Community Health Needs Assessment

2019

Banner Health

McKee Medical Center

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EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act (ACA) has requirements that nonprofit hospitals must satisfy to maintain their tax-exempt status under section 501(c)(3) of the Internal Revenue Code. One such requirement added by the ACA, Section 501(r) of the Code, requires nonprofit hospitals to conduct a Community Health Needs Assessment (CHNA) and adopt implementation strategies to address the identified needs for the community at least once every three years. As part of the CHNA, each hospital is required to collect input from the individuals in the community, including public health experts as well as residents, representatives or leaders of low-income, minority, and medically underserved populations.

As part of the process for evaluating community need, a Banner Health CHNA Steering Committee was formed. This committee, which was commissioned to guide the CHNA process, was comprised of professionals from a variety of disciplines across the organization. This steering committee has provided guidance in all aspects of the CHNA process, including development of the process, prioritization of the significant health needs identified and development of the implementation strategies, anticipated outcomes, and related measures. A list of the steering committee members can be found in Appendix B.

Beginning in early 2019, Banner Health conducted an assessment for the health needs of residents of Loveland and Colorado as well as those in its primary service area (PSA). For the purposes of this report, the primary service area is defined as the area where the top 75 percent of patients for the respective facility originate from. The CHNA process undertaken and described in this report was conducted in compliance with federal requirements.

Headquartered in Phoenix, Arizona, Banner Health is one of the nation's largest nonprofit health care systems and is guided by our nonprofit mission: "Making health care easier, so life can be better." This mission serves as the cornerstone of operations at our 28 acute care facilities located in small and large, rural and urban communities spanning 6 western states. Collectively, these facilities serve an incredibly diverse patient population and provide more than $113M annually in charity care – treatment without expectation of being paid. As a nonprofit organization, we reinvest revenues to add new hospital beds, enhance patient care and support services, expand treatment technologies, and maintain equipment and facilities. Furthermore, we subsidize medical education costs for hundreds of physicians in our residency training programs in Phoenix and Tucson, Arizona and Greeley, Colorado.

With organizational oversight from a 13-member board of directors and guidance from both clinical and non-clinical system and facility leaders, our more than 50,000 employees work tirelessly to provide excellent care to patients in Banner Health hospitals, urgent cares, clinics, surgery centers, home care, and other care settings.

While we have the experience and expertise to provide primary care, hospital care, outpatient services, imaging centers, rehabilitation services, long-term acute care and home care to patients facing virtually any health conditions, we also provide an array of core services and specialized services. Some of our core services include: cancer care, emergency care, heart care, maternity services, neurosciences, orthopedics,

pediatrics and surgical care. Specialized services include behavioral health, burn care, high-risk obstetrics, Level 1 Trauma care, organ and bone marrow transplantation and medical toxicology. We also participate in a multitude of local, national and global research initiatives, including those spearheaded by researchers at our three Banner- University Medical Centers, Banner Alzheimer's Institute and Banner Sun Health Research Institute.

Ultimately, our unwavering commitment to the health and well-being of our communities has earned accolades from an array of industry organizations, including distinction as a Top 5 Large Health System three out of the five past years by Truven Health Analytics (formerly Thomas Reuters) and one of the nation's Top 10 Integrated Health Systems according to SDI and Modern Healthcare Magazine. Banner Alzheimer's Institute has also garnered international recognition for its groundbreaking Alzheimer's Prevention Initiative, brain imaging research and patient care programs. Further, Banner Health, which is the second largest private employer in both Arizona and Northern Colorado, continues to be recognized as one of the "Best Places to Work" by Becker's Hospital Review.

In the spirit of the organization's continued commitment to providing excellent patient care, Banner Health conducted a thorough, system wide Community Health Needs Assessment (CHNA) within established guidelines for each of its hospital and healthcare facilities with the following goals at the heart of the endeavor:

- Effectively define the current community programs and services provided by the facility.
- Assess the total impact of existing programs and services on the community.
- Identify the current health needs of the surrounding population.
- Determine any health needs that are not being met by those programs and services, and/or ways to increase access to needed services.
- Provide a plan for future programs and services that will meet and/or continue to meet the community's needs.

The CHNA results have been presented to the leadership team and board members to ensure alignment with the system-wide priorities and long-term strategic plan. The CHNA process facilitates an ongoing focus on collaboration with governmental, nonprofit and other health-related organizations to ensure that members of the community will have greater access to needed health care resources.

Banner Health has a strong history of dedication to community and of providing care to underserved populations. The CHNA process continues to help identify additional opportunities to better care for populations within the community who have special and / or unmet needs; this has only strengthened our commitment to improving the health of the communities we serve.

For McKee Medical Center leadership team, this has resulted in an ongoing commitment to continue working closely with community and healthcare leaders who have provided solid insight into the specific and unique needs of the community since the previous cycle. In addition, after accomplishing measurable changes from the actions taken in the previous CHNAs, we have an improved foundation to work from.

United in the goal of ensuring that community health needs are met now, and, in the future, these leaders will remain involved in ongoing efforts to continuously assess health needs and subsequent services.

INTRODUCTION

PURPOSE OF THE CHNA REPORT

The purpose of this CHNA is to identify and prioritize significant health needs of the community served by McKee Medical Center (MMC). The priorities identified in this report help to guide the hospital's ongoing community health improvement programs and community benefit activities. This CHNA report meets requirements of the ACA that nonprofit hospitals conduct a CHNA at least once every three years.

McKee Medical Center is dedicated to enhancing the health of the communities it serves. The findings from this CHNA report serve as a foundation for understanding the health needs found in the community and will inform the implementation strategies selected. This report complies with federal tax requirements set forth in Internal Revenue Code Section 501(r) requiring hospital facilities owned and operated by an organization described in Internal Revenue Code Section 501(c)(3) to conduct a CHNA at least once every three years. Regarding the CHNA, the ACA specifically requires nonprofit hospitals to:

1. Collect and take into account input from public health experts, community leaders, and representatives of high need populations – this includes minority groups, low-income individuals, medically underserved populations, and those with chronic conditions;
2. Identify and prioritize community health needs;
3. Document a separate CHNA for each individual hospital; and,
4. Make the CHNA report widely available to the public. In addition, each nonprofit hospital must adopt an implementation strategy that describes how the hospital will address the identified significant community health needs.

This is the third cycle for Banner Health, with the second cycle completed in 2016. Feedback on the previous CHNA and Implementation Strategy will be addressed later in the report.

This CHNA report was adopted by the Banner Health's board on December 6, 2019.

This report is widely available to the public on the hospital's website bannerhealth.com, and a paper copy is available for inspection upon request at CHNA.CommunityFeedback@bannerhealth.com

Written comments on this report can be submitted by email to:
CHNA.CommunityFeedback@bannerhealth.com

ABOUT MCKEE MEDICAL CENTER

McKee Medical Center is a 115-bed acute care hospital located within northern Colorado, in Loveland. The medical center has served the community for more than 30-years. During that time, it is has never strayed from the community focus, constantly striving to live the Banner Health mission, "Making health care easier, so life can be better".

McKee Medical Center is committed to providing a wide range of quality of care, based on the needs of the community, including the following services:

- Cancer Care
- Heart Care
- Orthopedics
- Surgical Services
- Women's services

The facility also operates The Seasons Club, a group that strives to enhance the quality of life for mature adults through health promotion, education, and recreation; as well as Stepping Stones, an adult day care program.

A staff of 270 active staff physicians, nearly 670 other health care professionals and support staff, and more than 290 volunteers, provides personalized care complemented by leading technology from Banner Health and resources directed at preventing, diagnosing, and treating illnesses. On an annual basis, McKee Medical Center's health care professionals render care to – 76,000 outpatients, over 9,000 inpatients, and around 24,000 patients in the Emergency Department (ED). The staff also welcomes an average of 440 newborns into the world each year.

McKee Medical Center serves Loveland and Larimer County, leveraging the latest medical technologies to ensure safer, better care for patients. Physicians and clinical personnel document patient data in an electronic medical record rated at the highest level of implementation and adaptation by HIMSS Analytics, a wholly-owned nonprofit subsidiary of the Healthcare Information and Management Systems Society.

This facility is also part of the Banner iCare™ Intensive Care Program where specially trained physicians and nurses back up the bedside ICU team and monitor ICU patient information 24 hours a day, seven days a week. The Maternity Services department uses an intelligent OB program to help reduce the chances of complications during labor and delivery.

To help meet the needs of uninsured and underinsured community members, McKee Medical Center follows Banner Health's process for financial assistance, including financial assistance and payment arrangements. A strong relationship with the community is a very important consideration for Banner Health. Giving back to the people through financial assistance is just one example of our commitment. In 2018, McKee Medical Center reported $6,181,000 in Charity Care for the community while we wrote off an additional $4,413,000 in bad debt on uncollectable money owed to the facility.

DEFINITION OF COMMUNITY

McKee Medical Center is located in Loveland, Colorado, within Larimer County in the northern part of the state. Loveland is the second largest city in Larimer County and is located just south of Fort Collins, its

larger neighbor and the county seat. The two cities have been steadily growing toward each other over the last several decades and are considered a single metropolitan area by the U.S. government. The establishment of county-owned open space between the two communities in the 1990's was intended to create a permanent buffer between them.

DESCRIPTION OF COMMUNITY

Primary Service Area

The Primary Service Area (PSA) is determined based on where the top 75 percent of patients for the respective facility originate from. In Table 1 the top ~75 percent of the McKee Medical Center PSA is listed.

Table 1. Primary Service Area

Zip	County	Town	%	Cumulative
80537	Larimer County	Loveland	34.7%	34.7
80538	Larimer County	Loveland	33.2%	67.9%
80513	Larimer County	Berthoud	6.1%	74.0%

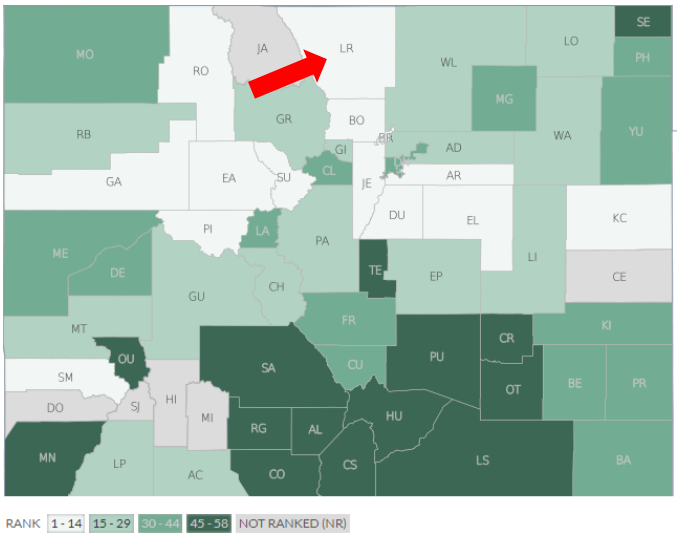
Source: McKesson, 2018

Source: Banner Strategy and Planning

Hospital Inpatient Discharges and Map

McKee Medical Center's Inpatient Origin by Zip Code data informs the primary service area. For the 2019 CHNA report the data derives from the 2018 calendar year and is determined by the top 3 contiguous quartiles, equaling 75 percent of total discharges. Loveland and Windsor accounted for 68 percent of McKee Medical Center's inpatient discharges in 2018, an additional 7 percent of discharges came from Berthoud.

Health Outcomes Ranking and Map

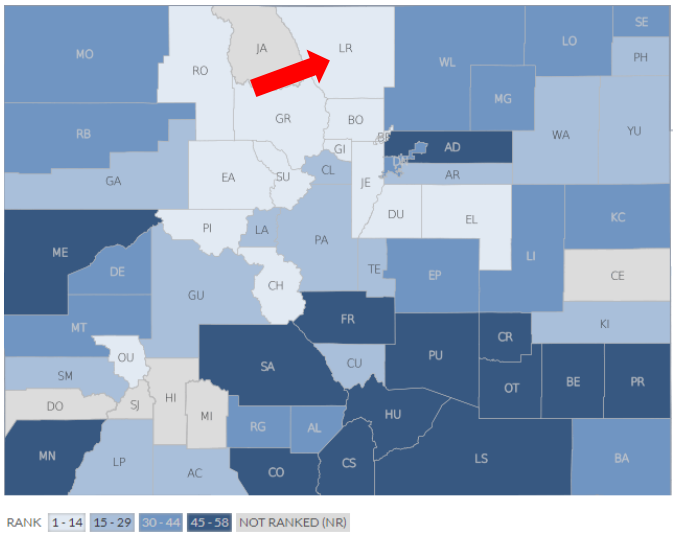


Source: County Health Rankings and Roadmaps, 2018

2019 Colorado County Health Outcomes Rankings: Larimer ranked #7 out of the 58 participating counties, an increase in ranking from the 2016 health outcomes (#8 of 59). The health outcomes determine how healthy a county is by measuring how people feel while they are alive and how long they live. Health outcomes are influenced by health factors, which are thus influenced by programs and policies in place at the local, state, and federal levels. Health outcomes indicate whether health improvement plans are working. Listed below are the two areas that the study looked at when determining health outcomes:

- Length of Life: measuring premature death and life expectancy.
- Quality of Life: measures of low birthweight and those who rated their physical and mental health as poor. (County Health Rankings, 2019)

Health Factors Ranking and Map



Source: County Health Rankings and Roadmaps, 2018

2019 Colorado County Health Factors Rankings: Larimer ranked #12 out of the 58 participating counties, a decrease in rankings from 2016 health factors (#10 of 59). Health factors represent things that can be modified to improve the length and quality of life and are predictors for how healthy communities can be in the future. While there are many factors, from education to the environment in which a person lives, this study focused on the following four factors:

- Health Behaviors: rates of alcohol and drug abuse, diet and exercise, sexual activity, and tobacco use.
- Clinical Care: showing the details of access to quality of health care.
- Social and Economic Factors: rating education, employment, income, family and social support, and community safety.

- Physical Environment: measuring air and water quality, as well as housing and transit. (County Health Rankings, 2019)

COMMUNITY DEMOGRAPHICS

Table 2 provides the specific age, gender distribution, and data on key socio-economic drivers of health status of the population in the McKee Medical Center primary service area compared to Larimer County and the state of Colorado.

Table 2. Community Demographics

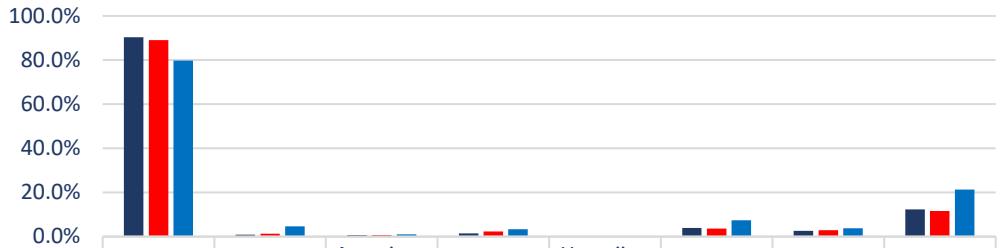
	McKee Medical Center	Larimer County	Colorado
Population: estimated 2018	126,202	365,203	5,640,545
Gender			
• Male	49.4%	50.0%	50.3%
• Female	50.6%	50.0%	49.7%
Age			
• 0 to 9 years	11.8%	10.9%	12.2%
• 10 to 19 years	12.2%	12.6%	12.8%
• 20 to 34 years	18.7%	24.6%	21.8%
• 35 to 64 years	39.2%	36.3%	39.0%
• 65 to 84 years	16.2%	13.7%	12.6%
• 85 years and over	2.1%	1.8%	1.6%
Social & Economic Factors			
• No HS diploma	5.0%	4.4%	8.5%
• Median Household Income	$70,900	$68,600	$72,400
• Unemployment	1.7%	1.9%	2.2%

Source: Advisory Board 2019

Race/Ethnicity (PSA, County and State)

The primary service area has a larger population of White (90%) to that of the state (80%). The other race and ethnicity populations have a higher prevalence overall in the state, as opposed to that of the county and PSA.

Chart A. Race / Ethnicity, 2019



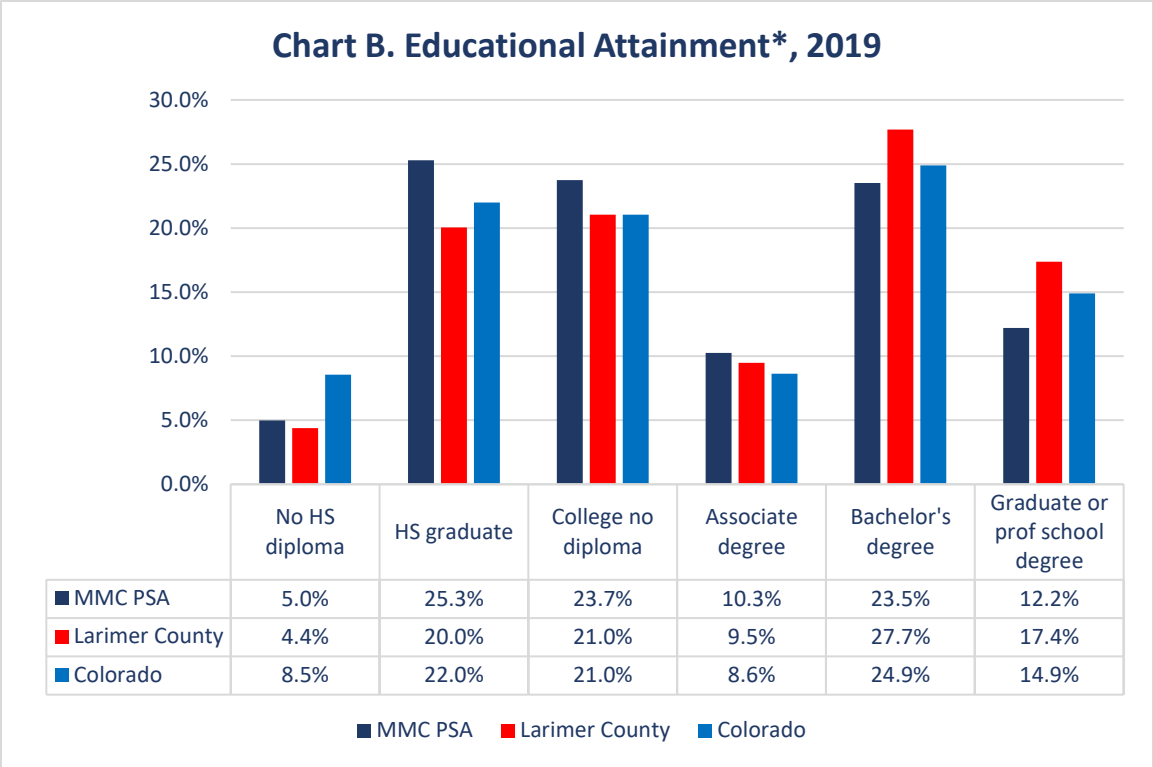
	White	Black	American Indian / Alaskan Native	Asian	Hawaiian / Pacific Islander	Other Race	Multirace	Hispanic
MMC PSA	90.4%	0.9%	0.7%	1.5%	0.1%	3.9%	2.6%	12.3%
Larimer County	89.1%	1.3%	0.7%	2.4%	0.1%	3.6%	2.9%	11.6%
Colorado	79.7%	4.6%	1.0%	3.4%	0.1%	7.4%	3.7%	21.3%

MMC PSA Larimer County Colorado

Sources: Crimson, Advisory Board, 2019

Educational Attainment (PSA, County and State)

McKee Medical Center's primary service area and the county have low rates of the population not completing high school in comparison to the state. For the primary service area, success in obtaining a bachelor's degree or higher falls below that of the county and state.

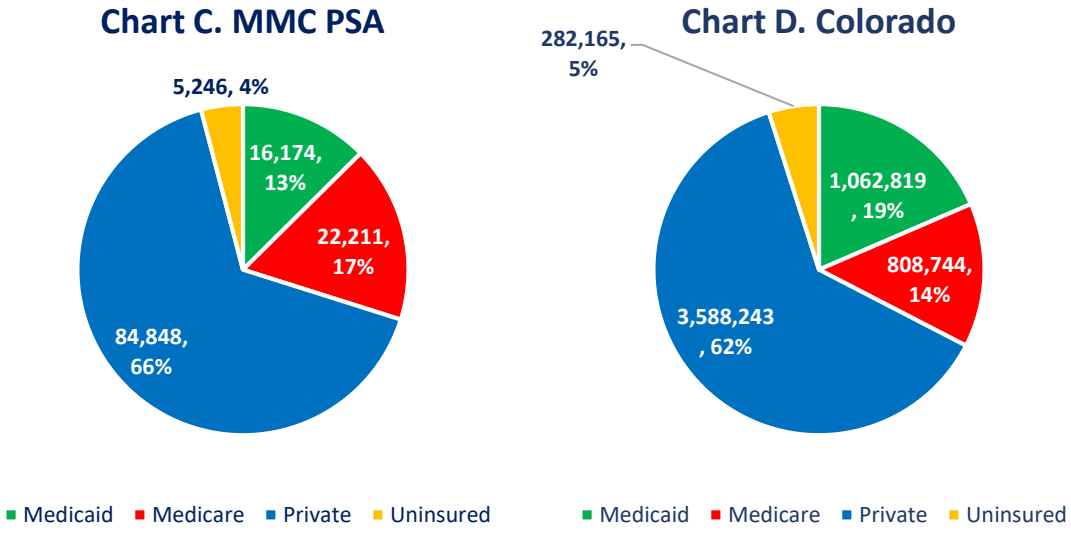


	No HS diploma	HS graduate	College no diploma	Associate degree	Bachelor's degree	Graduate or prof school degree
MMC PSA	5.0%	25.3%	23.7%	10.3%	23.5%	12.2%
Larimer County	4.4%	20.0%	21.0%	9.5%	27.7%	17.4%
Colorado	8.5%	22.0%	21.0%	8.6%	24.9%	14.9%

**Over the Age of 25; Sources: Crimson, Advisory Board, 2019*

Insurance Coverage Estimates for PSA and State of Colorado Population

The charts below indicate that the PSA has a higher percentage of the population who is insured privately than that of the state (66% to 62%). In terms of Medicaid and Medicare, the PSA has a larger population utilizing Medicare compared to Medicaid, it is the opposite for the state. This correlates with the PSA having a larger population who is 65+ to the state and the state having a larger unemployed population compared to the PSA.

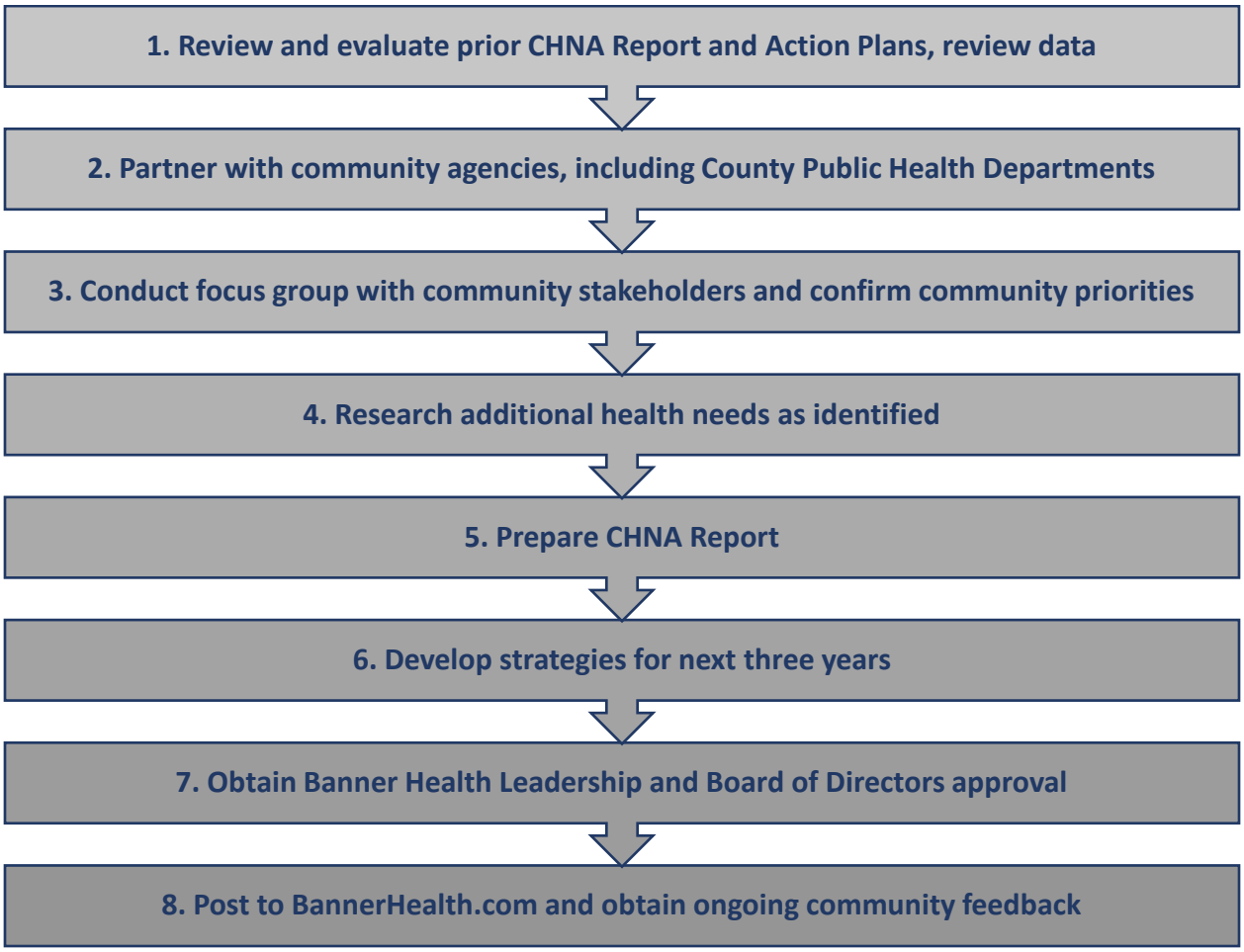


Source: 2017-18 Colorado State Data, Truven

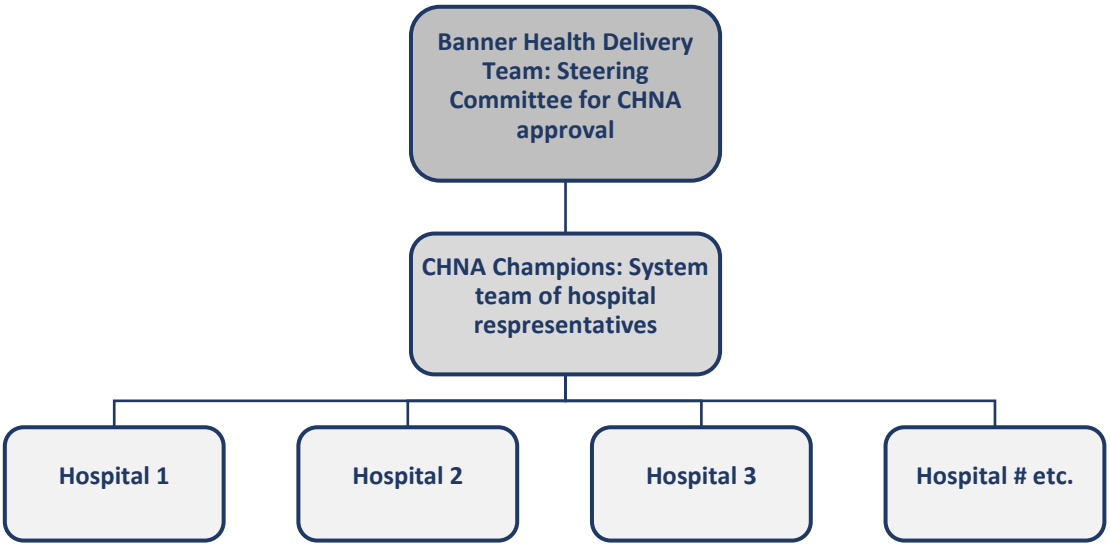
PROCESS AND METHODS USED TO CONDUCT THE CHNA

McKee Medical Center's process for conducting Community Health Needs Assessments (CHNAs) involve a leveraged multi-phased approach to understanding gaps in services provided to its community, as well as existing community resources. In addition, a focused approach to understanding unmet needs especially for those within underserved, uninsured and minority populations included a detailed data analysis of national, state and local data sources is conducted, including obtaining input from leaders within the community.

McKee Medical Center's eight step process based on experience from previous CHNA cycles is demonstrated below. The process involves continuous review and evaluation of CHNAs from previous cycles, through both the action plans and reports developed. Through each cycle Banner Health and McKee Medical Center has been able to provide consistent data to monitor population trends.



BANNER HEALTH CHNA ORGANIZATIONAL STRUCTURE



PRIMARY DATA / SOURCES

Primary data, or new data, consists of data that is obtained via direct means. For Banner, by providing health care to patients, primary data is created by providing that service, such as inpatient / outpatient counts, visit cost, etc. For the CHNA report, primary data was also collected directly from the community, through stakeholder meetings.

The primary data for the Community Health Needs Assessment originated from Cerner (Banner's Electronic Medical Record) and McKesson (Banner's Cost Accounting / Decision Support Tool). These data sources were used to identify the health services currently being accessed by the community at Banner locations and provides indicators for diagnosis-based health needs of our community. This data was also used to identify the primary services areas and inform the Steering Committee (Appendix C) and facility champions on what the next steps of research and focus group facilitation needed to entail.

SECONDARY DATA / SOURCES

Secondary data includes publicly available health statistics and demographic data. With input from stakeholders, champions, and the steering committee, additional health indicators of special interest were investigated. Comparisons of data sources were made to the county, state, and PSA if possible.

Data analytics were employed to identify demographics, socioeconomic factors, and health trends in the PSA, county, and state. Data reviewed included information around demographics, population growth, health insurance coverage, hospital services utilization, primary and chronic health concerns, risk factors and existing community resources. Several sources of data were consulted to present the most

comprehensive picture of McKee Medical Center's PSA's health status and outcomes. Appendix B has the data sources listed.

DATA LIMITATIONS AND INFORMATION GAPS

Although the data sources provide an abundance of information and insight, data gaps still exist, including determining the most appropriate depth and breadth of analyses to apply. Additional gaps include:

Table 3. Data Limitations and Information Gaps

Data Type	Data Limitations and Data Gaps
Primary Data	• Data not available on all topics to evaluate health needs within each race / ethnicity by age-gender specific subgroups. • Limited data is available on diabetes prevalence and health risk and lifestyle behaviors (e.g. nutrition, exercise) in children. • Data limited to county may over generalize population and may not be representative of specific zip code populations serviced.
Secondary Data	• Data not available on all topics to evaluate health needs within each race / ethnicity by age-gender specific subgroups. • Not all counties participated in the Colorado County Health Outcomes and Health for 2018, thus understanding the health rankings for the county was limited due to the lack of a complete data set. • Public transportation is based on commuter's data.

COMMUNITY INPUT

Once gaps in access to health services were identified through data analytics, as explained above, Banner Health system representatives worked with McKee Medical Center's leadership to identify those impacted by a lack of health-related services. The gaps identified were used to drive the conversation in facilitating Community Stakeholder Focus Groups. Focus group participants involved PSA community leaders, community focused programs, and community members, all of which represented the uninsured, underserved, and / or minority populations. These focus groups (through a facilitated conversation) reviewed and validated the data, providing additional health concerns and feedback on the underlying issues for identified health concerns. A list of the organizations that participated in the focus groups can be found under Appendix C and a list of materials presented to the group can be found under Appendix D.

PRIORITIZATION OF COMMUNITY HEALTH NEEDS

To be considered a health need the following criteria was taken into consideration:

- The county had a health outcome or factor rate worse than the state / national rate
- The county demonstrated a worsening trend when compared to state / national data in recent years
- The county indicated an apparent health disparity
- The health outcome or factor was mentioned in the focus group
- The health need aligned with Banner Health's mission and strategic priorities

Building on Banner Health's past two CHNAs, our steering committee and facility champions worked with Banner Health corporate planners to prioritize health needs for Cycle 3 of the CHNA. Facility stakeholders, community members, and public health professionals were among major external entities involved in identifying health needs, which were then brought to the steering committee. Both Banner Health internal members, and external entities were strategically selected for their respective understanding of community perspectives, community-based health engagement, and health care expertise.

Using the previous CHNAs as a tool, the steering committee reviewed and compared the health needs identified in 2019 to the previous health needs. The group narrowed the community health needs to three. It was determined that Banner Health, as a health system would continue to address the same health needs from Cycle 2, the 2016 CHNA, due to the continued impact these health needs have on the overall health of the community. These needs and the strategies to address the needs align with the short- and long-term goals the health system has, specific strategies can be tailored to the regions Banner Health serves, and the health needs can address many health areas within each of them. The graphic below lists the three health needs, and the areas addressed by the strategies and tactics.

Access to Care	Chronic Disease Management	Behavioral Health
•Affordability of care •Uninsured and underinsured •Healthcare provider shortages •Transportation barriers	•High prevalence of: heart disease, diabetes, and cancer •Obesity and other factors contributing to chronic disease •Health literacy	•Opioid Epidemic •Vaping •Substance abuse •Mental health resources and access

DESCRIPTION OF PRIORITIZED COMMUNITY HEALTH NEEDS

Banner Health has a strong history of dedication to its community and of providing care to the underserved populations. The CHNA process continues to help identify additional opportunities to better care for populations within the community who have special and / or unmet needs; this has only strengthened our commitment to improving the health of the communities we serve. The following statements summarize each of the areas of priority for McKee Medical Center and are based on data and information gathered through the CHNA process.

PRIORITY #1: ACCESS TO CARE

Access to care is a critical component to the health and wellbeing of community members. Often individuals without insurance, and even those who are underinsured, experience greater difficulty readily accessing health care services, particularly preventative and maintenance health care. This can be very costly, both to the individuals and the health care system. Focus group participants overwhelmingly felt that access to care is an important issue for the community.

Low-income populations are known to suffer at a disproportionate rate to a variety of chronic ailments, delay medical care, and have a shorter life expectancy compared to those living above the poverty level (Elliott, Beattie, Kaitfors, 2001). Understanding income and its correlation to access to care, primarily through access to health insurance, is necessary to understand the environmental factors that influence a person's health. Research supports the correlation between income and health, compared to high-income Americans those with low-incomes have higher rates of heart disease, diabetes, stroke, and other chronic conditions (Khullar, Dhruv, Chokshi, 2018).

Table 4 breaks down the percentage of the community living in various states below poverty levels. Overall it appears that Larimer County's population living below FPLs is representative to that of the state at a slightly higher rate.

Table 4. Percentage Below Federal Poverty Level (FPL) 2013 – 2017

	Larimer County	Colorado	U.S.
Population Below FPL			
50%	6.4%	5.14%	6.48%
100%	12.45%	11.51%	14.58%
185%	25.14%	25.08%	30.11%
200%	27.46%	27.55%	32.75%

Children Below FPL			
100%	10.9%	18.32%	20.31%
200%	27.98%	45.08%	42.24%

Source: U. S. Census Bureau, American Community Survey, 5-Year Estimates, 2013 – 2017

A Health Professional Shortage Area is a designation indicating a health care provider shortage in primary, dental, and / or mental health. In the US 23% of the population is living in an area affected by a HPSA compared to 19.2% of Colorado and 15.1% of Larimer County (HHS, February 2019). While the populations living in Larimer County and Colorado do not meet the designation of an HPSA – both the state and county have a higher ratio of population to primary care physicians when compared to the national 90th percentile.

Table 5 shows the ratio of the population to primary care physicians, in year 2019 Larimer County continues to minimally decrease in the ratio of population to provider.

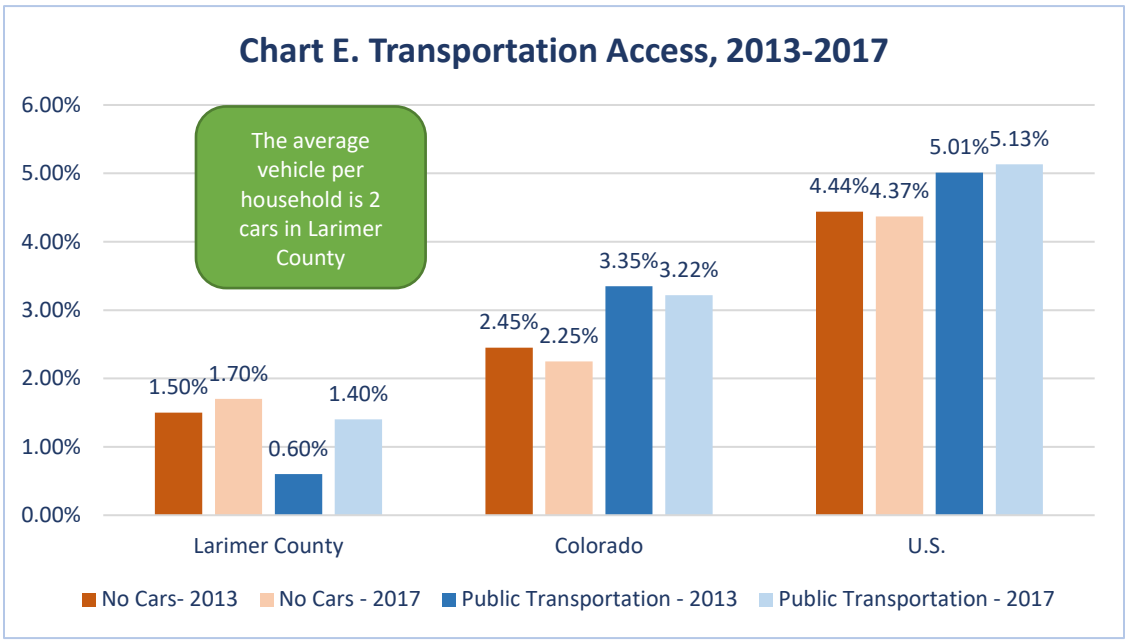
Table 5. Ratio of Population to Primary Care Physicians

	Larimer County	Overall in Colorado	Top U.S. Performers (90th Percentile)
2017	1,160:1	1,240:1	1,040:1
2018	1,160:1	1,240:1	1,030:1
2019	1,140:1	1,230:1	1,050:1

Source: County Health Rankings, 2017-2019

Transportation barriers are often associated as a barrier to healthcare access – including missed appointments, delayed care, and missed / delayed medication use. These results lead to poor health management, and to poor health outcomes (Syed, Gerber, Sharp, 2013).

In 2013 1.3 percent of the Larimer County residents had no car, by 2017 that increased to 1.7 percent. Over the same period of time, public transportation use has doubled in Larimer County, yet is still significantly behind the national average. For this report we have used commuter data to interpret general utilization of public transportation for county residents. Lack of public transportation can lead to low utilization of public transportation services. These transportation barriers in Chart E can impact access to care due to the lack of alternative transportation methods.



Source: Census Bureau, American Community Survey, 5-Year Estimates, 2013 - 2017

PRIORITY #2: CHRONIC DISEASE MANAGEMENT

Chronic diseases such as cancer, diabetes, and heart disease affect the health and quality of life of Larimer County residents, but they are also major drivers in health care costs. In Colorado alone cardiovascular disease is the number one cause of premature death.

In Table 6 you can see that while the mortality rate of cardiovascular disease in Colorado is the number one cause of death in Larimer County at 153.0 per 100,000 of the population. The mortality rate of Alzheimer's diseases and diabetes is greater than the state average. This could be due to Larimer County having a slightly more aged population compared to the state (Table 2).

Table 6. Chronic Disease Mortality Rates, 2018

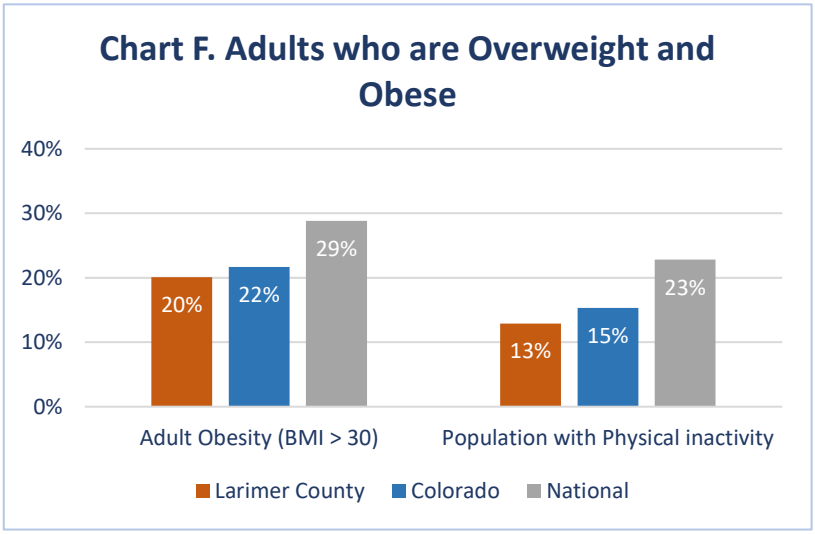
	Larimer	Colorado
Cardiovascular Disease	153.0 (141.0-165.0)	167.9 (164.6-171.2)
Cancer	117.9 (107.2-128.6)	126.2 (123.3-129.0)
Chronic Lower Respiratory Diseases	37.2 (31.3-43.1)	43.3 (41.9-45.0)
Unintentional Injuries	44.6 (37.6-51.5)	51.2 (49.4-53.1)
Pneumonia and Influenzas	10 (7.0-13.1)	9.6 (8.8-10.3)

Diabetes Mellitus	16.1 (12.1-20.2)	15.8 (14.8-16.9)
Alzheimer's Disease	30.7 (25.3-36.2)	28.9 (27.5-30.3)

Source: Colorado Department of Public Health and Environment, 2018

Obesity can be an indicator for chronic diseases down the road (Chart F). Obesity is defined as having a Body Mass Index (BMI) score greater than 30 (BMI > 30.0), while being overweight, a precursor to obesity is defined as having a BMI from 25 to 30 (CDC, 2015). Body Mass Index is determined by a person's height and weight. Obesity can contribute to chronic diseases, as well as environmental factors such as physical inactivity and food access (CDC, 2017).

Chart F shows the populations national, state and county trends of obesity and physical inactivity prevalence. Larimer County has an adult obesity and physical inactivity rate that is lower than state averages and national averages. While lower than state and national rates, 1/5th of the county population is recognized as obese. During the focus group participants discussed physical inactivity as a concern in their community.



Source: County Health Rankings, 2019

Data collected in 2016 indicates there are food access concerns in Larimer County. The county has about 12 grocery stores per 100,000 residents, which is significantly lower than the states ratio of 16 and the U.S. at 21 per 100,000 (US Census Bureau, 2019). Access to foods, specifically to fresh and healthy food can become a strong indicator for positive health behaviors, measuring access to local grocery stores is a way to measure access.

PRIORITY #3: BEHAVIORAL HEALTH (SUBSTANCE ABUSE / DEPRESSION / BEHAVIORAL HEALTH)

Behavioral Health encompasses both mental health conditions, such as depression and anxiety disorder; and substance abuse issues, including opioid addiction, alcohol, illicit drugs, and tobacco. According to the Substance Abuse and Mental Health Services Administration, in 2018 47.6 million U.S. adults experienced mental illness, representing 1 in 4 adults or 19.1 percent of the adult population in the U.S (SAMHSA, 2019). In Larimer County the ratio of the population to Mental Health Care Providers is higher compared

to the state average, this lack of access to mental health providers can have reverberating effects on the behavioral health of a community.

Table 7. Access to Mental Health Care Providers in 2019

	Larimer County	Colorado	U.S.
Ratio of Population to Mental Health Providers	320:1	300:1	310:1

Source: County Health Rankings, 2019

2019 County Health data indicates 14 percent of residents in Colorado reported their health as "fair or poor" compared to the national average of 12 percent. The average number of self-reported mentally unhealthy days is greater in Colorado when compared to the national average. Adults in Larimer County (10%) report having mental distress, slightly higher compared to the state estimate (9.9%) (CDPHE, 2017).

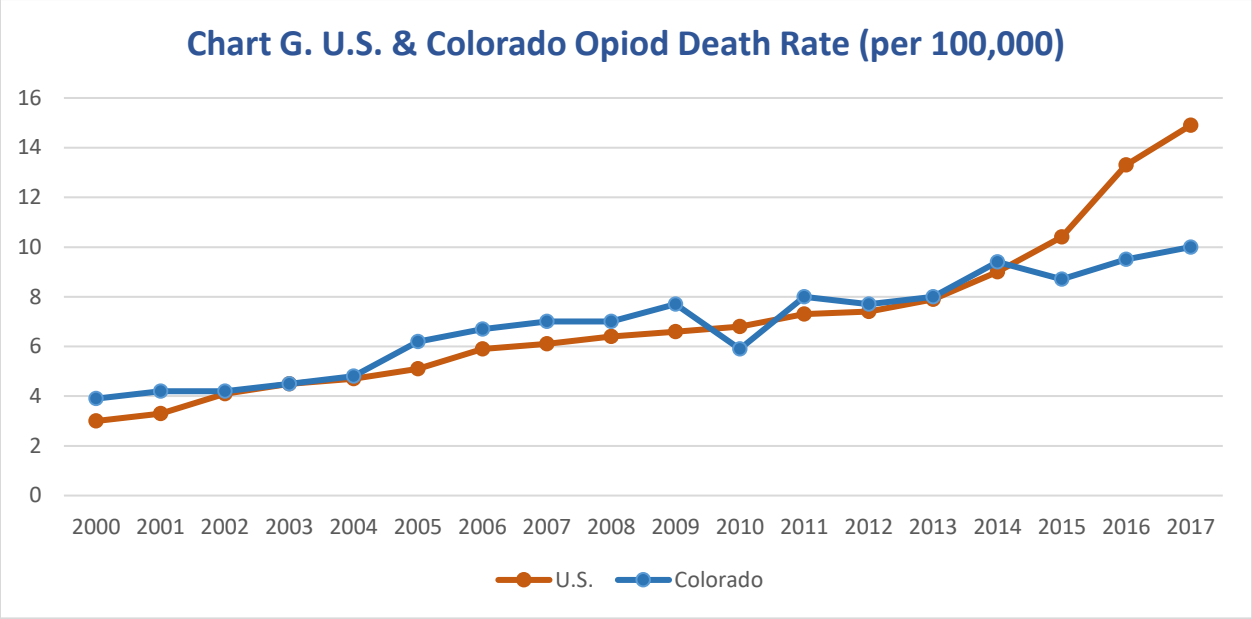
Table 8 indicates the suicide mortality rate is slightly higher in Larimer County, compared to the state.

Table 8. Substance Abuse and Suicide Mortality Rates, 2018

	Larimer County	Colorado
Suicide	22.2	21.6
Drug-Induced Deaths	14.8	17.2
Alcohol-Induced Deaths	12.7	16.3
Drug Induced Overdose	14.29	16.5
Drug Overdose involving any opioid (prescription or illicit, including heroin)	6.22	9.1

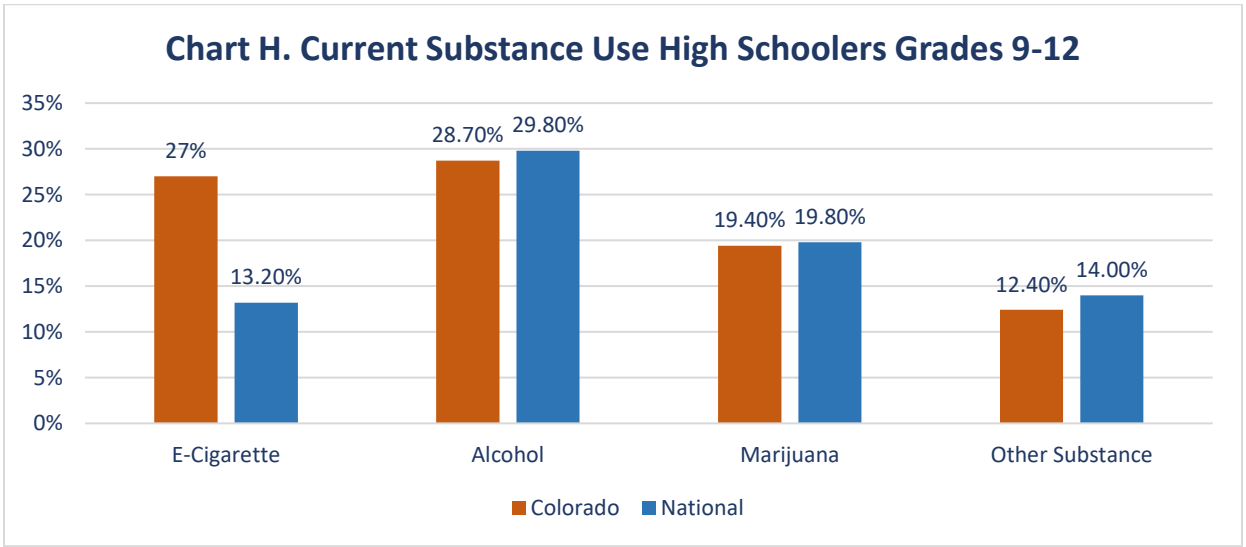
Source: Colorado Department of Public Health and Environment, 2018

The opioid crisis is affecting communities throughout the United States, in Colorado there has been a steady increase in the number of opioid deaths from 2000 to 2017 (Chart G). While Larimer County has had a decrease in opioid prescriptions 65.4 per 100,000 in 2006 to 52.7 per 100,000 in 2017, there continues to be an increase in opioid overdoses (CDC, July 2017). This trend can be an indicator for increased opioid addiction and use of illicit opioids.



Source: Centers for Disease Control and Prevention, January 2019

E-Cigarette use (electronic vapor product use) among Colorado High Schoolers is much higher compared to national rates (Chart H). Use of alcohol, marijuana and other substances for Colorado high schoolers are similar to national average. Colorado has a significantly higher prevalence of current (past 30 days) e-cigarette use compared to the national rate (21% Colorado vs. 13.2% national). Pacific Islander youth in Colorado are at twice the rate as the state average for other substance abuse and are at a higher risk of alcohol and e-cigarette use, compared to their peers (Healthy Kids of Colorado Survey, 2017).



Source: Healthy Kids Colorado Survey (HKCS), 2017

Lung disease as the result of vaping is a rising health concern, specifically its effects on the health and health behaviors of youth, as of November there are currently over 2,000 confirmed and probable cases, not including cases that are under investigation. Vaping has affected 36 states, resulted in nearly 50 deaths, and the numbers continue to rise (CDC, September 2019). Characteristics that factor into an adolescent smoking include, older age (High School aged), being male, being white (compared to Black and Hispanic adolescents), lacking college plans, having parents who are not college educated, and experiencing highly stressful events (HHS, 2019). Based on data in Chart H, it is clear there is a gap in tobacco use education in young Colorado communities.

NEEDS IDENTIFIED BUT NOT PRIORITIZED

Focus Group participants discussed their concerns regarding inactivity, lifestyle choices, tobacco cessation, and health education in their communities. It was determined that while all are important and addressing these health needs in the long term would have a positive effect on the community's health, the current health priorities were encompassing enough that the listed health needs would be addressed in the upcoming cycle by the three prioritized community health needs.

2016 CHNA Follow Up and Review

Feedback on Preceding CHNA / Implementation Strategy

In the focus groups the facilitators referred to the cycle 2 CHNAs significant areas. Specific feedback on the impact the strategies developed to address the health need is included in Table 9 below. In addition, the link to the 2016 report was posted on the Bannerhealth.com website and made widely available to the public. Over the past three years little feedback via the email address has been collected, but the account has been monitored.

In order to comply with the regulations, feedback from cycle 3 will be solicited and stored going forward. Comments can be sent to CHNA.CommunityFeedback@bannerhealth.com

Impact of Actions Taken Since Preceding CHNA

Table 9 indicates what actions have been taken on the cycle 2 CHNA action plan in creating impact in the McKee Medical Center PSA.

Table 9. Implementation Strategies 2016 for McKee Medical Center Primary Service Area

Significant Need #1: Access to Care
Strategy #1: Increase use of Banner Urgent Care facilities and improve access to primary care services
Impact of Tactics: • We offer extended hours of Primary Care Provider (PCP) clinics within Banner Medical Group • We collaborate with other local healthcare resources to align potential patients with our services • MMC offers and participates in free health activities for the community, including health screenings, and health fairs • McKee Medical Center continues to promote participation in MyBanner, our online patient portal • We have implemented patient centered medical homes in our community, via Banner Medical Group.
Significant Health Need #2: Chronic Disease (Diabetes / Heart Disease)
Strategy #1: Increase personal management of Chronic Disease
Impact of Tactics: • MMC continues to work to increase our mammography screenings • We provide chronic disease educational offerings in the community, leveraging our partnerships with community-based organizations to help host and promote the events to a broader community population
Significant Need #3: Behavioral Health (Mental Health & Substance Abuse)
Strategy #1: Increase identification of behavioral health needs and access to early interventions
Impact of Tactic • We have deployed a depression screening tool in Primary Care Provider (PCP) clinics and Pediatric Provider clinics within Banner Medical Group.

- We are continuing to partner with local behavioral health inpatient facilities to provide acute stabilization care and discharge planning and follow-up for patients who do not have a payer source.
- We are opening a 17 bed acute psychiatric stabilization unit for geriatric patients.
- We are opening a senior behavioral health outpatient clinic that will provide outpatient psychiatric care for geriatric patients with behavioral health needs. This unit will also provide step-down care for the Inpatient geriatric psychiatric unit to provide a continue of care and to prevent readmission.
- We provide psychiatric crisis assessments in all three Banner emergency departments.
- We have added tele-psych assessment capability to all three Banner emergency departments.
- We participate in local community interagency groups which identify and collaborate regarding services for residents.
- We partner with Rocky Mountain Crisis Partners for follow care for at risk patients.
- We collaborate with local law enforcement and mobile assessment team to identify behavioral health needs and proper use of resources.

APPENDIX A. STAKEHOLDERS AND RESOURCES POTENTIALLY AVAILABLE TO ADDRESS NEEDS

Listed below are available resources in the community to address the three priority needs. This list, while not exhaustive, identifies individuals/ organizations external to Banner Health that represent the underserved, uninsured, and minority populations. Stakeholders were identified based on their role in the public health realm of the hospital's surrounding community. These stakeholders are individuals/ organizations with whom we are collaborating, or hope to do, around improving our communities. Each stakeholder is vested in the overall health of the community and brought forth a unique perspective with regards to the population's health needs. This list does not include all the individuals and organizations that have participated in the focus groups.

Name of Organization	Website	Phone Number	Address	Priority Area
Summit Stone	www.summitstonehealth.org	970-494-4200	4856 Innovation Dr. Ste B Fort Collins, CO 80525	BH/SA
North Range Behavioral Health	www.northrange.org	970-347-2120	928 12th Street Greeley, CO 80631	BH/SA
Northeast Health Partners	www.northeasthealthpartners.org	888-502-4189	710 11th Avenue Suite 203 Greeley, CO 80631	BH/SA
North Colorado Health Alliance	www.northcoloradohealthalliance.org	970-350-4673	2930 11th Avenue | Evans, CO 80620 1010 A Street, Greeley, CO 80631 302 3rd Street SE, Loveland, CO 80537	All
Front Range Behavioral	www.frontrangementalhealth.com	800-511-2795	1067 E. US Hwy 24, #294, Woodland Park, CO 80863	BH
Banner Health Medical Group	www.bannerhealthnetwork.com	800-827-2464		CD/AC
Banner North Colorado Family Medicine	https://www.bannerhealth.com/locations/greeley/north-colorado-family-medicine	970-810-2424	1600 23rd Ave Greeley, CO 80634	CD/AC
Larimer Health Department	www.larimer.org/health	970-498-7000	220 W. Oak Street Fort Collins, CO 80521	All
Neurofeedback Clinic	www.ncnoco.net	970-493-4580	4415 Boardwalk Drive Fort Collins, CO 80525	BH

APPENDIX B. LIST OF DATA SOURCES

PRIMARY AND SECONDARY DATA SOURCES

The primary data sources that were utilized to access primary service information and health trends include:

Advisory Board (2019) Primary Service Area Demographic Data.

Elliott, M. K. Beattie, S. E. Kaitfors. (May 2001) Health needs of people living below poverty level. Family Medicine; 33(5): 361–366.

Health and Human Services – Health Resources and Services Administration (February 2019) Health Professional Shortage Area.

Health and Human Services – Office of Population Affairs. (April 2019) Adolescents and Tobacco: Risk and Protective Factors

Colorado Department of Public Health and Environment. (2017) CDPHE Community Level Estimates on Health Conditions and Risk Behaviors 2014-17.

Colorado Department of Public Health and Environment. (2018) Colorado Health Information Dataset.

Colorado Department of Public Health and Environment. (2017) Health Kids Colorado Survey.

County Health Rankings and Roadmaps. (2019) Colorado Health Outcomes and Factors.

Khullar, Dhruv and Chokshi, Dave A. (October 2018) Health, Income, & Poverty: Where We Are & What Could Help. Health Affairs – Health Policy Brief the Culture of Health.

McKesson. (2018) Primary Service Area Data Set.

National Center for Disease Prevention and Health Promotion – Population Health. (2012) Behavioral Risk Factor Surveillance System.

National Center for Disease Prevention and Health Promotion – Division of Nutrition, Physical Activity, and Obesity. (May 2015) Healthy Weight – Assessing Your Weight Body Mass Index.

National Center for Chronic Disease Prevention and Health Promotion – National Center for Injury Prevention and Control. (July 2017) Opioid Overdose - U.S. County Prescribing Rates, 2017.

National Center for Chronic Disease Prevention and Health Promotion – Division of Nutrition, Physical Activity, and Obesity. (2017). Adult Obesity Causes and Consequences.

National Center for Chronic Disease Prevention and Health Promotion. (January 2019) CDC Wonder Online Database.

National Center for Disease Control and Prevention – Smoking & Tobacco Use. (November 2019) Outbreak of Lung Injury Associated with the Use of E-Cigarette, or Vaping, Products.

National Center for Chronic Disease Prevention and Health Promotion – National Center for Health Statistics. (2019) Stats of the State of Colorado.

Substance Abuse and Mental Health Services Administration - Center for Behavioral Health Statistics and Quality. (2019). Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health.

Syed, S. T., Gerber, B. S., & Sharp, L. K. (2013). Traveling towards disease: transportation barriers to health care access. *Journal of community health*

Truven. (2017-18) Colorado State Data

U.S. Census Bureau. (2017) American Community Survey

FOCUS GROUPS

Engagement Activity	Partners Included	Topics of Discussion
Opioid Prevention Work Group and Health System Behavioral Health	Summit Stone Behavioral Health, University of Colorado Health, North Range Behavioral Health, North Larimer Health District, Larimer County Health Dept.	Implementation of ALTO in health system Emergency depts., Implementation and operationalizing ED and jailed patients to Medication Assisted Therapy for substance use disorder
Colorado Opiate Synergy Larimer and Weld County	Northeast Health Partners, Northern Colorado Health Alliance, Front Range Behavioral Health, Summitstone Behavioral Health, Opisafe, UC Health, BH Recovery, Rocky Mountain Health Plan, Greeley Fire, Banner Health	Improvement in the substance use disorder by use of medically assisted therapy. Reduction in overdose deaths, decrease in opioid prescription related hospitalization rate
ALTO-Alternatives to Opioids	All Banner Health facilities in Colorado and system wide	Implementation of EMR care sets for the transitions to ALTO therapies in the ED
Affiliated Skilled Nursing Facility Quarterly meeting	14 independent Skilled Nursing facilities in Weld and Larimer County, Banner Health Post-Acute Care Leadership	Utilization, length of stay, readmissions for skilled nursing facility patients
McKee and Banner Fort Collins Perinatal Care Council	Banner Medical Group Obstetricians	Implementation of Colorado Perinatal Care Collaborative Guidelines for Reduction for Nulliparous C-Section rates

APPENDIX C. STEERING COMMITTEE AND CHNA FACILITY-BASED CHAMPIONS

STEERING COMMITTEE

Banner Health CHNA Steering Committee, in collaboration with McKee Medical Center's leadership team and Banner Health's Strategic Planning and Alignment department were instrumental in both the development of the CHNA process and the continuation of Banner Health's commitment to providing services that meet community health needs.

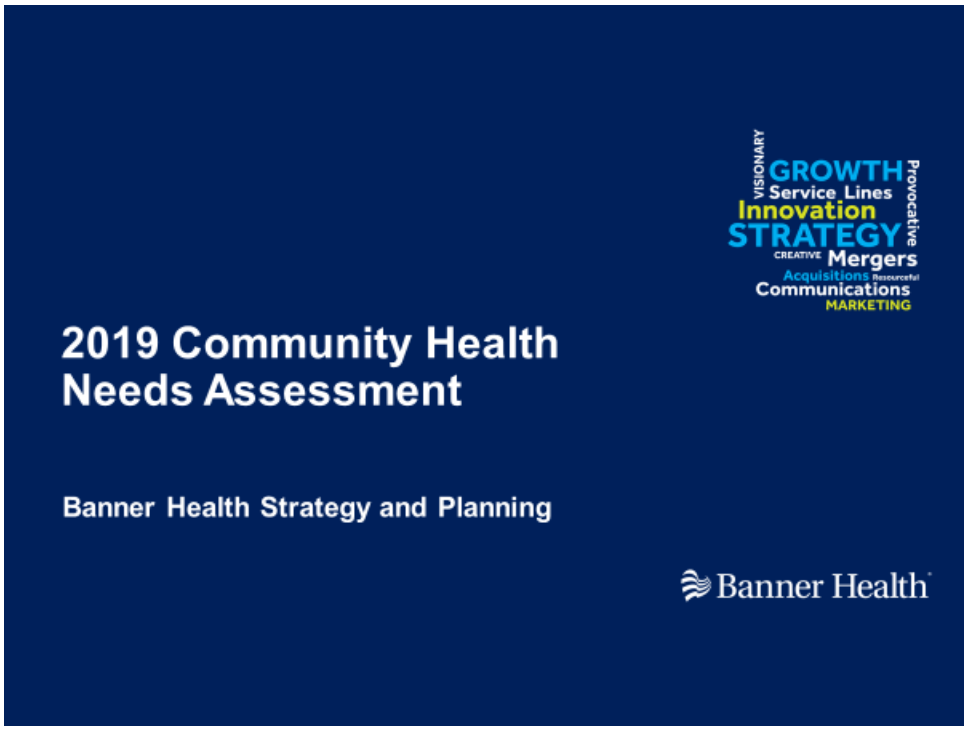
Steering Committee Member	Title
Darin Anderson	Chief of Staff
Derek Anderson	AVP HR Community Delivery
Ramanjit Dhaliwal	AVP Division Chief Medical Officer Arizona Region
Phyllis Doulaveris	SVP Patient Care Services / CNO
Kip Edwards	VP Facilities Services
Anthony Frank	VP Financial Operations Care Delivery
Russell Funk	CEO Pharmaceutical Services
Larry Goldberg	President University Medicine Division
Margo Karsten	President Western Division / CEO Northern Colorado
Becky Kuhn	Chief Operating Officer
Patrick Rankin	CEO Banner Medical Group
Lynn Rosenbach	VP Post-Acute Services
Joan Thiel	VP Ambulatory Services

CHNA Facility-Based Champions

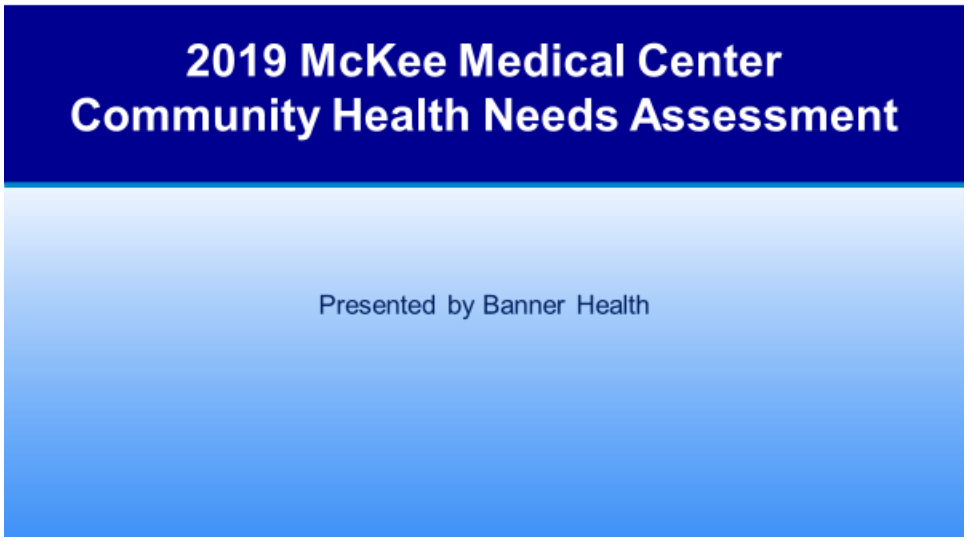
A working team of CHNA champions from each of Banner Health's 28 Hospitals meets on a monthly basis to review the ongoing progress on community stakeholder meetings, report creation, and action plan implementation. This group consists of membership made up of CEOs, CNOs, COOs, facility directors, quality management personnel, and other clinical stakeholders.

APPENDIX D. MATERIALS USED IN FOCUS GROUP

Slides used for focus groups



Banner Health



Banner at a Glance

- 28 Acute Care and Critical Access Hospitals
- Behavioral Hospital
- Banner Health Network
- Banner Network Colorado
- Banner Medical Group and Banner – University Medical Group with nearly 2,000 physicians and advanced practitioners and more than 200 Banner Health Centers and Clinics
- Banner Home Care and Hospice
- Outpatient Surgery
- Urgent Care
- Banner – University Medicine division
- $7 billion in revenue in 2015
- AA- bond rating
- $746 million in community benefits, including $62.9 million in charity, 2015

Banner Health

Community Health Needs Assessment Purpose

- Gather input and feedback from community leaders that represent the community
- Validate and/or identify significant areas of healthcare need within the community
- Promote collaborative partnerships
- Identify opportunities to engage with the community in addressing potential areas of need
- Requirement of the Patient Protection and ACA

Banner Health

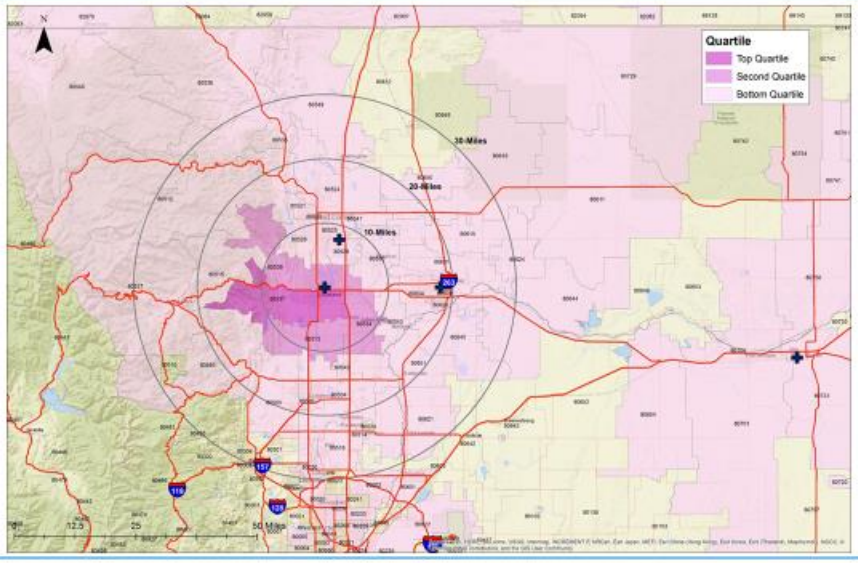
2018 Community Benefit

Facility:	Bad Debt:	Charity Care:	2018 Community Benefit:
NCMC	$15,460,000	$34,291,000	**$49,751,000**
McKee	$4,413,000	$6,181,000	**$10,594,000**
Ft. Collins	$1,838,000	$1,914,000	**$3,752,000**
NOCO Total:	**$21,711,000**	**$42,386,000**	**$64,097,000**

Source: Banner Financials December 2018 - Unaudited

MMC - Inpatient Origin by Zip Code

January 1, 2017 through December 31, 2017 (Top 3 contiguous quartiles = 75% of total discharges)



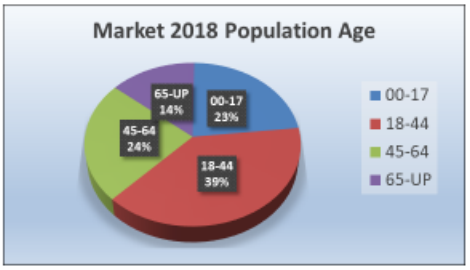
Source: Banner Strategy and Planning

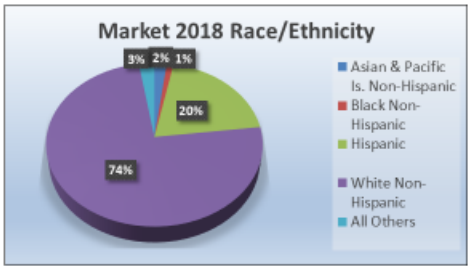
MMC 2018 Demographic Snapshot – Larimer and Weld Co

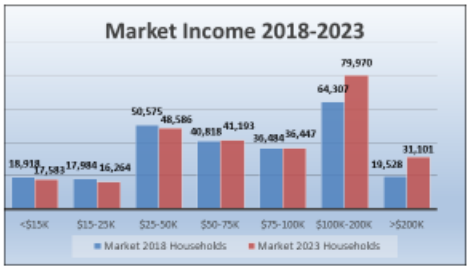
Sg2 MARKET SNAPSHOT

Banner Health
Larimer and Weld Counties, Colorado

Population and Gender	Market 2018 Population	Market 2018 % of Total	Market 2023 Population	Market 2023 % of Total	Market Population % Change
Female Population	321,272	49.9%	348,914	50.0%	8.6%
Male Population	322,343	50.1%	348,907	50.0%	8.2%
Total	**643,615**	**100.0%**	**697,821**	**100.0%**	**8.4%**

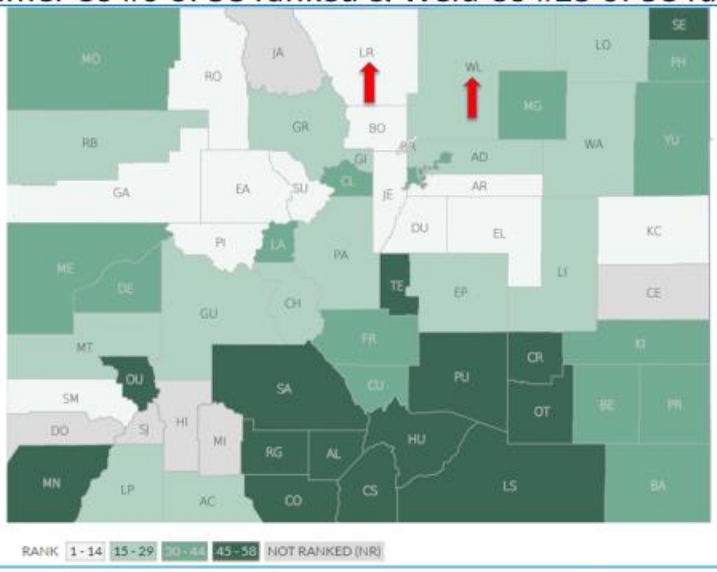






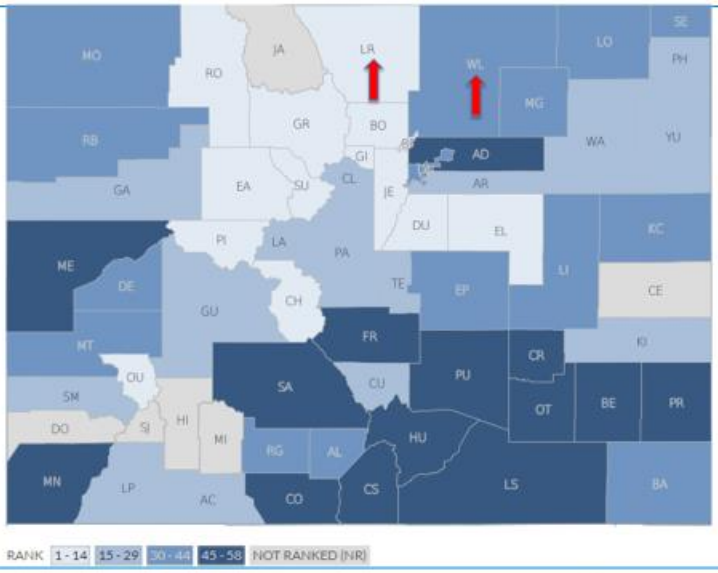
Source: SG2 Health Care Intelligence

2018 Colorado County Health Outcomes Rankings
Larimer Co #6 of 58 ranked & Weld Co #23 of 58 ranked



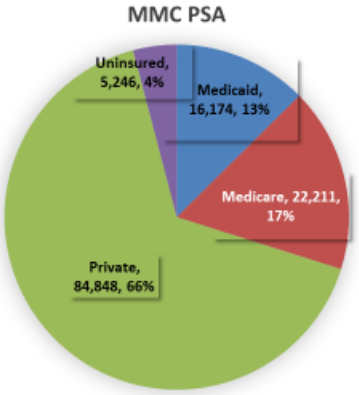
http://www.countyhealthrankings.org/app/colorado/2018/rankings/outcomes/overall

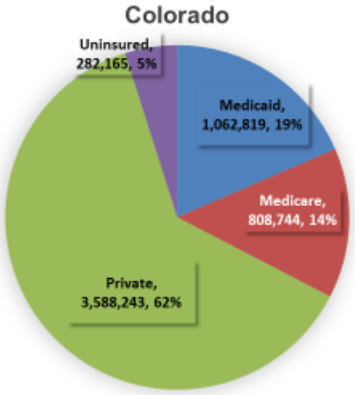
2018 Colorado County Health Factors Rankings
Larimer Co #12 of 58 Ranked & Weld Co #32 of 58 Ranked



http://www.countyhealthrankings.org/app/colorado/2018/rankings/outcomes/overall

2019 Insurance Estimates = Top 75% Patient Origin*





PSA/Top 75% Patient Origin Zip Codes:
80513, 80534, 80537, 80538

Source: 2017-18Q2 Colorado State Data

Source: Truven

County Health Rankings

Health Outcomes

- Health outcomes in the *County Health Rankings* represent how healthy a county is. They measured two types of health outcomes: how long people live (mortality) and how people feel while alive (morbidity).

Health Factors

- Health factors in the *County Health Rankings* represent what influences the health of a county. They measured four types of health factors: health behaviors, clinical care, social and economic, and physical environment factors. In turn, each of these factors is based on several measures.

Source: www.countyhealthrankings.org

2019 County Health Rankings

- Larimer County ranks 6th out of 58 Colorado Counties in Health Outcomes
- Adult smoking, and excessive drinking are areas of improvement to explore, compared to national benchmark.
- Areas of strength include lower physical inactivity, teen births, and most clinical care measures.
- Lower percentage of mammography screenings than US benchmark
- Higher unemployment than US benchmark

	Larimer County	Rank of 58	Top U.S. Performers	Colorado
Health Outcomes		6		
Length of Life		10		
Premature death	4,900		5,300	5,700
Quality of life		8		
Poor or fair health**	10%		12%	12%
Poor physical health days**	3.0		3.0	3.4
Poor mental health days**	3.2		3.1	3.6
Low birth weight	8%		6.0%	9%
Health Factors		12		
Health Behaviors		8		
Adult Smoking**	13%		14%	16%
Adult Obesity	18%		26%	21%
Food Environment Index	7.9		8.6	8.2
Physical Inactivity	13%		20%	15%
Access to exercise opportunities	94%		91%	91%
Excessive Drinking**	22%		13%	21%
Alcohol impaired driving deaths	31%		13%	35%
Sexually transmitted infections	340.0		145.1	445.4
Teen births	14		15	24
Clinical Care		5		
Uninsured	7%		6%	9%
Primary Care Physicians	1,160:1		1,030:1	1240:1
Dentists	1,240:1		1,280:1	1290:1
Mental Health Providers	350:1		330:1	330:1
Preventable Hospital Stays	30		35	31
Diabetic Monitoring	88%		91%	84%
Mammography Screening	66%		71%	60%

Area of Strength
Area of Concern

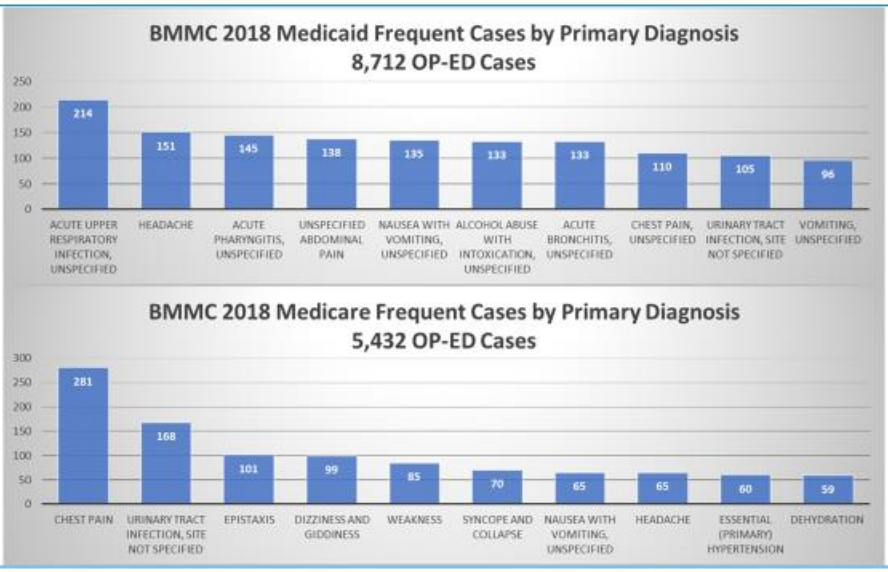
Source: http://www.countyhealthrankings.org/app/colorado/2018/rankings/larimer/county/outcomes/overall/snapshot
** Data should not be compared to prior years

	Larimer County	Rank (of 58)	U.S. Benchmark	Colorado
Social & Economic Factors		16		
High School Graduation	79%		95%	77%
Some College	81%		72%	71%
Unemployment	2.8%		3.2%	3.3%
Children in Poverty	10%		12%	13%
Income Inequality	4.5		3.7	4.5
Children in Single-parent households	25%		20%	28%
Social Associations	9.0		22.1	8.7
Violent crimes	208		62	309
Injury Deaths	68		55	74
Physical Environment		54		
Air pollution-particulate matter	7.8		6.7	5.4
Drinking water violations	Yes		No	No
Severe housing problems	18%		9%	17%
Driving alone to work	75%		72%	75%
Long commute-driving alone	26%		15%	34%

Area of Strength
Area of Concern

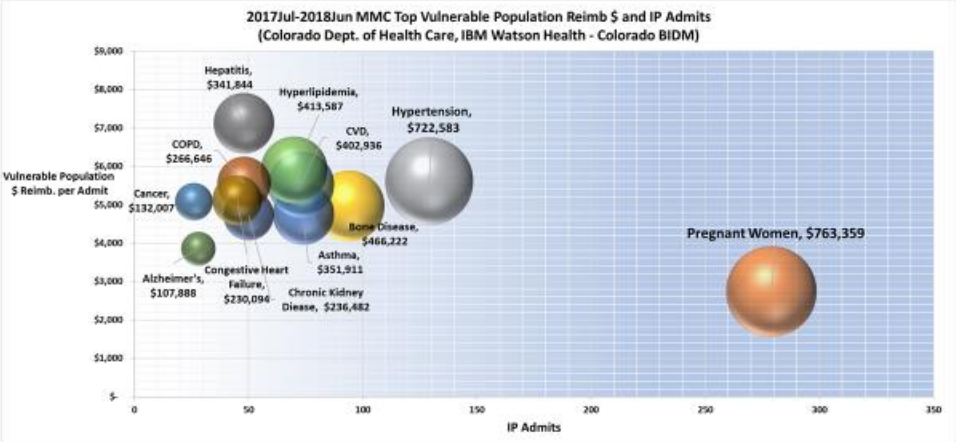
Source: http://www.countyhealthrankings.org/app/colorado/2018/rankings/larimer/county/outcomes/overall/snapshot
** Data should not be compared to prior years

Outpatient ED Visits Frequent Diagnosis



Source: Banner McKesson 2018 Full year

Vulnerable Populations IP Admits and Reimb - MMC



Top Needs Not Being Met