan including mapping access to healthy foods and safe exercise areas, quality of housing, and other topics of interest specifically related to the outcomes of concern. If the overarching goals and strategies were incorporated within the specific 4 priority areas it might be clearer how they are contributing to meeting the goals within those areas.

APPENDIX E – COMMUNITY RESOURCES

Note: The following list was generated through conversations with stakeholders and community members. It is not intended to be a comprehensive list of all community resources

Behavioral Health	
Judy's House	http://www.judishouse.org
Aspen Center	http://www.aspencounselingcenter.com/welcome
Aurora Mental Health Center	http://www.aumhc.org
Catholic Charities	http://www.ccharitiescc.org/
Children First	http://www.ccfor.org/
Community Reach Center	http://www.communityreachcenter.org
Denver Health	http://www.denverhealth.org
Head Start Programs	http://eclkc.ohs.acf.hhs.gov/hslc/HeadStartOffices
Jefferson Ctr. Mental Health	http://www.jcmh.org/
Jewish Family Services	http://jewishfamilyservice.org
Maria Droste Counseling Center	http://www.mariadroste.org
Mental Health Corporation of Denver	http://mhcd.org/about-us
Rocky Mountain Youth Clinic	http://www.rmyclinics.org/about
Second Wind Foundation	http://www.thesecondwindfund.org

Obesity	
Child Health/ Early Childhood Obesity Prevention (ECOP)	https://www.colorado.gov/pacific/cdphe/ecop
Hunger Free Colorado	http://www.hungerfreecolorado.org
LiveWell	http://livewellcolorado.org
Metro Community Provider Network	http://mcpn.org/about-us
Rocky Mountain Youth Clinic	http://www.rmyclinics.org/about

Physical Activity	
Healthy Eating Active Living (HEAL)	http://livewellcolorado.org/healthy-policy/heal-cities-and-towns
Metro Community Provider Network	http://mcpn.org/about-us

Nutrition	
Boys and Girls Club Denver	http://www.bgcmd.org
Boys and Girls Club Pikes Peak	http://www.bgcppr.org
Broomfield Public Library	http://www.ci.broomfield.co.us/library
Colfax Community Network	http://colfaxcommunitynetwork.org
Colorado Farm to Table	http://coloradofarmtotable.org
Comitis Crisis Center	www.coloradogives.org/ComitisCrisisCenter
Cooking Matters	http://www.cookingmatters.org
Epworth Foundation	http://epworthfoundation.org
Hunger Free Colorado	www.hungerfreecolorado.org
Jeffco Community Health Improvement Network	http://www.chd.dphe.state.co.us/chaps
Metro Community Provider Network	http://mcpn.org/about-us
Rocky Mountain Youth Clinic	http://www.rmyclinics.org/about

Dental	
Metro Community Provider Network	http://mcpn.org/about-us
Oral Health Colorado	http://oralhealthcolorado.org
Rocky Mountain Youth Clinic	http://www.rmyclinics.org/about

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