2022 Community Health Needs Assessment
October 2022

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Executive Summary

Overview of Vail Health

Vail Health is a nonprofit community healthcare system serving patients and guests from around the world. We are guided by the mission to elevate health across our mountain communities and by our vision to be the leading mountain healthcare system attracting the best talent to advance quality health for everyone in our communities.

The Vail Health System is made up of several health care entities including Vail Health Hospital, Colorado Mountain Medical (CMM), Eagle Valley Behavioral Health (EVBH), Howard Head Sports Medicine (HHSM), Shaw Cancer Center, the Vail Valley Surgery Center, the Dillon Surgery Center and the Steadman Philippon Surgery Center

Regulatory Requirements

Under Internal Revenue Service section 501(r)(3)(A), all nonprofit hospital organizations must complete a Community Health Needs Assessment (CHNA) once every three years and adopt an implementation strategy to meet the community health needs identified through the CHNA. The CHNA must take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and be made widely available to the public.

This report is available to the public at: https://www.vailhealth.org/about/community-health-needs. A paper copy of this report can be made available upon request by emailing Amy Lavigne, Vail Health's Director of Quality.

Purpose of the CHNA Report

The purpose of this CHNA Report is to identify and prioritize significant health needs of the community served by the Vail Health System. The priorities identified will help to support Vail Health's ongoing commitment to community health by guiding future community health initiatives and community benefit activities. In addition, the 2022 CHNA was used to develop a 2022 Implementation Strategy which is a written plan describing Vail Health's community health areas of priority and approaches for addressing the needs of the community identified.

CHNA Methodology

A multi-phased approach, which included quantitative and qualitative research methods, was used to identify and analyze priority community health needs within Eagle County. The process included:

- A comprehensive analysis of health and population health-related data - including demographic, economic, and social indicators
- Facilitation of 13 partner and community focus groups which solicited community input to identify the community's health needs
- Creation of a Gap Analysis which identified existing community needs and strategies to address them

Impact of Previous CHNA Implementation Strategy (2019)

In 2019, Vail Health completed a CHNA and developed a supporting, three-year Implementation Strategy to guide community benefit activities across Eagle County. Vail Health committed to devote resources and expertise to address the health need priorities identified through the prioritization process:

1. Access to Care;
2. Behavioral Health;
3. Chronic Disease; and
4. Health Equity.

The following is an evaluation of the programs, services, initiatives, and partnerships sponsored by Vail Health to address the health priorities identified in the 2019 CHNA.

PRIORITY 1: ACCESS TO CARE

Increasing access to quality, affordable, and comprehensive health care was a continuing priority identified in the 2016 and the 2019 CHNA Implementation Plans. Since 2019, the following strategies have been implemented to address access to care for Vail Health's community.

- **Community Health Program** - In a continued partnership between Vail Health and MIRA (Mobile Intercultural Resource Alliance), the Community Health Program kicked off in June 2021 to offer free healthcare screenings aimed at identifying diabetes and cardiac disease to uninsured residents of Eagle County. The free screenings and consultation with a medical provider offer increased awareness regarding risks for diabetes and cardiac disease and the opportunities for individuals to implement interventions and lifestyle changes to mitigate those risks. Community health screenings consist of a comprehensive evaluation of the individual's social history, family medical history, health status, and lifestyle. By identifying and addressing social determinants of health such as health coverage, food insecurity, housing, and health literacy, the Community Health Program provides patient-centered care that promotes whole person wellness. In addition to screenings, this program also offers community fitness classes and nutritional education and consultation. The majority of patients seen are low income, Spanish speaking, and many are undocumented. The trust built by MIRA in the most vulnerable neighborhoods in our community has helped to increase patient volumes for the program and increase access to critical health screenings for individuals who do not have a medical home. Patients are referred for follow up treatment at Mountain Family Health Center (MFHC), our community's Federally Qualified Health Center (FQHC) for ongoing care.

Total # of patients screened/served in YR 1 (Jul 21-Dec 21)	**136**
Total # of patients screened/served in YR 2 so far (Jan 22-Oct 22)	**203**
Total # of patients referred to MFHC (Jul 22-Oct 22)	**42**

- **Provide support for community-based organizations offering free and reduced cost health care services**[1]
    - **Support MIRA Bus** - Vail Health donated a mobile 72' RV outfitted as a medical clinic to the Eagle Valley Community Foundation in late 2018 to travel to neighborhoods, community sites and workplaces throughout Eagle County to offer a variety of resources

[1] Proposed ***Access to Care*** strategy 2 of 9 from Vail Health's 2019 Implementation Strategy

and services to address comprehensive health and Social Determinants of Health (SDoH) gaps to the communities with the largest disparities. Vail Health continues to provide ongoing financial support for this program. Examples of resources and services offered include health education and screenings, support in applying to public assistance programs, food resources, workforce development, and coordination with early childhood and physical activity programming.

- **Support of Mountain Family Health Center (MFHC)** - Vail Health financially supports the local Federally Qualified Health Center (FQHC) in Eagle County through subsidized rent for clinical space in Edwards, CO. In January 2023, Vail Health expanded its support and facilitated the clinic's relocation to Avon, CO, into a clinical location that provides patients with greater accessibility via the public transportation system, further increasing access to care. Vail health is fully covering MFHC rent for the next 5 years in this new location. In addition, Vail health has provided $155,000 in funding to MFHC over the past two years to support their integrated behavioral health program.

- **Support of Mobile Behavioral Health Crisis Response System** - Vail Health provides significant funding support for our local mobile behavioral health crisis response system operated by Your Hope Center. Your Hope Center crisis clinicians work in partnership with community paramedics and local law enforcement to respond to all 911 behavioral health calls, meeting patients at their point of need in the community. Your Hope Center is the only crisis organization in the state that is staffed to respond 24 hours a day, 7 days a week, 365 days a year. The goal is to provide care, assessment and stabilization in the community versus transporting patients to the hospital or county jail. To date, we have seen a 74% reduction of behavioral health transports that previously would have been transported to the hospital emergency department and county jail, saving patients and the healthcare system approximately.

➢ **Olivia's Fund -** Olivia's Fund was developed by Vail Health in April 2020 to provide up to six free mental health and/or substance use sessions per year for anyone who lives or works in Eagle County and demonstrates a basic financial need. Olivia's Fund provides in-person or virtual counseling with over 100 in network licensed clinicians at no cost to patients in our community, regardless of insurance or immigration status.

Therapy sessions provided 2020-2021	**More than 1800**
Therapy sessions provided 2021-2022	**More than 3200**

➢ **Family Connects Program** - Vail Health partnered with Eagle County Public Health to launch the Family Connects program in October of 2022. This is an evidence-based program that connects parents of newborns to the community resources they need through universally available postpartum nurse home visits. Through a partnership with Vail Health, we are ensuring every parent of a child born in Eagle County has the opportunity to receive a free home visit to support them in this critical moment of the family's life.

➢ **Provide health insurance eligibility and enrollment assistance for uninsured residents accessing services**[2]

[2] Proposed ***Access to Care*** strategy 7 of 9 from Vail Health's 2019 Implementation Strategy

- **Medicaid Community Outreach & Enrollment** - Vail Health employs dedicated, bilingual Medicaid Enrollment Specialists to help screen uninsured residents for Medicaid eligibility and other healthcare funding options, such as Connect for Health Colorado or the Mountain Family Health Center Sliding Scale program. Vail Health staff work with clients to get them screened for various Social Determinants of Health and help them get enrolled in community benefit programs as well as connect them to other local resources, such as transportation, childcare and food services to meet their needs.

  Total # lives approved for Medicaid (Mar 21-Oct 22**)** **353**

➢ **Continue recruitment efforts and partnership opportunities to bring specialty care physicians to Eagle County[3]**

- **Expansion of Specialty Care** - In the past few years CMM and VH have added physicians in the following specialties: 1 Ophthalmologist, 1 Otolaryngologist, 1 Endocrinologist, 2 Dermatologists, and 3 Psychiatrists.

- **Integrated Behavioral Health at CMM -**CMM, a primary care practice serving over eighty percent of local residents in the Eagle River Valley, was acquired by Vail Health in July 2019. This acquisition made it possible to integrate behavioral health providers into the primary care practice to offer outpatient and integrated behavioral health care across the community. This increased access to behavioral health care with providers who accept all commercial and public insurance. Previously less than 2% of private providers in the community were accepting insurance. Behavioral healthcare is now the largest service line at CMM, serving more patients each month than are seen for primary or other specialty care services at the practice.

- **Behavioral Health Case Management** - In October of 2021, the behavioral health case management program was launched as a non-clinical, non-emergent community-based service to help Eagle County residents navigate the complex system of behavioral health care and connect people to available resources and services that best meet their needs when they experience barriers to access. The Behavioral Health Case Managers provide support and help coordinate services with clients. The Behavioral Health Case Managers are bilingual in Spanish. To date, 395 clients have received services and have been connected to resources such as outpatient therapy, crisis services, employment assistance, insurance assistance, and more.

- **Mountain Strong Employee Assistance Program (EAP) -** In December 2019, Vail Health established a new and innovative behavioral health employee assistance program (EAP), known as “Mountain Strong,'' for Vail Health employees and dependents. This pilot program was designed to increase access to local behavioral healthcare. In prior years, behavioral health services were available through the hospital's existing EAP, however, the employee benefit was only utilized by 1.7% of employees across the healthcare system. Mountain Strong panels local, licensed behavioral health providers and provides six free sessions per incident per year to all employees and dependents. Utilization of the behavioral health EAP increased to over 16% in the first year and to over 20% in the second year of implementation. Mountain Strong has over 100 licensed providers in the

[3] Proposed ***Access to Care*** strategy 1 of 9 from Vail Health’s 2019 Implementation Strategy

network and is now serving 10 local businesses, covering approximately 8,000 lives in Eagle County: more than any other commercial payer in our community.

Therapy sessions provided 2020-2021	**More than 2600**
Therapy sessions provided 2021-2022	**More than 2900**

- **Explore options and partners to provide transportation to access health and social services**[4]
  - **Transportation for Seniors to Access Health Services -** Vail Health supports Eagle County Public Health and Environment's Healthy Aging Program with funding to support transportation services for Eagle County seniors who face transportation barriers to accessing healthcare appointments.
  - **Community Paramedicine Program -** Vail Health partners with Eagle County Paramedics to support the Community Paramedic Program to provide patient care in the home for both short-term and long-term management of referred patients from local healthcare providers and hospital staff. Community Paramedics provide general services such as home blood draws, vital signs and weight checks, oxygen saturation checks and immunizations, as well as patient education, disease management and follow up care and social, home safety and screenings.
  - **Transportation Support for Detox and Victims First Care Patients -** Vail Health contracts with Ride Taxi to provide free transportation services for patients going to and from a detox facility, as well as for individuals accessing services through the Victims First Care Program, a program that provides sexual assault nurse examinations and forensic nurse examinations to victims of assault.
- **School-Based Clinicians** - Vail Health partnered with Eagle County Public Health, Eagle County School District, and Your Hope Center in 2019 to increase the number of licensed behavioral health clinicians located in middle and high schools in the Eagle County School District. As of the 2022-23 school year, there is a licensed clinician assigned to every K-12 school in the district to provide assessment, therapy and referrals for students during the school day, reducing barriers to treatment and increasing access to care.
- **Explore options to increase evaluation services and access to occupational and speech therapies for youth with developmental disabilities**[5]
  - **Speech Therapy Program at Howard Head Sports Medicine (HHSM)** - In November 2021, Vail Health launched a new Speech Therapy program at Howard Head Sports Medicine (HHSM), the first in Eagle County. The Speech Therapy team consists of 2 Speech Language Pathologists who evaluate and treat both children and adults with disorders in the areas of speech, language, cognition, voice, and swallowing.
- **Community Health Workers -** A service that helps Eagle County residents navigate the complex healthcare system and connects people to available resources that best meet their needs when they experience barriers to care. The community health workers partner with several agencies in

[4] Proposed ***Access to Care*** strategy 2 of 9 from Vail Health's 2019 Implementation Strategy

[5] Proposed ***Access to Care*** strategy 3 of 9 from Vail Health's 2019 Implementation Strategy

the community that have been identified as "entry-points" to ensure people have someone to help them access care. Through integrated community outreach and care coordination, community health workers promote wellness and improve the health of the community. Additionally, community health workers provide informal counseling, health education, social support, and advocacy for the health needs of individuals and the community.

- **Promote and support candidate entry into careers in the healthcare field**[6]
    - **Support the Colorado Mountain College Surgical Technology Program to increase the number of college students pursuing a career as a Surgical Technologist**
    - **Behavioral Health Scholarship Program:** Since 2020, Vail Health Behavioral Health has supported 5 bilingual, bicultural local women in obtaining their master's degree in Social Work through Denver University, with two additional currently enrolled in the program with an expected graduation date of May 2023. In addition, these individuals were supported in obtaining internship placements across the Vail Health System and various partner organizations to accrue hours toward their licensure, leading to subsequent full-time employment opportunities for all.

PRIORITY 2: BEHAVIORAL HEALTH

Reducing substance use disorder in our community and improving outcomes for people with a mental health and/or substance use disorder and their families was one of the identified community health priorities from the 2019 CHNA. Since 2019, the following strategies, programs, and initiatives have been implemented to address availability and delivery of behavioral health care for Vail Health's community.

- **Creation of Behavioral Health Non-Profit and Behavioral Health Service Line -** In July 2019, Eagle Valley Behavioral Health (EVBH) was established by a $60 million dollar commitment over 10 years by Vail Health to transform the community's behavioral health system. In addition, Vail Health committed to raising an additional $100 million over the next 10 years, as well as building an $60 million 28 bed psychiatric hospital bringing the total financial commitment to $220 million to support behavioral health services in Eagle County. EVBH serves as a backbone organization leading community collaboration with over 30 local partners including law enforcement, the school district, county government and nonprofits to transform Eagle County's behavioral health system of care. This includes collecting and reporting data to measure the impact of behavioral health strategies to ensure long-term success as we work to improve health outcomes over time.

- **Community Benefit and Fundraising Support for Partner Nonprofits -** Since January 2020, Vail Health has provided over $9.8 million dollars in funding to support community partners in providing behavioral health services in the community, including prevention, education, peer support, crisis intervention, provider recruitment, and school-based services. In addition, the Vail Health Foundation actively raises funding and applies for grants to support over 30 local community nonprofit organizations to support behavioral health programming in the community.

- **Develop a comprehensive, cross-functional behavioral health facility, with plans to include a bus stop linking the campus to the county's ECO transit system.**[7]

[6] Proposed ***Access to Care*** strategy 9 of 9 from Vail Health's 2019 Implementation Strategy

[7] Proposed ***Behavioral Health*** strategy 1 of 6 from Vail Health's 2019 Implementation Strategy

- **Edwards Community Health Campus** - Vail Health is building a community health campus centrally located in Edwards, CO in partnership with local nonprofits who serve the community. In addition to the future site of the inpatient psychiatric hospital, this campus is currently home to outpatient behavioral health services, clinical engagement and case management, the community's food pantry, a youth center focusing on the needs of first generation middle and high school students, and future site of a new specialty outpatient behavioral health clinic to provide innovative treatment services.

- **Precourt Healing Center Inpatient Hospital** - Vail Health has begun construction of a 60 million dollar, 28-bed in-patient psychiatric hospital (14 beds for adolescents and 14 beds for adults) in Edwards, Colorado. The facility is scheduled to open by 2025. This 50,000 square-foot facility will reduce the need for our community members to be transported over two hours away to seek this level of inpatient behavioral healthcare and will support the continuum of behavioral health services now offered in our community.

- **Wiegers Family Mental Health Clinic -** Construction has been completed on a high-acuity outpatient Behavioral Health Clinic which has added four large group rooms and over six private treatment offices to our clinical treatment team.

- **Community Mental Health Center (CMHC) Designation Obtained** - In July 2021, Vail Health's Eagle Valley Behavioral Health was designated by the Colorado Office of Behavioral Health as the first new Community Mental Health Center (CMHC) in the state of Colorado - the only organization to receive this designation in the past 40 years.

- **Behavioral Health Entity (BHE) Licensure Obtained** - In January 2022, Vail Health's Eagle Valley Behavioral Health became the first organization in Colorado to receive licensure as a Behavioral Health Entity (BHE). This licensure was the final step needed to complete the process of receiving designation as the 18th Community Mental Health Center (CMHC) in Colorado.

➢ **Improve behavioral health provider access and capacity by attracting and retaining providers, implementing telemedicine services, exploring innovative ways to lower care access barriers, and integrating behavioral health care into all primary care settings to include behavioral health screenings at all primary care visits.**[8]

- **Integrated Behavioral Health at CMM -** CMM, a primary care practice serving over eighty percent of local residents in the Eagle River Valley, was acquired by Vail Health in July 2019. This acquisition made it possible to integrate behavioral health providers into the primary care practice to offer outpatient and integrated behavioral health care across the community. Behavioral healthcare is now the largest service line at CMM, serving more patients each month than are seen for primary or other specialty care services at the practice.

- **Master of Social Work Scholarship** - Vail Health supports a partnership with a local nonprofit, My Future Pathways, and Denver University's Graduate School of Social Work to support local Spanish speaking youth who are seeking to obtain their Master of Social Work. This partnership supports youth so they can stay in their community as they pursue

[8] Proposed ***Behavioral Health*** strategy 2 of 6 from Vail Health's 2019 Implementation Strategy

higher education, secure internships within their fields, and obtain employment in the behavioral health field. This program increases provider access and capacity by growing the workforce and prioritizing bilingual students who can help fill a dire need for Spanish-speaking providers.

- **Behavioral Health Loan Repayment Program -** Vail Health partnered with My Future Pathways to administer a loan repayment program as a recruitment and retention tool for licensed behavioral health providers who serve the Eagle County community. Recipients of this program commit to five years of service providing accessible care for our community either by working at an approved community organization or by participating in Olivia's Fund and Mountain Strong as a provider. To date, this program has supported 21 individuals working across 6 different organizations in our valley.

- **Olivia's Fund -** Olivia's Fund provides up to six free mental health and/or substance use sessions per year for anyone who lives or works in Eagle County and demonstrates a basic financial need. Olivia's Fund provides in-person or virtual counseling with over 100 in network licensed clinicians at no cost to patients in our community, regardless of insurance or immigration status.

- **Mountain Strong Employee Assistance Program (EAP) -** In December 2019, Vail Health established a new and innovative behavioral health employee assistance program (EAP), known as "Mountain Strong", for Vail Health employees and dependents. This pilot program was designed to increase access to local behavioral healthcare. In prior years, behavioral health services were available through the hospital's existing EAP, however, the employee benefit was only utilized by 1.7% of employees across the healthcare system. Mountain Strong panels local, licensed behavioral health providers and provides six free sessions per incident per year to all employees and dependents. Utilization of the behavioral health EAP increased to over 16% in the first year and to over 20% in the second year of implementation. Mountain Strong has over 100 licensed providers in the network and is offered to over 10 local businesses, serving approximately 8,000 lives in Eagle County: more than any other commercial payer in our community.

➢ **Promote a county-wide coordinated approach to behavioral health care through continuous communication, systems, and plans among partner organizations, and establishment of a community-wide behavioral health electronic medical record exchange.**[9]

- **Community EHR and Coordinated Approach to Behavioral Health** - While a single EHR for all Behavioral Health (BH) partner organizations in the Valley is impossible at this time due to excessive costs and workforce shortages to pull off such an project, a coordinated approach to Behavioral Health is not. Eagle Valley Behavioral Health (EVBH) facilitates regular meetings with community partners to discuss continuous communication, systems, and plans regarding BH in the Valley.

- **Community Health Workers -** A service that helps Eagle County residents navigate the complex healthcare system and connects people to available resources that best meet their needs when they experience barriers to care. The community health workers partner with several agencies in the community that have been identified as "entry-

[9] Proposed ***Behavioral Health*** strategy 3 of 6 from Vail Health's 2019 Implementation Strategy

points" to ensure people have someone to help them access care. Through integrated community outreach and care coordination, community health workers promote wellness and improve the health of the community. Additionally, community health workers provide informal counseling, health education, social support, and advocacy for the health needs of individuals and the community.

- **Behavioral Health Case Management** - In October of 2021, the behavioral health case management program was launched as a non-clinical, non-emergent community-based service to help Eagle County residents navigate the complex system of behavioral health care and connect people to available resources and services that best meet their needs when they experience barriers to access. The Behavioral Health Case Managers provide support and help coordinate services with clients. They have extensive background in behavioral health, but they are not licensed therapists. The Behavioral Health Case Managers are bilingual in Spanish. To date, 395 clients have received services and have been connected to resources such as outpatient therapy, crisis services, employment assistance, insurance assistance, and more.

- **Community Stabilization Program** - Vail Health partnered with Your Hope Center to develop and launch a Community Stabilization Program in November of 2021. This program provides comprehensive, individualized wrap-around services to those most at-risk individuals. These services are intended to prevent psychiatric hospitalization and keep individuals at home in their natural environment in the community while they stabilize and heal through a set of diligently followed protocols to ensure their safety.

  Positive impact from November 2021 - August 2022:

  181 Clients served via 1,822 encounters
  33% under the age of 18
  66% referred by Your Hope Center
  16% referred by Vail Health ED
  86% of individuals enrolled via Mental Health Crisis Track
  14% of individuals enrolled via Primary Substance Abuse Track

➢ **Provide prevention and education initiatives to increase protective factors and decrease common risk factors for behavioral health issues, with a focus on civic engagement, social connections, and stigma reduction.**[10]

- **Anti-Stigma Campaign** - Over the past three years, Vail Health has invested in a comprehensive marketing campaign launched in October 2019 aimed at mental health prevention, education and reducing stigma to encourage local residents to seek help from new behavioral health services now available in the community.

- **Peer Support Groups -** Vail Health launched behavioral health peer support programs in 2020 to offer ongoing group-oriented care with a qualified and vetted group leader for community members looking to connect with individuals with similar lived experience. Peer groups have been formed to support a variety of populations in the community, including first responders, Spanish speaking youth, men and women, LGBTQ+, loss and

[10] Proposed ***Behavioral Health*** strategy 4 of 6 from Vail Health's 2019 Implementation Strategy

grief supports, substance use, and more.

- **Provide crisis response and transition services to provide care and stabilize behavioral health patients in the field or in the privacy of their home and connect them to appropriate outpatient services.**[11]

    - **Mobile Crisis Response System** - Vail Health provides significant funding support for our local mobile crisis response system operated by Your Hope Center. Your Hope Center crisis clinicians work in partnership with community paramedics and local law enforcement to respond to all 911 behavioral health calls, meeting patients at their point of need in the community. Your Hope Center is the only crisis organization in the state that is staffed to respond 24 hours a day, 7 days a week, 365 days a year. The goal is to provide care, assessment and stabilization in the community versus transporting patients to the hospital or county jail. To date, we have seen a 74% reduction of transports to the hospital emergency department and county jail, saving patients and the healthcare system approximately.

- **Work with Eagle County School District to increase funding to support the placement of additional school-based clinicians and develop a comprehensive wellness curriculum.**[12]

    - **School-Based Clinicians** - Vail Health partnered with Eagle County Public Health, Eagle County School District, and Your Hope Center in 2019 to increase the number of licensed behavioral health clinicians located in middle and high schools in the Eagle County School District. As of the 2022-23 school year, there is a licensed clinician assigned to every K-12 school in the district to provide assessment, therapy and referrals for students during the school day, reducing barriers to treatment and increasing access to care.

PRIORITY 3: CHRONIC DISEASE

Another area identified as a community health priority from Vail Health's 2019 CHNA is reducing risk factors and premature death attributed to chronic diseases and improving quality of life for individuals with chronic diseases. Since 2019 the following strategies have been implemented to address chronic disease for Vail Health's community.

- **Collaborate with community partners to encourage healthy eating and physical activity among residents.**[13]

    - **Support MIRA Bus** - Vail Health donated a mobile 72' RV outfitted as a medical clinic to the Eagle Valley Community Foundation in late 2018 to travel to neighborhoods, community sites and workplaces throughout Eagle County to offer a variety of resources and services to the community. Vail Health continues to provide ongoing financial support for this program. Examples of resources and services offered include health education and screenings, support in applying to public assistance programs, food resources, workforce development, and coordination with early childhood and physical activity programming.

[11] Proposed ***Behavioral Health*** strategy 5 of 6 from Vail Health's 2019 Implementation Strategy

[12] Proposed ***Behavioral Health*** strategy 6 of 6 from Vail Health's 2019 Implementation Strategy

[13] Proposed ***Chronic Disease*** strategy 1 of 11 from Vail Health's 2019 Implementation Strategy

- **Support of the Community Market -** Vail Health supports the Eagle Valley Community Foundations' Community Market by providing subsidized rent at a centrally located space at the Edwards Community Health Campus for the local food pantry to operate, providing fresh, healthy food to individuals in our community in need of food assistance.

➢ **Develop programs to support education, training, and tools to reduce and manage diabetes.**[14]

- **Community Health Program** - In a continued partnership between Vail Health and MIRA, the Community Health Program kicked off in June 2021 to offer free healthcare screenings aimed at identifying diabetes and cardiac disease to uninsured residents of Eagle County. The free screenings and consultation with a medical provider offer increased awareness regarding risks for diabetes and cardiac disease and the opportunities for individuals to implement interventions and lifestyle changes to mitigate those risks. Community health screenings consist of a comprehensive evaluation of the individual's social history, family medical history, health status, and lifestyle. By identifying and addressing social determinants of health such as health coverage, food insecurity, housing, and health literacy, the Community Health Program provides patient-centered care that promotes whole person wellness. In addition to screenings, this program also offers community fitness classes and nutritional education and consultation. The majority of patients seen are low income, Spanish speaking, and many are undocumented. The trust built by MIRA in the most vulnerable neighborhoods in our community has helped to increase patient volumes for the program and increase access to critical health screenings for individuals who do not have a medical home. Patients are referred for follow up treatment at Mountain Family Health Center (MFHC), our community's Federally Qualified Health Center (FQHC) for ongoing care.

Total # of patients screened/served in YR 1 (Jul 21-Dec 21)	**136**
Total # of patients screened/served in YR 2 so far (Jan 22-Oct 22)	**203**
Total # of patients referred to MFHC (Jul 22-Oct 22)	**42**

➢ **Expand the Vail Health Complex Patient Committee to address the needs of medically complex patients with chronic disease.**[15]

- **Expansion of Vail Health's Complex Patient Committee** - Over the past 3 years, Vail Health's Complex Patient Committee has evolved to focus on coordination and collaboration related to all patient populations, including the medically complex. This committee has grown beyond behavioral health partners and includes community partners from throughout the continuum of care. The committee changed its name to the Community Referral Coordination Committee due to the focus on streamlining care coordination and transitions between entities and ensuring community coordination efforts meet the needs of all patients and especially those with complex health and/or social issues. The committee meets monthly and has proven its value through effective process improvement leading to successful care coordination and improved patient outcomes.

➢ **Explore opportunities to increase providers, service locations, and available hours of operation**

[14] Proposed ***Chronic Disease*** strategy 2 of 11 from Vail Health's 2019 Implementation Strategy

[15] Proposed ***Chronic Disease*** strategy 3 of 11 from Vail Health's 2019 Implementation Strategy

for specialty care, including endocrinology and cardiology.[16]

- **Expansion of Specialty Care** - In the past few years CMM and VH have added physicians in the following specialties: 1 Ophthalmologist, 1 Otolaryngologist, 1 Endocrinologist, 2 Dermatologists, and 3 Psychiatrists. These physicians evaluate patients in Vail, Avon, Edwards, and Eagle.

➢ **Participate in and/or host free community health fairs targeting diverse populations.**[17]

- 2020: Town of Frisco Health Fair - January
- 2021: High School Physicals in Vail - June; Community Health Nutrition Talk with MIRA in Avon - July; Tournament of Connection in Eagle Villas - July; and MIRA Health and Wellness Fair in Edwards Mobile Homes - October
- 2022: Aging Well EXPO in Edwards - May; High School Physicals in partnership with Steadman, Edwards, and Eagle - May; Senior Summit Resource Fair, Frisco - June; and Four MIRA Resource and Health Fairs - June & July (Two Rivers, Dotsero; The Aspens Mobile Home Community, Avon; Eagle Villas, Eagle; Eagle River Village Mobile Home community, Edwards).

➢ **Care Coordination -** CMM added care coordinators to their staff to allow careful management of the high-risk patient population. These positions assure that patients are provided appropriate screenings, vaccines, and specialty referrals.

➢ **Support Eagle County Paramedics to continue home visits for medication compliance, safety assessments, and the Emergency Triage, Treat, and Transport (ET3) program to address emergency health care needs for Medicare patients.**[18]

- **Community Paramedicine Program -** Vail Health partners with Eagle County Paramedics to support the Community Paramedic Program to provide patient care in the home for both short-term and long-term management of referred patients from local healthcare providers and hospital staff. Community Paramedics provide general services such as home blood draws, vital signs and weight checks, oxygen saturation checks and immunizations, as well as patient education, disease management and follow up care and social, home safety and screenings.

PRIORITY 4: HEALTH EQUITY

The final community health priority from Vail Health's 2019 CHNA was improving health-related quality of life and well-being for all individuals, with a focus on Latinx and seniors. Since 2019 the following strategies have been implemented to address health equity for Vail Health's community.

➢ **Conduct community outreach to assist Latinx residents with eligibility determination and enrollment in subsidized health insurance programs.**[19]

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16 Proposed ***Chronic Disease*** strategy 4 of 11 from Vail Health's 2019 Implementation Strategy

17 Proposed ***Chronic Disease*** strategy 6 of 11 from Vail Health's 2019 Implementation Strategy

18 Proposed ***Chronic Disease*** strategy 10 of 11 from Vail Health's 2019 Implementation Strategy

19 Proposed ***Health Equity*** strategy 1 of 8 from Vail Health's 2019 Implementation Strategy

- **Medicaid Community Outreach & Enrollment** - Vail Health employs dedicated, bilingual Medicaid Enrollment and Insurance Navigation Specialists to help screen uninsured residents for Medicaid eligibility and other healthcare funding options. Vail Health staff work with clients to help them get enrolled in community benefit programs as well as connect them to other local resources, such as transportation, childcare and food services.

➢ **Partner with the Regional Accountable Entity (RAE) to implement the Accountable Health Communities Model (AHCM) screening tool in the Emergency Department for Medicaid and/or Medicare patients, with patient navigation follow-up care provided by the RAE.[20]**

- **SDOH Screening Tool -** Vail Health partnered with the RAE to implement the AHCM screening tool for Social Determinants of Health (SDOH) as part of the Centers for Medicare and Medicaid Services' (CMS) research project. The tool was used by the hospital Social Work team for Medicare and Medicaid patients in the Emergency Department until CMS completed the project in spring 2022. Patients who screened positive were provided resources and connected to the RAE's care coordination team. Additionally, data was collected at the local and regional level by the West Mountain Regional Health Alliance as well as the RAE and has been utilized to inform housing, food, and other SDOH initiatives.

➢ **Partner with senior care providers to increase access to transitional care and wrap-around support services for senior patients.[21]**

- **Partnership with Caregiver Connections -** Vail Health began partnering with Caregiver Connections in May of 2022 to provide support for the aging population and their caregivers through case management, respite programs, support groups, activities and resource connections.

- **Partnership with Castle Peak Senior Life & Rehabilitation** - CMM partners with Castle Peak Senior Life & Rehabilitation to provide Medical Direction for this facility and daily medical services.

- **Transportation for Seniors to Access Health Services -** Vail Health supports Eagle County Public Health and Environment's Healthy Aging Program with funding to support transportation services for Eagle County seniors who face transportation barriers to accessing healthcare appointments.

➢ **Provide health education and screenings, public assistance application support, food resources workforce development, early childhood education coordination, and physical activity programming within communities, through MIRA and other initiatives.[22]**

- **Support of MIRA Bus** - Vail Health donated a mobile 72' RV outfitted as a medical clinic to the Eagle Valley Community Foundation in late 2018 to travel to neighborhoods, community sites and workplaces throughout Eagle County to offer a variety of resources

[20] Proposed ***Health Equity strategy*** 2 of 8 from Vail Health's 2019 Implementation Strategy

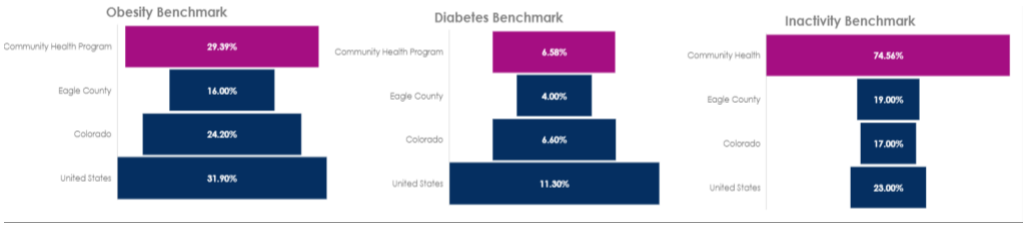
[21] Proposed ***Health Equity*** strategy 3 of 8 from Vail Health's 2019 Implementation Strategy

[22] Proposed ***Health Equity*** strategy 6 of 8 from Vail Health's 2019 Implementation Strategy

and services to the community. Vail Health continues to provide ongoing financial support for this program. Examples of resources and services offered include health education and screenings, support in applying to public assistance programs, food resources, workforce development, and coordination with early childhood and physical activity programming.

- **Community Health Program** - In a continued partnership between Vail Health and MIRA, the Community Health Program kicked off in June 2021 to offer free healthcare screenings aimed at identifying diabetes and cardiac disease to uninsured residents of Eagle County. The free screenings and consultation with a medical provider offer increased awareness regarding risks for diabetes and cardiac disease and the opportunities for individuals to implement interventions and lifestyle changes to mitigate those risks. Community health screenings consist of a comprehensive evaluation of the individual's social history, family medical history, health status, and lifestyle. By identifying and addressing social determinants of health such as health coverage, food insecurity, housing, and health literacy, the Community Health Program provides patient-centered care that promotes whole person wellness. In addition to screenings, this program also offers community fitness classes and nutritional education and consultation. The majority of patients seen are low income, Spanish speaking, and many are undocumented. The trust built by MIRA in the most vulnerable neighborhoods in our community has helped to increase patient volumes for the program and increase access to critical health screenings for individuals who do not have a medical home. Patients are referred for follow up treatment at Mountain Family Health Center (MFHC), our community's Federally Qualified Health Center (FQHC) for ongoing care.

  Health disparities identified by Community Health Program:



  The data collected is utilized to inform decisions regarding future programming for the Community Health Program, including expansion of the Community Fitness Program to offer additional free fitness classes in partnership with additional community organizations (My Future Pathways).

➢ **Partner with the Vail Valley Partnership to support workforce housing initiatives.**[23]

- **Partnership with Vail Valley Partnership -** Vail Health partners with the Vail Valley Partnership to support workforce housing initiatives.

➢ **Promote Health Equity by expanding education materials and interpretation services in Spanish and promoting hiring of bilingual staff**

[23] Proposed ***Health Equity*** strategy 4 of 8 from Vail Health's 2019 Implementation Strategy

- **Master of Social Work Scholarship** - As part of our workforce development strategy to recruit and retain qualified bilingual providers, Vail Health supports a partnership with a local nonprofit, My Future Pathways, and Denver University's Graduate School of Social Work to support local Spanish speaking youth who are seeking to obtain their Master of Social Work. This partnership supports youth so they can stay in their community as they pursue higher education, secure internships within their fields, and obtain employment in the behavioral health field. This program increases provider access and capacity by growing the workforce and prioritizing bilingual students who can help fill a dire need for Spanish-speaking providers.

- **Translation Services -** Vail Health continues to have contracts in place to provide various language access solutions, including Vail Valley Interpreters for live medical interpretation services in Spanish, MARTII, an online, video and audio-based tool providing medical interpretation services in over 250 languages, and Cesco to support translation services across all of Vail Health Systems.

- **Website Accessibility in Spanish -** In an effort to continue to make all our information available in Spanish, the second most used language in Eagle County, the Vail Health Marketing department used Google's application programming interface (API) to facilitate automatic artificial intelligence-based translation of all our websites into Spanish.

➢ **Provide reduced-cost childbirth, breastfeeding, and parenting support classes, targeting at-risk mothers.**[24]

- **Partnership with United Way Youth Closet -** Vail Health's Family Birthing Center partnered with the United Way's Youth Closet and Toy Chest to bring free and bilingual lactation support at the Youth Closet location in the Edwards Community Health Campus. These classes are held on the first Tuesday of every month from 1-3pm and drop ins are welcome.

- **Family Connects Program** - Vail Health partnered with Eagle County Public Health to launch the Family Connects program in October of 2022. This is an evidence-based program that connects parents of newborns to the community resources they need through universally available postpartum nurse home visits. Through a partnership with Vail Health, we can ensure every parent of a child born in Eagle County will have the opportunity to receive a free home visit to support them in this critical moment of the family's life.

➢ **Support the Education Foundation of Eagle County to promote Science, Technology, Engineering, and Mathematics (STEM) education, targeting underserved youth.**[25]

- **Support of Education Foundation for Underserved Youth -** Vail Health provides funding for the Education Foundation of Eagle County to promote Science, Technology, Engineering, and Mathematics (STEM) education, targeting underserved youth. In addition, Vail Health Behavioral Health provides funding for My Future Pathways, an

[24] Proposed ***Health Equity*** strategy 7 of 8 from Vail Health's 2019 Implementation Strategy

[25] Proposed ***Health Equity*** strategy 8 of 8 from Vail Health's 2019 Implementation Strategy

organization that supports local Hispanic youth in pursuing positive pathways through scholarships, mentoring and other programs.

- **COVID-19 Pandemic Response**

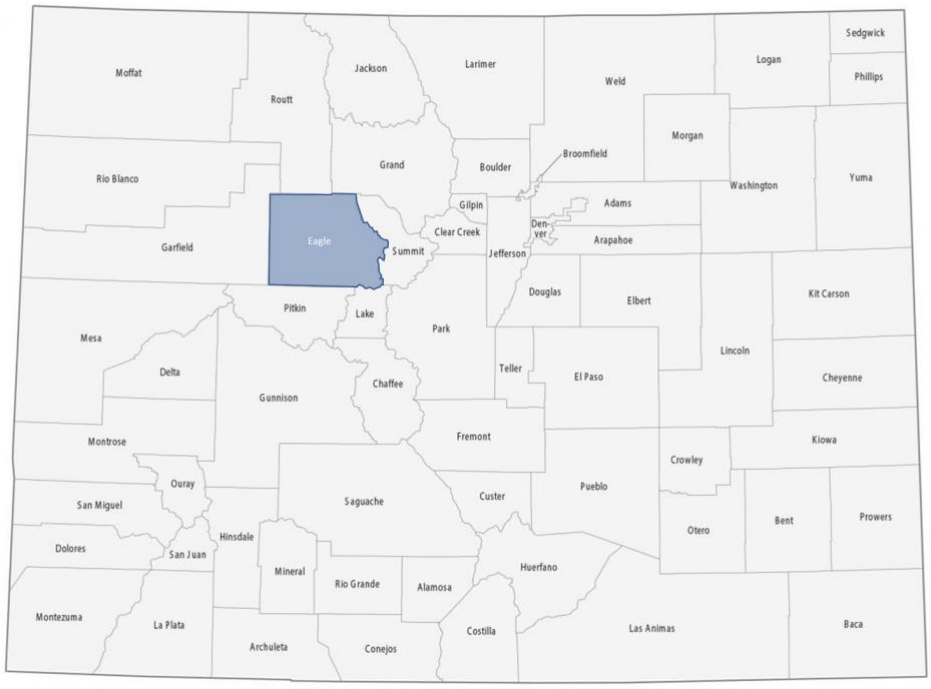
    - Vail Health partnered with the Colorado Department of Public Health and Environment (CDPHE) to provide a coordinated response during the COVID-19 pandemic. Testing locations central to population centers in Summit and Eagle counties were established with both Antigen and PCR testing available to the public, at no charge. Patients needing results in 24 - 48 hours, or a test for domestic and international air-travel were able to find an appointment online, receive a same-day test, and receive their results in the Vail Health patient portal or by written request to Medical Records. As a popular destination for adventure travelers, our community testing operations consistently served patients from all over the world from 2020, until at-home tests were able to fulfill public demand in March of 2022.

      Once vaccines were available towards the end of 2020, Vail Health and Colorado Mountain Medical worked with CDPHE to provide clinics in Vail and Eagle. The Delta and Omicron variants emerged at which point booster clinics in Eagle were set up to provide vaccines to community members that were eligible under CDC guidelines, as well as patients seeking their first dose.

2022 Community Health Needs Assessment

Community Served

For the purpose of this CHNA, the Vail Health community is defined as Eagle County. Eagle County represents the geographic area most proximate to Vail Health and the area in which the largest portion of Vail Health patients reside.



Demographic Characteristics of the Community Served

Why are demographics important?
Vulnerable populations are at risk for disparate healthcare access and outcomes because of economic, cultural, racial, or health characteristics. Examining data across different populations is important because people's experiences vary from one community to the next, resulting in different health risks and needs. The following data has been collected and analyzed in an effort to identify and address health disparities. Knowing the specific health needs of our community enables us to tailor health improvement efforts to the appropriate priority populations, work to minimize disparities, and promote an equitable approach to health improvement planning.

Demographics of Eagle County
Demographic characteristics of the population residing within Eagle County, in comparison with the state overall, are shown in the tables below. Values highlighted in **blue** indicate measures that vary from the state value and have the potential to influence the type or level of resources needed in the community. The data in the tables below is primarily sourced from the 2020 Census and published by the United States Census Bureau on their website. Other data sources used are cited accordingly with respect to the tables that reference them.

Population:

	Colorado	Eagle County
Population	5,773,714	55,727

Source:2020 US Census Bureau

Eagle County is located in northwest Colorado, approximately 100 miles west of Denver. At 1,700 square miles, Eagle County is the 27th largest county in Colorado by geographic area out of 64 counties and with 55,727 residents, it is the 15th most populated county. Approximately 44,000 are located in the Eagle River Valley alone.

Age:

	Colorado	Eagle County
Percentage below 18 years of age	21.4%	20.8%
Percentage 65 years and older	15.1%	13.8%
Median age	36.9	36.8

Source:2020 US Census Bureau

20.8% of Eagle County's population is below 18 years of age. 13.8% of Eagle County's population is 65 years and older. The median age in Eagle County is 36.8.

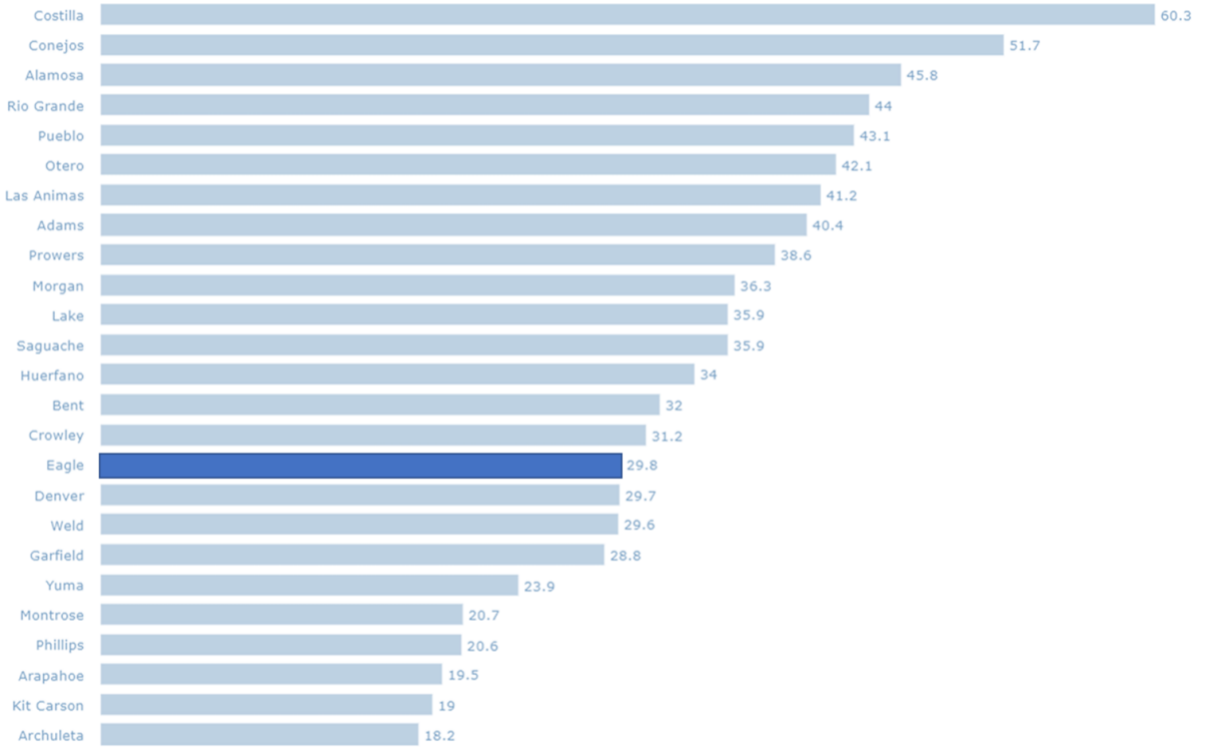
Race & Ethnicity:

	Colorado	Eagle County
Percent American Indian & Alaskan Native	1.7%	1.3%
Percent Non-Hispanic Black	4.7%	1.5%
Percent Hispanic	21.7%	**29.3%**
Percent Non-Hispanic White	67%	66.9%
Percent Asian	3.6%	1.5%
Percent Native Hawaiian/Other Pacific Islander	0.2%	0.1%

Source:2020 US Census Bureau

In 2020, 67% of Eagle County self-identified as Non-Hispanic White (36.5k people) and 29.3% (16.1k people) self-identified as Hispanic, making up the large majority (96.3%) of Eagle County's total population. Eagle County ranks as Colorado's 16th most Hispanic county out of 64 counties.

25 Most Hispanic Counties in Colorado



Heritage & Citizenship:

	Colorado	Eagle County
Foreign-born population, as percent	9.5%	**15.3%**
Citizenship, as percent	94.8%	**90.1%**

Source:2020 US Census Bureau

Eagle County's foreign-born population is 15.3% which is a significantly higher percentage than Colorado's 9.5%. Additionally, the self-identified citizenship rate of Eagle County is 90.1% which is also significantly lower than Colorado's 94.8%.

Families & Living Arrangements:

	Colorado	Eagle County
Households	2,540,822	33,539
Average household size	2.6	**2.94**
Language other than English spoken at home	16.4%	**25.7%**

Source:2020 US Census Bureau

Economic Stability & Poverty:

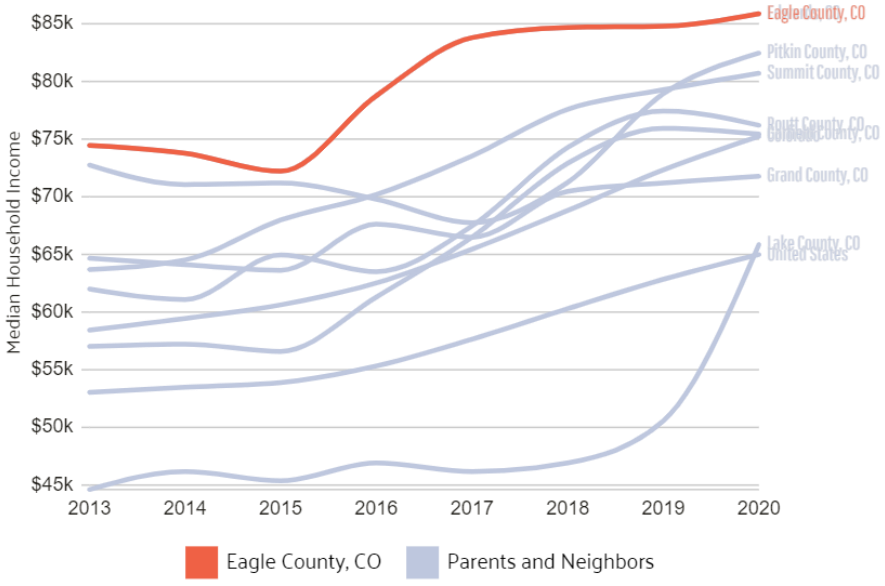
	Colorado	Eagle County
Median household income	$75,231	$85,877
Percent persons in poverty	9.78%	9.19%
Largest demographic living in poverty Second largest demographic living in poverty Third largest demographic living in poverty	Females 18-24 Females 25-34 Males 18-24	**Males 25-34** **Females 25-34** **Females 35-44**

Source:2020 US Census Bureau

In 2020, households in Eagle County had a median annual income of $85,877, which was more than the median annual income of $75,231 across Colorado. 9.19% of the population for whom poverty status is determined in Eagle County, CO (5.03k out of 54.7k people) live below the poverty line, a number that is lower than the state average of 9.78% and the national average of 12.8%. The largest demographic living in poverty in Eagle County are Males 25-34, followed by Females 25-34, and then Females 35-44.

The following chart shows how the median household income in Eagle County, CO compares to that of its neighboring and parent geographies.

Eagle County Median Household Income Compared with Neighboring & Parent Geographies



Median household income in Eagle County is higher than parent or neighbor geographies, with the closest median household income being Pitkin and Summit Counties.

Self-Sufficiency Standard (2 adults + 1 preschooler + 1 school age)				
COUNTY	Annual Self-Sufficiency Standard	As a percentage of:		
		Federal Poverty Guidelines	Minimum Wage	Median Family Income
Eagle County	$76,362	304%	177%	140%

Source:2018 Self Sufficiency Standard

While the median household income in Eagle County is higher than the Colorado average, the cost of living is also higher. According to a 2018 report published by the Self Sufficiency Standard, a family of two adults, one preschooler and one school-aged child would need to make a minimum of 304% of the Federal Poverty Level (FPL) to be self-sufficient in Eagle County. This means that, while many individuals are above the 100% FPL, they are still living in poverty in this community, but are ineligible to access public assistance and other public benefits.

Affordability is the key obstacle for locals seeking to buy and rent in Eagle County. Housing prices are increasing in part due to a shortage in supply. Communities originally designed for locals are transitioning and seeing higher percentages of second homeowners.

The median home price in Eagle County is $1.1M. The average household buying power is $436,170 creating an Affordability Gap of $663,830. Of the 31,912 homes in Eagle County, more than 44% are vacant or part-time residents. Affordability and location are the highest priority for buyers who compete with second homeowners and investment buyers for homes at all price points.

Across Eagle County, there are extremely low vacancy rates in rental apartments resulting in limited choices and rising costs for renters. Proximity to work for renters is the highest priority. Renters face impacts resulting from short term rentals limiting choices and causes overcrowding or unhealthy living conditions with the remaining supply. Many renters are not only cost burdened but are now forced to commute long distances, placing more burden on the environment and traffic. 75% of renters want to move to a different home within 5 years and 90% desire to own their home.

Education:

	Colorado	Eagle County
High school graduate or higher	92.1%	90.9%
Bachelor's degree or higher	41.6%	50.5%

Source:2020 US Census Bureau

Health:

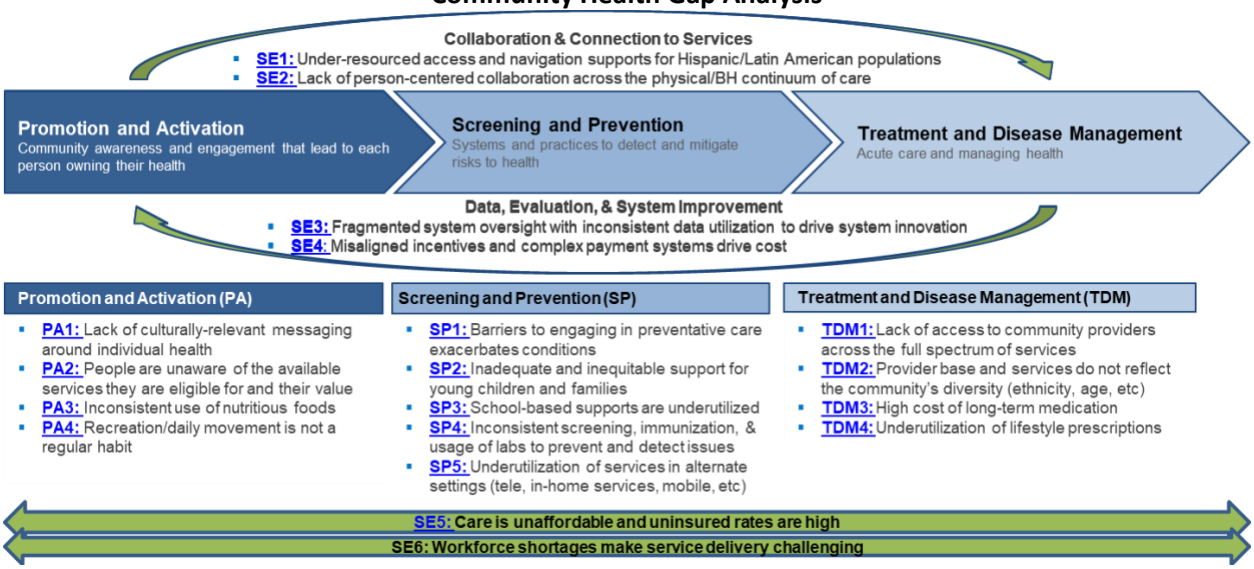
	Colorado	Eagle County
Percent persons with a disability, under age 65 years	7.4%	4%
Percent persons without health insurance, under age 65 years	9.3%	**16.3%**

Source:2020 US Census Bureau

Prioritization Process and Identified Priority Areas

Vail Health developed a Population Health Steering Committee led by Chris Lindley, Vail Health's Chief Population Health Officer and made up of persons who represent the broad interests of the community served by Vail Health including representatives from Vail Health, key partner organizations, Eagle County, and State Officials. The findings from the CHNA research were shared with the Steering Committee and asked to solicit input into community health priorities. The Steering Committee analyzed the data and developed a Community Health Gap Analysis which identified 19 gaps or health needs in the community. In conjunction with the identification of the community health gaps were approaches and strategies on to address them. The full Community Health Gap Analysis can be found in Appendix IV.

Community Health Gap Analysis



After development of the Gap Analysis and identification of health needs, the group then developed the Population Health Initiative: a collaborative, community approach to address the identified health needs of Eagle County. Shown below are the 8 areas of priority that emerged.

Identified Community Health Areas of Priority

Following the identification and approval of priority health needs, the Population Health Steering Committee developed the 2022-2024 Implementation Strategy.

Vail Health 2022-2024 Implementation Strategy for Community Health Improvement

Vail Health developed an Implementation Strategy to guide community benefit activities across Eagle County. As determined by the prioritization process, Vail Health will devote resources and expertise to address the following 8 priorities:

1. Engage, Enroll, and Connect People to Whole-Person Health
2. Bring Care to the People
3. Focus Prevention and Early Intervention on Our Greatest Health Opportunities
4. Increase Utilization of Healthy Foods
5. Address Healthcare Staffing Shortages with a Focus on Increased Diversity
6. Increase Early Childhood and Family Supports
7. Improve System Interoperability and Integration (address the SEs)
8. Advance Policy to Improve Community Health, Increases Access, Lower Cost, & Drive Engagement

The Implementation Plan builds upon previous health improvement activities and takes into consideration the evaluation of impacts from the previous Implementation Plan cycle, while recognizing new health needs and a changing health care delivery environment identified in the 2022 CHNA. The 8 priority areas identified with strategies to address them are outlined below.

Priority Area I: Engage, Enroll, and Connect People to Whole-Person Health

- ➢ Enhance comprehensive care coordination
- ➢ Implement Find Help for service navigation and closed-loop referral system for SDOH
- ➢ Implement supportive services to enable in-person visits
- ➢ Launch a campaign to improve individual health literacy
- ➢ Expand community health worker programs
- ➢ Support community with Colorado public health programs (i.e. Medicaid, CHP+, etc.)

Priority Area II: Bring Care to the People

- ➢ Continue to expand MH, SUD services, and physical health services in the community
- ➢ Ensure Funding & Sustainability of Community Health Programs on MIRA
- ➢ Explore options to expand Mobile At-Home Health Services with community partners
- ➢ Bolster access and choice through expanded Use of Tele-supports
- ➢ Engage with employers in programs to expand reach into the workplace
- ➢ Offer extended hours to ensure that available appointments accommodate Valley resident schedules

Priority Area III: Focus Prevention and Early Intervention on Our Greatest Health Opportunities

- ➢ Expand Metabolic Screening, Education, Testing, and Access to Supports
- ➢ Increase maternal health screening
- ➢ Develop easily accessible lactation supports in multiple languages
- ➢ Improve Maternal Mental Health
- ➢ Expand Gender-specific Preventative Health Programs
- ➢ Implement family-focused Screening and Treatment for ACES, MH, and SUD

Priority Area IV: Increase Utilization of Healthy Foods

- ➢ Increase The Community Market's ability to source and provide nutritious foods
- ➢ Maximize Utilization and Quality of Federal Nutrition Programs
- ➢ Revamp school meals for all regardless of income

Priority Area V: Address Healthcare Staffing Shortages with a Focus on Increased Diversity

- ➢ Recruit to Optimize the Mix of Providers and Staff Across qualifications
- ➢ Retain and Grow Healthcare Providers and Workforce
- ➢ Accelerate Growth of Healthcare Leaders Who Are Not White Males as a Part of Broader DEI Efforts
- ➢ Implement Bilingual Pay Policies to Attract and Grow Language Acquisition for Valley Health Care Workforce

Priority Area VI: Increase Early Childhood and Family Supports

- ➢ Expand home visitation
- ➢ Expand Parent/Family Training and Peer Supports
- ➢ Expand the Use of Whole-child Therapeutic Teams
- ➢ Implement Family Connect Model

Priority Area VII: Improve System Interoperability and Integration

- ➢ Align Population Health work across VH system, MFHC, and community partner organizations
- ➢ Better Align Operations & back-office management of MFHC & VHS
- ➢ Invest in health record interoperability, releases of information, etc., to enable seamless case management across various systems of care and human service organizations
- ➢ Develop a data and evaluation system and rhythm to measure the system's performance and drive continuous improvement

Priority Area VIII: Advance Policy to Improve Community Health, Increases Access, Lower Cost, & Drive Engagement

- ➢ Explore availability of primary care for all residents at an affordable price
- ➢ Implement Common Front Door Access for Patient Care at VH/ CMM
- ➢ Expand & align VHS & CMM's Financial Assistance Policies
- ➢ Ensure Financial Sustainability via Appropriate Contracted Reimbursement Rates
- ➢ Pursue grants related to the Community Collaborative Response initiative

Vail Health will continue its work to improve the health and well-being of Eagle County residents, guided by the 2022 CHNA and our mission to elevate health across our mountain communities. We encourage you to visit our website to learn more about the CHNA and our community health improvement initiatives: vailhealth.org.

Appendix I: Data Tables and Sources

https://www.census.gov/quickfacts/eaglecountycolorado

http://www.communitycommons.org/collections/Community-Health-Needs-Assessments

https://datausa.io/profile/geo/eagle-county-co

https://www.eaglecounty.us/localinfo/communities

https://gisgeography.com/colorado-county-map/

https://www.indexmundi.com/facts/united-states/quick-facts/colorado/hispanic-or-latino-population-percentage#chart

https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3

https://www.realtor.com/

https://selfsufficiencystandard.org/wp-content/uploads/2021/10/CO18_SSS_Web.pdf

https://www.slifersmithandframpton.com/vail-valley-slifer-report

https://statisticalatlas.com/state/Colorado/

https://usafacts.org/data/topics/people-society/population-and-demographics/our-changing-population/state/colorado/county/eagle-county

https://www.vailhealthbh.org/education-and-events/education-and-prevention-services

https://www.vailhealthbh.org/get-help-now/behavioral-health-case-management

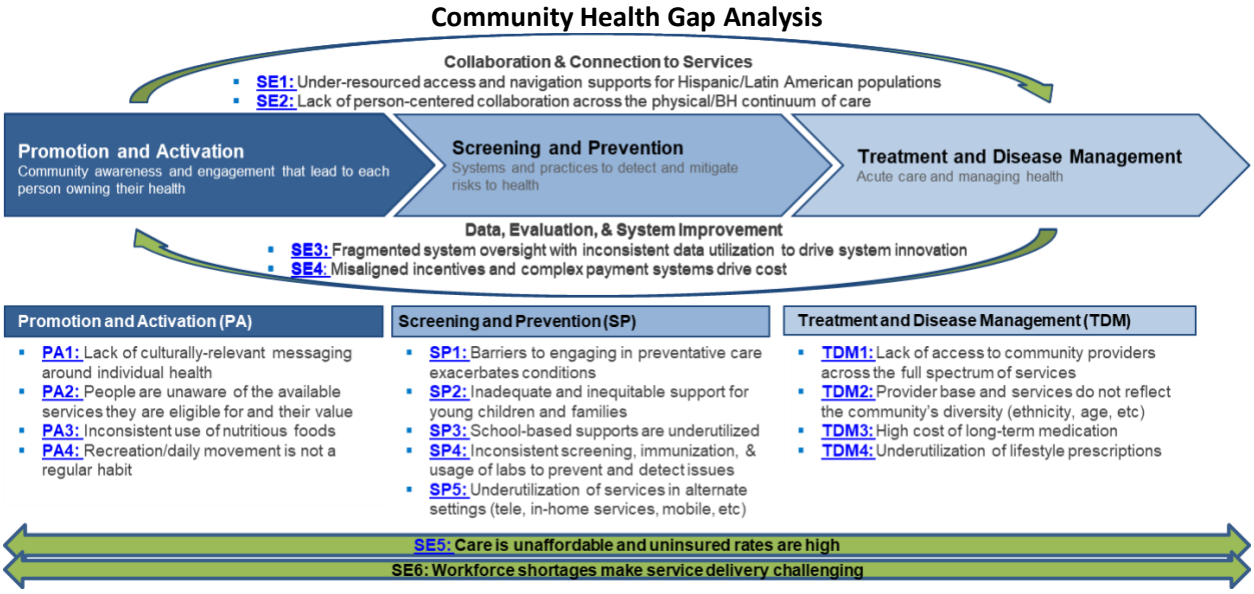
https://www.vailhealthbh.org/about/initiatives-and-strategies

https://www.vailhealth.org/locations

https://www.yourhopecenter.org/services

Appendix II: Community Partners

Appendix III: Community Health Gap Analysis - Full Report



COMMUNITY HEALTH GAP ANALYSIS DEFINITIONS

Promotion and Activation (PA): Community awareness and engagement that lead to each person owning their health

Screening and Prevention (SP): Systems and practices to detect and mitigate risks to health

System Enablers (SE): Attributes that enable a seamless experience and high system performance.

Treatment and Disease Management (TDM): Acute care and managing health

LIST OF COMMUNITY HEALTH-RELATED GAPS IDENTIFIED

List of the 19-community health-related gaps identified, with prefix labels of the community health continuum area they address:

1. SE1: Under-resources access and navigation supports for Hispanic/Latin American populations
2. SE2: Lack of person-centered collaboration across the physical/BH continuum of care
3. SE3: Fragmented system oversight with inconsistent data utilization to drive system innovation
4. SE4: Misaligned incentives and complex payment systems drive cost
5. SE5: Care is unaffordable and uninsured rates are high
6. SE6: Workforce shortages make service delivery challenging
7. PA1: Lack of culturally relevant messaging around individual health
8. PA2: People are unaware of the available services they are eligible for and their value
9. PA3: Inconsistent use of nutritious foods
10. PA4: Recreation/daily movement is not a regular habit
11. SP1: Barriers to engaging in preventative care exacerbates conditions
12. SP2: Inadequate and inequitable support for young children and families
13. SP3: School-based supports are underutilized
14. SP4: Inconsistent screening, immunizations, and usage of labs to prevent and detect issues
15. SP5: Underutilization of services in alternate settings (tele, in-home services, mobile, etc.)

16. TDM1: Lack of access to community providers across the full spectrum of services
17. TDM2: Provider base and services do not reflect the community's diversity (ethnicity, age, etc.)
18. TDM3: High cost of long-term medication
19. TDM4: Underutilization of lifestyle prescriptions

STRATEGIES/APPROACHES ADDRESSING EACH GAP

In conjunction with the identification of the community health gaps were approaches and strategies on to address them. The following are the Gap Overviews as they were developed and presented to the Population Health Steering Committee in January 2022.

SE1: Under-resourced access and navigation supports for Hispanic/Latin American populations

Description of the Unmet Need: The health care system is composed of many different organizations, each with their own mission and range of services. And, some overlaps exist, with organizations duplicating services and gaps exist with no services available in our region. These organizations do not have enough culturally and linguistically responsive services and supports, including social determinants, to meet the population's needs. Navigating this fragmented system can be challenging, both in terms of finding the information on available services AND knowing whether patients are eligible to receive them (and at what cost). Guidance is not always available in multiple languages and may contain jargon that makes it hard for people to understand. Payors typically communicate billing/coverage information in English with longer wait times in Spanish.

Details include:

- Health literacy differs widely and is influenced by education levels, experience, and other factors
- The messenger matters—Hispanic/Latin American populations display high-trust for physicians but less trust for other medical credentials and those with no credential
- Undocumented people may be concerned about filling out paperwork with personal information
- Attempts have been made to harmonize self-directed navigation tools (e.g., service directories across providers), but these are time consuming to maintain
- The Community Resource Network is beneficial but does not integrate (not embedded) with internal tools; streamlined technology is required to provide seamless navigation (led by QHN)

What the Data Tell Us:

- 30+% of the Eagle River Valley population is Spanish-speaking and 52% of Valley students identify as Hispanic/Latin American
- As of 2019, 18% of Eagle Count residents are first generation immigrants. 87% of non-citizens are Hispanic/Latin American
- 30+% of the Spanish-speaking population do not have health insurance
- Edwards has the largest mobile home community in the State AND some of the state's most expensive real estate; less than 10% of these homes are resident-owned
- 98% of the MIRA bus service recipients are Spanish speaking
- Expand outreach and navigation supports to the undocumented and underserved communities, using the community health worker/Promotoras model and MIRA

Ideas to Close the Gap:

- Expand outreach and navigation supports to the undocumented and underserved communities, using the community health worker/Promotoras model and MIRA
- Expand outreach and navigation supports to the undocumented and underserved communities, using the community health worker/Promotoras model and MIRA
- Experiment with a one-stop shop for program awareness, eligibility, and enrollment that is safe and conveniently located; complement with similar services to MIRA and consider locating at NorthStar campus to access the range of services planned there.

SE2: Lack of person-centered collaboration across the physical/BH continuum of care

Description of the Unmet Need: Caring for an individual's health, particularly those with complex needs, can involve the services of many different organizations. A single person may have a primary care provider, one or more specialists, and a behavioral health provider while also participating in several social services programs that help address the social determinants of health. Connection between these providers is both spotty and critical. Closed-loop referrals that cross organizational boundaries are particularly challenging.

Details include:

- Complexity of the system across providers disincentivizes connection to other providers, both in terms of offerings ("I don't know who has the expertise to help this patient") and capacity ("Who can see my patient the fastest?")
- Navigators and case managers provide much needed services and have been collaborating for 2+ years to improve systems of care. However, MFHC's case coordination position has been vacant for at least 2 years
- Schools also see needs and don't know how/who to connect to in the community.

What the Data Tell Us:

- Analyzing closed-loop referrals from CMM in 2021 to-date the data show there has been:
  - 4,229 first referrals from all providers and the loop have been closed on 27.4% of these
  - 2,704 first referrals from primary care providers and the loop have been closed on 30.7% of these
- Notes:
  - CMM is working to refine tracking methods to ensure accurate reporting
  - Risk stratification scoring between MFHC and CMM are inconsistent, making the true demand for complex case coordination difficult to size.

Ideas to Close the Gap:

- Expand person-centered supports and provide stipends for engaging in cross-agency case management
- Determine common goals and the data definitions and collection parameters across partners to improve outcomes
- Invest in shared health record information systems, releases of information, etc, to enable seamless case management

SE3: Fragmented system oversight with inconsistent data utilization to drive system innovation

Description of the Unmet Need: The Valley's providers and non-profit/government partners offer a wide variety of services and supports, but do not function as an integrated system. There are targeted efforts to pool funding, share data, and close system gaps, but the lack of a coordinated approach is the main reason for this effort and the opportunity is proven by the range and depth of gaps highlighted in this summary.

Details include:

- Vail Health, CMM, and MFHC each have their own electronic health record (EHR) software; these programs don't "talk" (NOTE: A single EHR for all VH affiliates is being pursued)
- Partners often approach the same funders for resources, which can result in perceived competition and high development costs
- The Valley has a history of effective shared advocacy, but more could be done to harness a collective voice and power.

What the Data Tell Us:

- Mountain Youth oversees a community directory that shows over 100 organizations in the valley providing services or resource connected to community health
- Analyzing closed-loop referrals from CMM in 2021 to-date the data show there has been:
- 4,229 first referrals from all providers and the loop have been closed on 27.4% of these
- 2,704 first referrals from primary care providers and the loop have been closed on 30.7% of these
- See notes on previous page

Ideas to Close the Gap:

- Establish the Population Health Department within VH to coordinate system design and transformation (e.g., expectations around services, roles, etc.; advocating for state & local policy/funding changes; coordinating fundraising to expand contributions while avoiding competition and lowering development costs; establish funding agreements to enable partner execution of key strategies; etc.)
- Harmonize resource lists across partners organizations providing health care and social determinants support
- Implement a single EHR across providers (underway for VH affiliates)
- Develop a data and evaluation system and rhythm to measure the system's performance & coordinate continuous improvement (system wide impacts beyond clinical outcomes)

SE4: Misaligned incentives and complex payment systems drive cost

Description of the Unmet Need: Providers have traditionally been rewarded for sick care v. preventative care; in fact, preventive care spending in the U.S. constituted 2.9% of total health expenditures in 2018. By nature, profit-based health systems are not often incentivized to control costs and provide cost effective care. These two features present significant challenges to arriving at the right care in the right setting in the most cost-effective way. Reimbursement for Physical and Behavioral health are quite different and can be complex. Practices negotiate rates for physical health reimbursement under a Fee for Service model while Behavioral Health providers are typically contracted with under a different model such as episodes of care. Page 28 has a comparison of coverages.

Details include:

- Separate payers and payment systems challenge consumers and providers alike. Depending on the services provided and the codes used, the same provider-patient pair may yield bills to one or the other payer (ex: Diagnostic code falls under a medical plan or a BH plan.).
- Separate contracting and credentialing systems add administrative burden to providers.
- Integration matters: For example, if systems fail to catch people moving toward BH crisis, then the physical health system realizes a high-cost ED visit and the need for emergency psych for a med refill; high-cost interventions that strain the provider base and the patient.

Ideas to Close the Gap:

- Work collectively across health care delivery partners to maximize revenues, including adopting designations that enable additional reimbursements
- Move to a payment model that pays for health rather than volume of care provided
- Establish a provider co-op with back-end reconciliation of payments so that the patient does not need to navigate the system
- Refine and expand "Choosing Wisely" campaigns—promote tests and procedures have evidence basis and are proven to be cost effective rather than utilization of tools we have (e.g., if you have an MRI machine, you do a lot of MRIs)

SE5: Care is unaffordable and uninsured rates are high

Description of the Unmet Need: The Valley's high cost of living and high uninsured rates are barriers to seeking care. People fear that seeking care will result in them owing money they cannot pay, and there is a lack of transparent pricing that would help them understand their financial responsibility. Uninsured people and Medicaid members may access ED care for needs that could have been handled in a lower-cost environment. Payment options and sliding scales may not fit people's situation so they seek care elsewhere and we lose the ability to follow-up

Details include:

- Undocumented people and their family members needing services that might result in a public charge, may choose not to do so if they are currently in immigration proceedings.
- Charity programs providing aid to the uninsured may exclude undocumented people.
- Receipts of large and/or multiple health care bills are a contributor of stress.
- The MIRA bus offers free screening, but the lack of health insurance is a barrier to accessing the care patients are referred to, particularly specialist referrals
- The Valley's Medicaid enrollment program show promising results See "What the Data Tell Us"

What the Data Tell Us:

- 18% of the Valley's population is uninsured; this is about 3x the state average of 6.5%
- In 2019, 30% of the uninsured population is Medicaid eligible, and the majority are children
- Current (2) Medicaid enrollment officers; would need about 5 years to get to the 30% of insured.
- Medicaid Referrals efforts have strong payback:
- 232 Patients referred total since 3/15
- 190 Patients successfully connected to financial services (Medicaid, Emergency Medicaid, Food & Housing resources)

- 96 Enrolled into traditional Medicaid
- 41 Patients denied (18% denial rate)
- At current compensation, each enrollment guide must enroll 30 patients in Medicaid to cover her costs; in the first 6 months enroll 190

Ideas to Close the Gap:

- Explore a no-cost primary care model
- Work to create a more affordable insurance option for benefit year 2023
- Align shoppable services with statewide/regional prices to avoid leakage
- Pursue designations that enable providers to receive additional reimbursements
- Educate Valley residents around change rules related to the public charge and alternatives to accessing the ED

PA1: Lack of culturally relevant messaging around individual health

Description of the Unmet Need: Changing behaviors related to health will require engagement of each individual in the community. Individual motivations vary, however, so approaches must also vary. Cultural tendencies and beliefs underpin actions, so raising awareness and providing knowledge must be done in ways that are relevant. For example, marketing in the Valley is often targeted at the affluent white community and may not be relevant to a broader group of Valley residents.

Details include:

- Hispanic/Latin American leaders pointed out the importance of harnessing social norms and traditions (e.g., influence of the family, influence of the home country, barriers to belonging, etc.) when addressing this group (Note: Latin America has a broad range of cultures and there is an opportunity to celebrate this diversity)
- School-aged kids are often more culturally integrated than their parents. Insular communities are self-reinforcing representing both a barrier and an opportunity.

What the Data Tell Us:

- 30+% of the Eagle River Valley population is Spanish-speaking and 52% of Valley students identify as Hispanic/Latin American
- As of 2019, 18% of Eagle Count residents are first generation immigrants. 87% of non-citizens are Hispanic/Latin American
- 30+% of the Spanish-speaking population do not have health insurance

Ideas to Close the Gap:

- Engage external marketing experts to study community needs to arrive at messaging that is relevant to targeted groups (e.g., salud v. bienestar; include research into messaging/approaches that are working)
- Launch tailored campaigns targeted at groups with greatest disparities (e.g., new Americans, etc.) and our greatest issues (e.g., substance use to combat stress, etc.) in the places that people consume information (the right channels/messengers); gather feedback and revising messages
- Train providers on the norms of delivering care to Hispanic/Latin American patients, noting that this is not a homogenous community

PA2: People are unaware of the available services they are eligible for and their value

Description of the Unmet Need: Health literacy is relatively low across the community/Valley. This general characteristic may reflect both the complexity of health care and the fact that everyone's individual health care experience differs due to factors outside their culture, income or other factors. Both social programs and insurance that promote health are poorly understood, as evidenced by significant gaps between eligibility and enrollment in nutrition programs like SNAP and WIC, and health programs like Medicare and Medicaid. Other factors limited participation in services that residents are eligible for include confusion/concern over accessibility, fear of law enforcement, public charge, and/or stigma.

Details include:

- Many of the insured population are not aware that they are eligible for primary care checkups and/or women's well-care visits
- Low utilization/penetration, particularly among Hispanic/Latin American (Zach)
- Emergency Medicaid could be available to undocumented people depending upon their circumstances
- Financial assistance programs are available through Bright Future Foundation, Salvation Army, and Olivia's fund, Mountain family, Vail Health, CMM depending upon circumstances and awareness
- Additional funding for CCCAP is available, which could allow family spending on health priorities

What the Data Tell Us:

- In 2019, 30% of the uninsured population is Medicaid eligible, and the majority are children
- September 2021 Medicaid Member Caseload by County reports shows 8,491 individuals enrolled in Medicaid:
- 4,050 age 20 and younger
- 4,441 age 21 and older
- 605 households are enrolled in SNAP, covering 1350 individuals (as of September 2021); eligible but unenrolled was 4,223 in 2019
- WIC has 764 people enrolled; eligible but not enrolled number for WIC was calculated by CO Blueprint to End Hunger in 2020 was 10,900
- 6% of the county's white population is experiencing poverty while the number is +12% for Hispanic/Latin Americans

Ideas to Close the Gap:

- Increase efforts for cross program enrollment (e.g., SNAP/WIC/Medicaid/Etc.)
- Expand the MIRA bus services to build awareness and engagement
- Invest in additional navigators and consolidated resources (e.g., interactive one-stop shop) for them to use when connecting people to services (might be SE3)
- Utilize community partners (e.g., churches, schools, NPs, etc.) and employers to raise awareness and build support for enrollment
- Expand use of the Promotoras/community health workers to engage with the Hispanic/Latin American community

PA3: Inconsistent use of nutritious foods

Description of the Unmet Need: Healthy lifestyle habits related to food and exercise are effective health management tools, and relatively affordable compared to medical care. Food related diseases include some major ones: obesity, heart disease, and type 2 diabetes. Food is relational: it is one of the main ways in which we connect with each other and, along with music, language, and traditions, a core component of each culture. Bridging the gap between current eating habits will require integrating changes into existing structures; physical access, knowledge of preparations, and addressing the economic reality of healthy food costs. Evidence-based information must be shared WITHOUT being overwhelming.

Details include:

- Food has a BH connection, particularly to depression and eating disorders (mainly in youth).
- Hispanic/Latin American leaders pointed out the importance of eating with family and how diets perceived as unusual (ex: heavy in kale) are unlikely to be observed for long: "connection to family is more important than benefits I can't see."

What the Data Tell Us:

- A recent RWJF poll indicates nearly 1 in 5 Latinos said diabetes was the biggest health issue for them and their families. A Latino child born today has a 50% chance of developing diabetes in his/her lifetime due to main risk factors like obesity and physical inactivity.
- The Valley has no Spanish-speaking nutritionists
- WIC has 764 people enrolled; eligible but not enrolled number for WIC was calculated by CO Blueprint to End Hunger in 2020 was 10,900
- 605 households are enrolled in SNAP, covering 1350 individuals (as of September 2021); eligible but unenrolled was 4,223 in 2019
- 9% of the U.S. population will have an eating disorder in their lifetime.

Ideas to Close the Gap:

- Expand Cooking Matters and other programs with a social component (e.g., "food with family", "food with friends")
- Harness cultural traditions to tailor diet goals in an attainable way (that's likely to succeed)
- Work with the food system to drive increased collaborations and access to nutritious foods (e.gcommunity markets, after-school programs, Double Up, mobile pantries, buy-local programs, increased donations of healthy foods, increased farmer market participation in Double Up, FBOR, etc.)
- Advocate for sugar taxes and restaurant menu change
- Work with school nutrition officers to tailor menus for cultural relevance, mandate adequate time for eating, and increase enrollment in Free and Reduced Lunch
- Enroll more families in SNAP and WIC and associated educators
- Expand availability to a Spanish-speaking nutritionist familiar with a range of Latin American foods
- Train food bank staff to recommend healthier foods
- Community gardens in MH parks, affordable housing
- Subsidize ECE free meals (EC is not part of K-12 meal programs)
- Engage employers around access programs (e.g., breastfeeding breaks, subsidized cafeteria, baselining of health values and offering nutrition support)

PA4: Recreation/daily movement is not a regular habit

Description of the Unmet Need: Despite evidence supporting improved physical and behavioral health, most Americans do not get sufficient daily exercise. Busy work, school, and family schedules may limit time to exercise, so integrating movement into the activities has become important. Building movement into each person's day can have a profound effect on long-term health.

Details include:

- Motivations for exercise vary but can include being able to chase children around the yard, getting outdoors, pain-free movement, stress relief, and increased sense of belonging.
- Each person's baseline is different: Some adults did not learn to swim, bike, or play sports as a kid and so may need coaching to learn these skills and to engage in them with their own children.
- Some recreation is expensive, but there are many options that are low-cost or no cost like parks, and open space. Awareness and familiarity are critical to engagement
- Chronic pain/joint pain is often rooted in additional pounds we carry, and this is an upward spiral (move less gain more, gain more move less, and so on).
- Transportation to/from activities can be a barrier to both kids and adults recreating physically.

What the Data Tell Us:

- Recent analysis by the CDC indicates:
- Less than 5% of adults participate in 30 minutes of physical activity each day
- Percent of adults aged 20 and over with obesity: 42.5% (2017-2018)
- Percent of adults aged 20 and over with overweight, including obesity: 73.6% (2017-2018)
- A recent study of Hispanic/Latin American adults showed that 67.6% did not meet physical activity recommendations of at least 150 minutes per week v. 55.6% nationally. The most frequently reported barriers included "lack of time," "very tired," and "lack of self-discipline" to exercise.
- CMM is currently caring for 1,341 people with diabetes and 5,041 people with hypertension.

Ideas to Close the Gap:

- Increase support for healthy lifestyle clubs and use success stories to feed engagement campaign(s)
- Reduce barriers to participation through low cost/no cost sports leagues (kids and adults—community event)—going in a group is essential (Latina soccer league!)
- Invest in employer/community-sponsored evaluation + contests and campaigns to establish habits
- Implement an activity passport ala "My Denver" card to enable kids free access to facilities and services
- Enhance free/low cost/rental bike programs, prioritizing connection to busses to make biking practical for longer journeys
- Underwrite ECO's $1 bus program to eliminate the cost for school-aged kids (EVBH subsidize free bus pass for school aged kids)
- Promote sports-based non-profits: Expand the Phoenix, Sober and Stoked, Veterans Expeditions, Equine Therapy (Veterans) or similar concepts
- Explore a bike program wherein any kid who wants a new bike can get one by working as trail/outdoor volunteers

SP1: Barriers to engaging in preventative care exacerbates conditions

Description of the Unmet Need: The reality of living in the Valley brings a number of barriers to engaging in preventative care, which can result in acceleration of avoidable conditions and limited engagement in one's health. Data show that for every dollar spent on preventative care, $Z downstream cost is avoided.

Details include:

- High cost of living may require working more than 1 job, which means appointments offered during the workday are not attractive to working adults. Some people cannot or don't want to take time off work to attend to their medical needs because of lower levels of job protections
- Language barriers and lack of culturally relevant providers disincentivize engagement
- Limited front door access to PCPs (ie difficult to get an appt within x amount of time/ahold of scheduler)
- Various healthcare IT systems across the valley that don't share data, making scheduling/ navigating hard for both providers and patients
- Long distances and limited public transportation can pose a barrier to getting to appointments
- Most health care facilities do not provide childcare, making access hard for parents of young children
- 18% of the valley is uninsured and for those with insurance, most plans do not support respite care for those engaging in long-term support of loved ones

What the Data Tell Us:

- The number 1 ranked service requested of visitors to the MIRA bus is medical care
- A recent RWJF poll indicates nearly 1 in 5 Latinos said diabetes was the biggest health issue for them and their families. A Latino child born today has a 50% chance of developing diabetes in his/her lifetime.
- A table of patient screening rates is shown below (value is beneath Medicaid quality payment threshold):

Condition	CMM	MFHC	Goal
Cervical Screening	66%	69%	>48%
Breast screening	53%	39%	>66%
Colon screening	61%	40%	>64$

Ideas to Close the Gap:

- Provide transportation reimbursement and explore rideshare partnership
- Collocated campus(es) with on-site childcare
- Respite support for caregivers so they can engage in self-care
- Track and follow-up with patients who are lacking in preventative screening
- Offer extended hours (early/late/weekend) to ensure that available appointments accommodate the schedules of valley residents
- Utilize outreach and promotion of alternative settings (employers, schools, weekend health fairs, etc.) to reach people in places they already spend time

SP2: Inadequate and inequitable support for young children and families

Description of the Unmet Need: Addressing the long-term health of the community requires taking care of the youngest members of our community. Adverse Childhood Experiences (ACEs), such as neglect, abuse, and other traumatic experiences result in dramatically different health and wellness outcomes as children grow to adulthood. Specifically, ACEs are correlated to higher incidences of depression, COPD, kidney disease, heart disease, diabetes, overweight/obesity, mental illness, and substance misuse. Reducing ACEs requires a strategy that addresses early-childhood mental health as well as the Social Determinants of Health (SDoH) through a mix of prevention, intervention and treatment actions. Parent engagement is fundamental, as is an understanding of child development.

Details include:

- Other specific examples of ACEs include growing up in a family with mental health or substance use problems, acrimonious divorce, witness to violence, incarceration, and growing up in poverty
- ACEs are passed to the next generation.
- Equitable access to cost-effective, high-quality Early Childhood Education (ECE) care is a critical barrier to both labor force participation AND kindergarten readiness. Using ARPA funding, an effort is underway to direct further investments to the ECE system.

What the Data Tell Us:

- 61% of adults had at least one ACE and 16% had 4 or more types of ACEs.
- CDC data indicate that 1 in 6 U.S. children aged 2–8 years (17.4%) had a diagnosed mental, behavioral, or developmental disorder. In Eagle County this translates to ~500 children.
- Preventing ACEs could reduce the number of adults with depression by as much as 44%.
- Children of depressed mothers are 2-3x more likely to develop a mood disorder, and are at increased risk for impaired functioning across multiple domains, including cognitive, social and academic functioning, and poor physical health
- Of Eagle County's 39 licensed childcare providers, (31 centers, 8 homes), 35 have CCCAP agreements (90%) but only 44% are rated as high quality (QRIS levels 3-5)

Ideas to Close the Gap:

- Promote safe, stable, nurturing relationships and environments where children live, learn, and play.
- Link adults to family-centered treatment approaches that include substance abuse treatment and parenting interventions like parenting classes, skills support, early-childhood home visitation, child-parent psychotherapy, and support for social-emotional learning supports those with persistent behavioral issues.
- Expand family resource offerings to reduce financial hardship that can lead to ACEs
- Train provider treating adult depression, maternal depression, and substance use to understand the consequences of that diagnosis on children and ensure timely examinations and interventions for children
- Increase equitable access to high-quality childcare (additional investments in this system are underway); particularly a therapeutic preschool option
- Expand the use of whole-child where therapeutic teams (family, teacher, therapists, interventionists, etc) share information to ensure comprehensive treatment

SP3: School-based supports are underutilized

Description of the Unmet Need: MFHC established a school-based health center in Avon in 2016, and then recently opened (5) others. This expansion has seen both successes and challenges. The most well-established clinic in Avon sees 25-35 patients/week. Location matters and it is believed that a location in a high school would drive additional teen visits, particularly around things that are confidential.

Details include:

- As they mature into adolescence and beyond, children can be effective change agents for their parents' health, providing motivation and helping to advocate and bridge cultures.
- After-school programs can provide supervised activities for kids that help them get more exercise, develop healthy relationships, avoid substance use, and connect to promotion activities.
- The MIRA/MFHC partnership is a strong force for prevention and connection. Recent innovations include diabetes and heart health programming.
- Dental is a top 5 need, with services present in small capacities through MFHC school-based health centers.
- Mobile home parks are not connected to the Eagle River sanitation and do not have fluoridated water, which is a contributor to poor dental health.

What the Data Tell Us:

- The County's HS graduation rate for White students is 99%, (58% go on to a Bachelors) and 54% for Hispanic students (with 13% pursuing a Bachelors)
- Per the 2020 census, 17.5% of the county is foreign born and WPR shows that 67.2% were born out of State, meaning that schools are a critical touch point for people who do not have long-standing relationships in the community
- Preventative screenings are reportedly down because of COVID.

Ideas to Close the Gap:

- Expand school-based clinics and adopt strategies to increase utilization explore how other school-based health clinics expand programming particularly to the undocumented communities, potentially by leveraging the trust earned by the schools
- Fund additional BH clinicians so that all schools have a provider on staff
- Continue efforts for a comprehensive health curriculum in all schools
- Increase the availability of mobile dental for kids (MIRA/Other)
- Increase availability of low/no-cost after school activities
- Pursue availability of fluoridated water to all residences in the Valley

SP4: Inconsistent screening, immunizations, and usage of labs to prevent and detect issues

Description of the Unmet Need: Utilization of immunization, screenings, and monitoring of regular lab results are evidence-based methods to promote and protect health.

Details include:

- Immunization: Rates across the region for typical vaccines are comparable to neighboring counties, but there is a lag in COVID vaccinations, particularly in the Roaring Fork Valley.
- Screening: Alignment on an agreed set of screenings for both adults and children, and the time to

perform them, will help identify conditions early enough to address while at low acuity. Other barriers to screening is provider knowledge of how to refer and the availability of services to provide service based on the referral.

- Labs: Understanding your own health values (e.g., blood pressure, cholesterol, glucose, etc) requires both education and engagement to manage. Usage of regular lab work is a key factor to informing the patient-provider dialogue and helping each person play an active role in improving their health.
- Getting the provider community on board is a critical lever and there is anecdotal evidence of reluctance in in pockets of the provider population, particularly related to immunization rates (MFHC childhood immunization age < 2 is 30% (affected by low influenza vaccination rates)) and some screenings (e.g., TB, alcohol, others).

What the Data Tell Us:

- COVID vaccine hesitancy ranges from .19% to 5.05% across Eagle County's 13 zip codes with Basalt being the most hesitant
- CMM began screening urgent care patients for SDoH in June and has completed 449 workflows
- CCMM is currently caring for 5,041 people with Hypertension and 1,341 people with diabetes
- A table of patients appropriately managed for key conditions is shown below (value is beneath Medicaid quality payment threshold):

Condition	CMM	MFHC	Goal
Hypertension	59%	52%	>57%
Diabetes (1&2)	58%	39%	>39%
Cervical Screening	66%	69%	>48%
Breast screening	53%	39%	>66%
Colon screening	61%	40%	>64$

Ideas to Close the Gap:

- Establish a reward program for COVID and other vaccinations
- Build upon "It's easy to care for your health" with immunization and screening messages/programs to educate both providers and parents
- Invest in provider culture to promote prevention and expand screening at primary care (and ensuring ample time to do so; consider engaging additional resources to support providers AND increasing availability by reducing the amount of time spent on intensive treatment)
- Replicate and incentivize "know your values" programs that determine thresholds, set cadence for check in, and gamify values
- Adopt on-line self-screening tools and electronic health monitoring tools
- Engage with employers in programs to expand reach into the workplace, particularly for large employers, the self-insured, and Mountain Strong participants

SP5: Underutilization of services in alternate settings (tele, in-home services, mobile, etc.)

Description of the Unmet Need: Seeking care in traditional settings presents several barriers, from office

hours, to transportation, to time off work, and so on. In physical health, a typical 2-hour visit (travel, parking, check-in, consultation, etc.), includes 10-15 minutes spent with the provider. Much of the care people require can be delivered in their homes, by mobile clinic, and/or via tele-health because it is not dependent upon the infrastructure of a higher-cost setting. The Valley has innovated recently with community paramedicine, nurse-family partnership the MIRA bus, tele-health during the Pandemic, and other advances. And while home health is selectively available, the current capacity is not adequate for demand.

Details include:

- MIRA mobile services have proven effective but are not yet available to all parts of the county. This is particularly important because MFHC's Edwards location is not on the bus route.
- Telehealth is used for specialty care like psychiatric and neurology via contract, and COVID has shown the potential for a wide variety of services to be provided without travel.
- Reimbursement disparities exist alternate settings earn payments well below traditional settings
- Care coordination and in-home visits are shown to lower readmission and shorten recovery
- Hospital at home pilot efforts are promising, offering true acute care at home at reduced costs.

What the Data Tell Us:

- -8-10% of HH and Hospice referrals are denied, and delays are experienced another 10% of the time
- Referrals for in-home wound care or IV ABT treatment are often unavailable, leaving the need for clinic treatment through SCC
- Rolling 12-month average for readmissions at VH is 3.35% and while this is low, there is still opportunity to decrease especially in the 4–30-day range with is usually attributed to a failed discharge plan/outpatient services and/or social determinants of health
- Growth in telehealth peaked in April 2020 but has stabilized at 38x pre-Covid levels. MFHC estimates that approximately 10% of visits are now tele visits
- Of those people seen on MIRA, 0 had contact with primary care since moving to the valley
- The cost of preventative screening (full panel, etc.) is only $406

Ideas to Close the Gap:

- Replicate MIRA bus and tailor and expand MIRA services (more BH, dental, etc.)
- Accelerate pilot of follow-up calls and scheduling to help strengthen the relationship with the PCP
- Expand community paramedicine
- Launch issue-specific mobile clinics to target most prevalent issues—heart health, child dental, other
- Grow home health services (include hospice? (Ensure culturally relevant)
- Develop a strategy to increase reimbursements for alternate settings
- Work with employers to access groups of people at the workplace simultaneously (consider incentivizing with discounts)
- Seek opportunity to pilot "Hospital at Home" in-home acute care

TDM1: Lack of access to community providers across the full spectrum of services

Description of the Unmet Need: The population of the Valley has demand for the full spectrum of health

services but does not currently have an adequate number or variety of services. This results in wait lists and/or the need for residents to seek care in other countries. Not receiving the needed care can result in increased acuity, poorer outcomes, and increased cost. Since the formation of EVBH, intensive recruitment and retention efforts have increased the number of BH providers from 97 to 152 since 2019, but a gap remains because awareness and availability drive demand.

Details include:

- A recent community health needs assessment indicates needs in primary care, specialty care (e.g., BH, neurology, gerontology, pediatric specialties, SUD prescribers, others), nursing, home health, and respite.
- Organizations have engaged in capacity agreements to create periodic availability of specialists (ex: 1 day per week) and providing on-demand support for PCMPs can expand their scope.

What the Data Tell Us:

- Lead time for family practice PCP visits as of 10/25/21 was ~10 days (3rd available) and at MFHC Edwards as of 11/1/21 ranges from 7-14 days; for specialties it can be months. Recruitment and retention are made challenging by the high cost of living
- CMM: Cardiology is up 20% in the clinic and 40% in procedures in the last 10 months
- Comparing April through October (not winter season), the VH ED has seen a 31% increase in visit volume between 2018 and 2021 (1,361 more patients)

Ideas to Close the Gap:

- Optimize the mix of providers across qualifications via targeted recruiting, retention, loan forgiveness, collaborative employer-sponsored housing, and other methods
- Intentionally grow specialty care to meet expanding needs (e.g., geriatrics, etc) through the use of capacity agreements
- Expand the use of tele-supports and supervision for providers to enable primary care to help manage complex conditions
- Utilize Hotspotting to improve care while reducing costs and overutilization
- Increase intensive outpatient support for SUDs

TDM2: Provider base and services do not reflect the community's diversity (ethnicity, age, etc.)

Description of the Unmet Need: The Valley is an increasingly diverse community, with residents spanning all ages and a breadth of national origins and cultures. This diversity is not mirrored in the health care workforce. Trust is a foundational element of all health care delivery. People are more likely to remain engaged with a provider who looks/speaks like them, particularly because health is a topic that involves vulnerability. There is an opportunity to align provider and leadership growth with ongoing efforts related to health equity and Diversity, Equity, and Inclusion (DEI) at several organizations (e.g., County, MFHC, VH, others).

Details include:

- In-person and technology-assisted translation services are consistently used, but there is a difference between cultural competence and linguistic competency.
- Providers and locations have different profiles, but recruitment/retention of diverse candidates is challenged by workplace cultures that are predominantly modeled after white male archetypes.

- Advice provided by someone with a physician credential may be more respected by people in the Hispanic/Latin American and geriatric communities, so promoting existing trust channels can help ensure that messages are follow-through occurrences.
- Diagnoses can vary when evaluated in one language v. another. For example, when evaluated in Spanish for behavioral health conditions, patients are less likely to be diagnosed.

What the Data Tell Us:

- 30+% of the Eagle River Valley population is Spanish-speaking and 52% of Valley students identify as Hispanic/Latin American
- As of 2019, 18% of Eagle Count residents are first generation immigrants. 87% of non-citizens are Hispanic/Latin American
- MFHC Board voted for strategic plan of 33% extended leadership to be Hispanic/Latino
- MFHC Edwards: 80% patient-facing staff bilingual; 65% of staff identify as Latin American. (Bilingual less a requirement recently because of hiring difficulties)
- By qualification provider breakdown--Average age, gender split, languages spoken, etc.

Ideas to Close the Gap:

- Accelerate growth of healthcare leaders who are not white males, as part of broader DEI efforts
- Develop recruitment strategies to build a pipeline of culturally competent providers, front office, and support personnel
- Implement bilingual pay policy and further incentivize language acquisition training for Valley providers
- Bolster provider choice through telehealth
- Engage in on-going dialogues with community members and leaders to refine offerings to be more reflective and responsive to all community members
- Build DEI vision into leader's accountability structures (e.g., compensation, metrics); start with patient experience insights disaggregated by ethnicity and using this to refine plans and targets

TDM3: High cost of long-term medication

Description of the Unmet Need: Some chronic diseases require long-term medication. Examples include diabetes, heart disease, depression, mood disorder, rheumatological conditions, and cancer. Utilization of generics is helpful and indeed mandated by some plans, and EMRs can provide information on cost at the point of prescription. Still, there is room to adopt strategies that help lower costs.

Details include:

- Blood pressure and cholesterol conditions are prevalent and proven to be manageable via lifestyle changes. Incentives may be useful in establishing new habits.
- Chronic pain due to overweight forces some people to utilize medications for pain management when weight management might be more effective
- Psychotropic medications (e.g., Benzodiazepines, valium, others) are prevalent due to efficacy but have long-term consequences
- "Therapy first" treatments in both physical and behavioral health are effective in some cases and decrease the cost and risks associated with some medications
- 340b pharmacy benefits allow access to medications at dramatic price subsidy, but are selectively

available to the uninsured population

What the Data Tell Us:

- Lantis is a long-acting insulin that costs $200 in the US v. $20 bucks in Mexico—the exact same medication at 1/10 the cost.
- Vail Health's per-member-per-month is $45 on Anthem plans

Ideas to Close the Gap:

- Subsidy to off-set costs for those with no other treatment options
- Insurance reform is needed to incentivize providers to manage health v. prescribe additional treatments
- Support providers to orient them toward lower utilization of medications, focusing on continuing education on nutrition, lifestyle, etc.
- Adjust provider compensation based on population health metrics (both physical and BH)
- Expand use of Prescriber tool/integrate with EMR, where not already done
- Explore group purchasing agreements

TDM4: Underutilization of lifestyle prescriptions

Description of the Unmet Need: Health care reimbursements track with the degree of invasiveness—insurance companies don't pay for helping someone take a long walk. Sometimes the interventions that DON'T pay are the best thing for the patient. Also, providers training programs are typically trained to practice medicine in ways consistent with the current system of symptom driven diagnosis and prescription rather than whole-person approaches. A scan of medical school curriculums shows that there is a 0.5 credit hour requirement for nutrition education and typically NO requirement for knowledge of physical fitness

Details include:

- Physical activity decreases the risk of chronic diseases and enhances treatment (B)
- Groups have been shown to be valuable to recovery and maintenance of health or those diagnosed with a chronic disease
- Technology like the Fitbit, Apple watch, and others generate real-time data that is useful in formation of new habits and compliance with prescriptions.
- Maintenance of healthy habits depends upon community reinforcement, so prescriptions should be encompassing of families, friends, etc.

What the Data Tell Us:

- In 2013, only 16% of older adults met national guidelines for physical activity
- For older adults, any physical activity is better than being sedentary (B recommendation). To promote and maintain health, older adults should aim for:
- At least 150 minutes of moderate-intensity aerobic activity, and
- 2 or more days of resistance training per week (B)
- A recent RWJF poll indicates nearly 1 in 5 Latinos said diabetes was the biggest health issue for them and their families. A Latino child born today has a 50% chance of developing diabetes in his/her lifetime due to main risk factors like obesity and physical inactivity.

Ideas to Close the Gap:

- Expand use of lifestyle prescriptions (e.g., food, exercise, etc.) through incentives (both for providers and patients)
- Establish additional relationships with organizations that have services to increase healthy lifestyles as a way to prevent and treat disease
- Grow peer supports to help individuals maintain health and manage their disease, including access to groups, sports teams, others
- Partner with recreation-based companies and nonprofits to use recreation as treatment
- Innovate within our employee populations to prove programs before expansion into the community
- Target required investments in provider continuing education toward lifestyle treatments and prescribed supports