Cover Page

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AdventHealth Parker

2025 Community Health Needs Assessment

Extending the Healing Ministry of Christ

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Letter from Leadership

At AdventHealth, we have a sacred mission of Extending the Healing Ministry of Christ. That obligation goes beyond our hospital walls and permeates into our communities. Our commitment is to address the health care needs of our community with a holistic focus, one that strives to heal and restore the body, mind and spirit. We want to help our communities get well and stay well.

Every three years, AdventHealth hospitals across the nation complete a Community Health Needs Assessment. During this assessment, we talk and work with community organizations, public health experts and people like you who understand our communities best. This in-depth look at the overall health of our communities and the barriers to care they experience helps AdventHealth better understand the unique needs in the various communities we serve.

We use this information to create strategic plans that address the issues that impact our communities most. At AdventHealth, we know that a healthy community is not a "one size fits all" proposition — everyone deserves a whole health approach that meets them where they are and supports their individual health journey.

This work would not be possible without the partnership of public health experts, community organizations and countless community members who helped inform this report. Through these ongoing partnerships and collaborative efforts, AdventHealth will continue to create opportunities for better health in all the communities we serve.

In His service,

Terry Shaw

Executive Summary

AdventHealth Parker and AdventHealth Castle Rock conducted their CHNA jointly. The Hospitals have a shared service area and historically partner in their initiatives. This ongoing collaboration has allowed the Hospitals shared service area to benefit from an alignment of resources between the two facilities and created a strategic approach to maximizing and improving outcomes.

Portercare Adventist Health System dba AdventHealth Parker will be referred to in this document as "The Hospital." AdventHealth Parker in Douglas County, Colorado conducted a community health needs assessment from December 2024 to May 2025. The goals of the assessment were to:

- Engage public health and community stakeholders, including low-income, minority and other underserved populations.
- Assess and understand the community's health issues and needs.
- Understand the health behaviors, risk factors and social determinants that impact health.
- Identify community resources and collaborate with community partners.
- Publish the Community Health Needs Assessment.
- Use the assessment findings to develop and implement a 2025-2027 Community Health Plan based on the needs prioritized in the assessment process.

Community Health Needs Assessment Committee

To ensure broad community input, AdventHealth Parker and AdventHealth Castle Rock created a joint Community Health Needs Assessment Committee (CHNAC) to help guide the Hospitals through the assessment process. The CHNAC included representation from both Hospitals, public health experts and the broad community. This included intentional representation from low-income, minority and other underserved populations.

The CHNAC met bi-monthly from December 2024 until May 2025. They reviewed primary and secondary data and helped to identify the top priority needs in the community.

See Prioritization Process for a list of CHNAC members.

Hospital Health Needs Assessment Committee

AdventHealth Parker convened its' own Hospital Health Needs Assessment Committee (HHNAC). The purpose of the HHNAC was to select the needs AdventHealth Parker would address due to the findings in the assessment. The HHNAC made this decision by reviewing the priority needs that were selected by the CHNAC and by the internal hospital resources available. With this information, the HHNAC was able to determine where AdventHealth Parker could most effectively support the community.

See Prioritization Process for a list of HHNAC members.

Data

AdventHealth Parker in collaboration with AdventHealth Castle Rock, the Douglas County Health Department and OMNI, a social research firm, collected both primary and secondary data. The primary data included community leader interviews, a pre-prioritization meeting, key informant interviews and focus groups. Secondary data included internal hospital utilization data (inpatient, outpatient and emergency department). This utilization data showed the top diagnoses for visits to the Hospital from 2022-2024. In addition, publicly available data from state and nationally recognized sources were used. Primary and secondary data was compiled and analyzed to identify the top 10 needs.

See Process, Methods and Findings for data sources.

Community Asset Inventory

The next step was to create a community asset inventory. This inventory was designed to help the CHNAC and the HHNAC understand the existing community efforts being used to address the 10 needs identified from the aggregate primary and secondary data. This inventory was also designed to prevent duplication of efforts.

See Available Community Resources for more.

Selection Criteria

The CHNAC participated in an initial prioritization process to better define health indicators. After primary data supplemented the initial prioritization meeting, a final prioritization meeting took place that focused on reviewing all data with a facilitated discussion session. The identified needs were then ranked based on clearly defined criteria

The HHNAC reviewed and discussed the needs identified by the CHNAC and the available resources to address them in the community. The HHNAC also considered the Hospital's current resources and strategies. Through these discussions the Hospital selected the needs it is best positioned to impact.

See Prioritization Process for more.

The following criteria were considered during the prioritization process:

A. Impact on Community: What are the consequences to the health of the community of not addressing this issue now?

B. Resources: Are there existing, effective interventions and opportunities to partner with the community to address this issue?

C. Outcome Opportunities: Do interventions addressing this issue have an impact on other health and social issues in the community?

Priorities to be Addressed

The priorities to be addressed are:

1. Health Care Access and Quality: Maternal Health
2. Mental Health: Substance Use Prevention
3. Neighborhood and Built Environment: Food Security

See Priorities Addressed for more.

Approval

On May 13, 2025, the AdventHealth Parker board approved the Community Health Needs Assessment findings, priority needs and final report. A link to the 2025 Community Health Needs Assessment was posted on the Hospital's website by May 13, 2025.

Next Steps

The Hospitals will work with the CHNAC and the HHNAC to develop a measurable implementation strategy called the 2025-2027 Community Health Plan to address the priority needs. The plan will be completed and posted on the Hospital's website by May 13, 2025.

About AdventHealth

AdventHealth Parker is part of AdventHealth. With a sacred mission of Extending the Healing Ministry of Christ, AdventHealth strives to heal and restore the body, mind and spirit through our connected system of care. More than 95,000 skilled and compassionate Team Members serve over 8 million patients annually. From physician practices, hospitals and outpatient clinics to skilled nursing facilities, home health agencies and hospice centers, AdventHealth provides individualized, wholistic care at nearly 50 hospital campuses and hundreds of care sites throughout nine states.

Committed to your care today and tomorrow, AdventHealth is investing in research, new technologies and in the people behind them to redefine medicine and create healthier communities.

In a 2020 study by Stanford University, physicians and researchers from AdventHealth were featured in the ranking of the world's top 2% of scientists. These critical thinkers are changing medicine and shaping the future of health care.

Amwell, a national telehealth leader, named AdventHealth the winner of its Innovation Integration Award. This telemedicine accreditation recognizes organizations that have identified connection points within digital health care to improve clinical outcomes and user experiences. AdventHealth was recognized for its innovative digital front door strategy, which is making it possible for patients to seamlessly navigate their health care journey. From checking health documentations and paying a bill to conducting a virtual urgent care visit with a provider, we're making health care easier — creating pathways to wholistic care no matter where your health journey starts.

AdventHealth is also an award-winning workplace aiming to promote personal, professional and spiritual growth with its workplace culture. Recognized by Becker's Hospital Review on its "150

Top Places to Work in Healthcare” several years in a row, this recognition is given annually to health care organizations that promote workplace diversity, employee engagement and professional growth.

AdventHealth Parker

AdventHealth Parker is a 170-bed hospital that has been a part of the growing Parker community since 2004. Previously known as Parker Adventist Hospital, AdventHealth Parker is proud to have ‘come home’ to AdventHealth in 2023. AdventHealth is one of the nation’s largest faith-based health care systems, with more than 100,000 employees, 55 hospitals and hundreds of care sites across nearly a dozen states.

With the mission of Extending the Healing Ministry of Christ, AdventHealth Parker supports our community with expert medical care and uncommon compassion. We have proudly served Parker, Aurora, Elizabeth, and the surrounding communities for 20 years and counting, specializing in emergency care, complex surgery, cancer care, and more.

Distinctive Services

- Bariatric care
- Cancer care
- Colorectal care
- Emergency care
- Genomics
- Heart and vascular care
- Imaging
- Mother and baby care
- Neurology and brain care
- Joint replacement and general orthopedics
- Outpatient infusion
- Robotic-assisted surgery
- Spine care
- Sports medicine and rehabilitation
- Surgery – inpatient and outpatient
- Wound care

Recognition

- Accredited Level II Trauma Center
- Nationally Certified Bariatric Program
- Accredited Breast Center of Excellence
- Accredited Cancer Center
- Accredited Chest Pain Center
- Primary Stroke Center Certification
- Certified Joint Replacement Program
- Level III Neonatal Intensive Care Unit (NICU)
- CMS Five-Star Rating for quality of care
- Magnet Recognition for Excellence in Nursing
- Leapfrog Emerald Award for patient safety, quality, and transparency
- American Heart Association Get with the Guidelines: Stroke Gold Plus Award
- Press Ganey Guardian of Excellence Award (Southlands ED)
- Newsweek Top Maternity Hospital in 2024

Community Programs

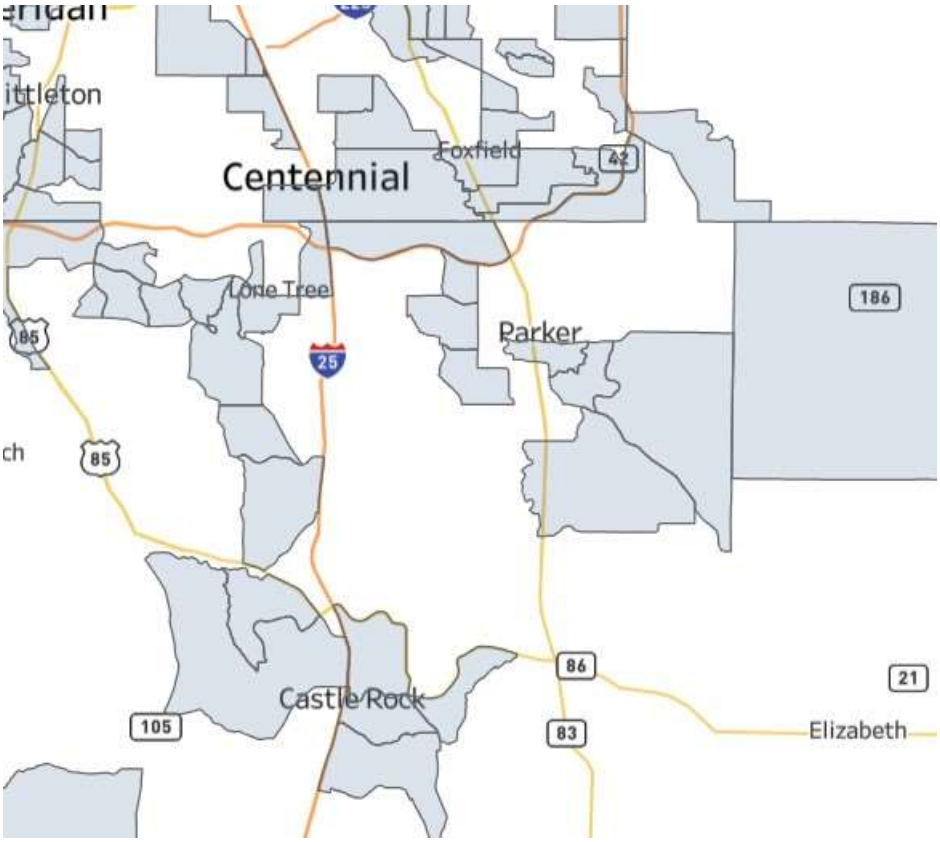
- AdventHealth Parker offers the community and patients a wide variety of support groups for people of all ages. Support groups include ones for stroke survivors, cancer survivors, and young survivors.
- We are also proud to provide our Healing Arts program to patients, which integrates music and visual arts into health care.
- Additionally, AdventHealth Parker is proud to partner with Newday Adventist Church to offer children in our area the opportunity to get a Christmas they may not otherwise have. Every year, families are invited to the Christmas Store to shop for gifts for the entire family. In 2024 alone, we served more than 1,100 people.

Community Overview

Community Description

Located in Douglas County, Colorado, AdventHealth Parker and AdventHealth Castle Rock combined their service areas to define their community as the Primary Service Area (PSA), the area in which 75-80% of its patient population lives. This includes 17 zip codes across Douglas County. AdventHealth Parker and AdventHealth Castle Rock's combined community will be referred to as the "Hospitals' community" or "Hospitals' PSA."

Demographic and community profile data in this report are from publicly available data sources such as the U.S. Census Bureau and the Center for Disease Control and Prevention (CDC), unless indicated otherwise. Data are reported for the Hospitals' PSA, unless listed differently. Data are also provided to show how the community compares locally, in the state, and at a national level for some indicators.



Community Profile

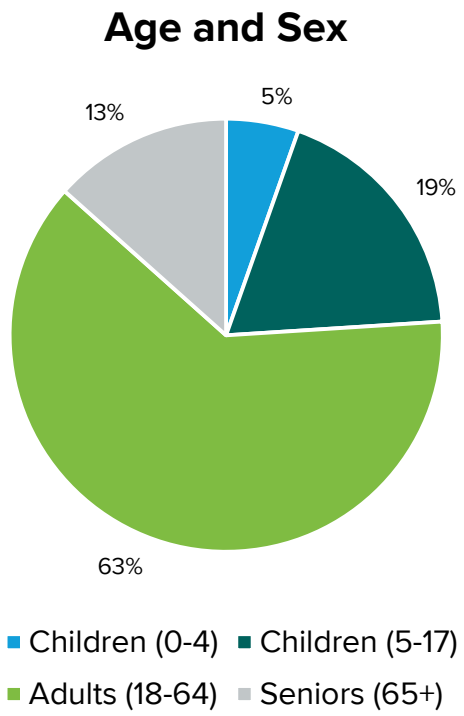
Age and Sex

The median age in the Hospitals' community is 39.5, slightly higher than that of state which is 37.5 and the US, 38.7.

Males are the majority, representing 50.4% of the population. Middle-aged men, 40-64 are the largest demographic in the community at 36.4%.

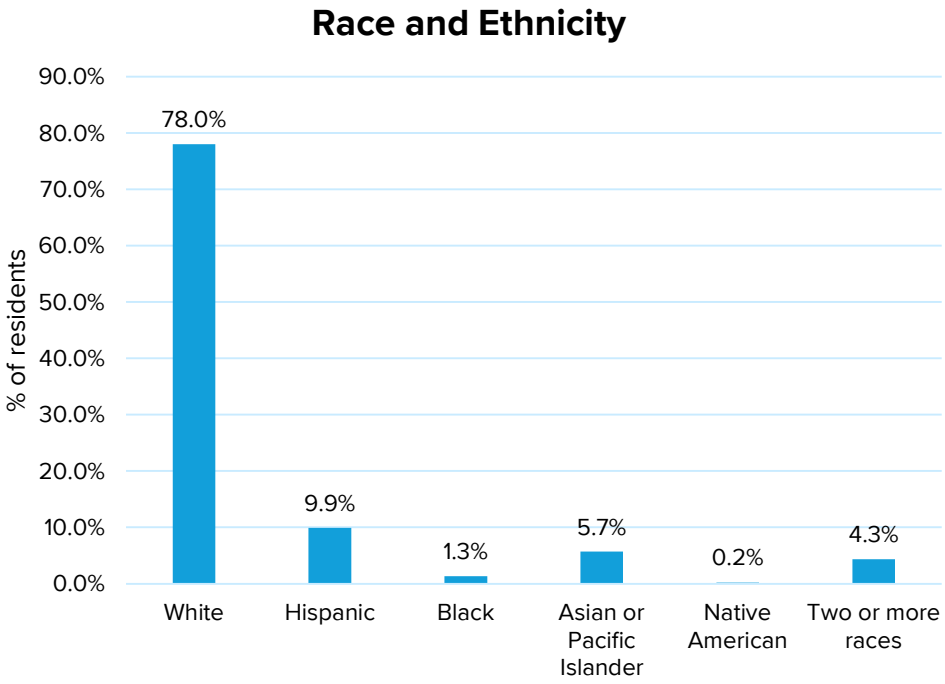
Children make up 24% of the total population in the community. Infants, those zero to five, are 5.4% of that number. The community birth rate is 54 births per 1,000 women aged 15-50. This is higher than the U.S. average of 51.58 and that of the state, 48.86. In the Hospitals' community, 5.4% of children aged 0-4 and 22.9% of children aged 5-17 are in poverty.

Seniors, those 65 and older, represent 13.4% of the total population in the community.



Race and Ethnicity

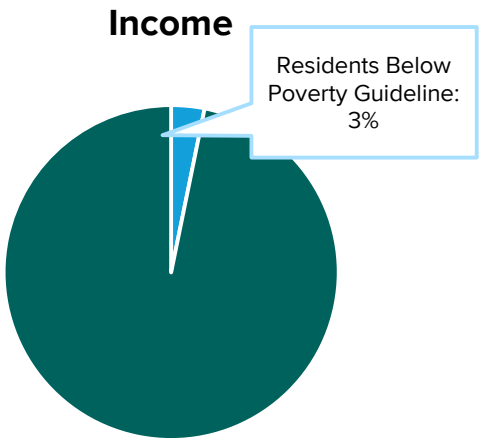
In the Hospitals' community, 78.6% of the residents are non-Hispanic White, 1.3% are non-Hispanic Black and 9.9% are Hispanic or Latino. Residents who are of Asian or Pacific Islander descent represent 5.7% of the total population, while 0.2% are Native American and 4.3% are two or more races.



Economic Stability

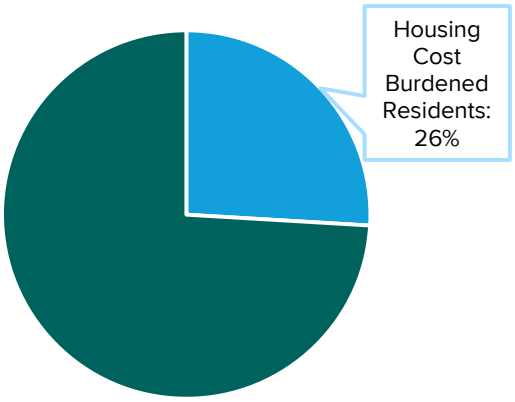
Income

The median household income in the Hospitals' community is $145,737. This is above the median for the state, which is $81,883. Although above the median, 3.7% of residents live in poverty, the majority of whom are under the age of 18.



Housing Stability

Increasingly, evidence is showing a connection between stable and affordable housing and health.[1] When households are cost burdened or severely cost burdened, they have less money to spend on food, health care and other necessities. Having less access can result in more negative health outcomes. Households are considered cost burdened if they spend more than 30% of their income on housing and severely cost burdened if they spend more the 50%.



Education Access and Quality

Research shows that education can be a predictor of health outcomes, as well a path to address inequality in communities.[2] Better education can lead to people having an increased understanding of their personal health and health needs. Higher education can also lead to better jobs, which can result in increased wages and access to health insurance.

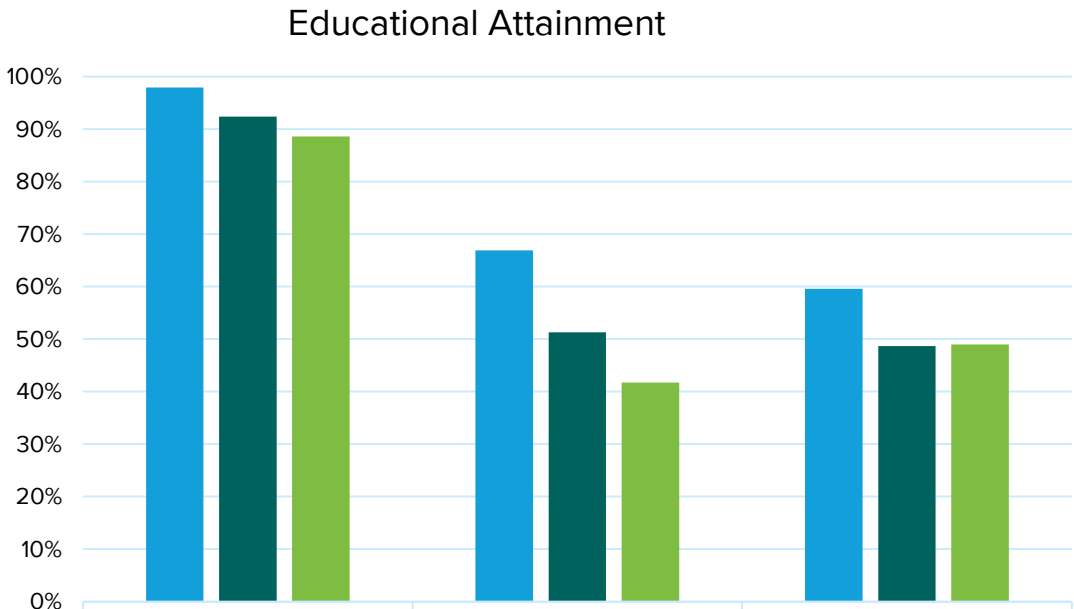
In the Hospitals' community, there is a 97.9% high school graduation rate, which is higher than both the state, (92.4%) and national average (88.6%). The rate of people with a post-secondary degree is also higher in the Hospitals' PSA than in both the state and nation.

Early childhood education is uniquely important and can improve children's cognitive and social development. It helps provide the foundation for long-term academic success, as well as improved health outcomes. Research on early childhood education programs shows that long-term benefits include improved health outcomes, savings in health care costs and increased lifetime earnings.[3]

In the Hospital's community, 59.6% of three- and four-year olds were enrolled in preschool. Although higher than both the state (48.7%) and the national (48.9%) average, there is still a large

[1] Severe housing cost burden* | County Health Rankings & Roadmaps
[2] The influence of education on health: an empirical assessment of OECD countries for the period 1995–2015 | Archives of Public Health | Full Text (biomedcentral.com)
[3] Early Childhood Education| Health Impact in 5 Years | Health System Transformation | AD for Policy | CDC

percentage of children in the community who may not be receiving these early foundational learnings.



	High School Graduation Rate	Post-Secondary Degree Rate	Preschool Enrollment Rate
Hospitals' PSA	97.9%	66.9%	59.6%
Colorado	92.4%	51.3%	48.7%
United States	88.6%	41.7%	48.9%

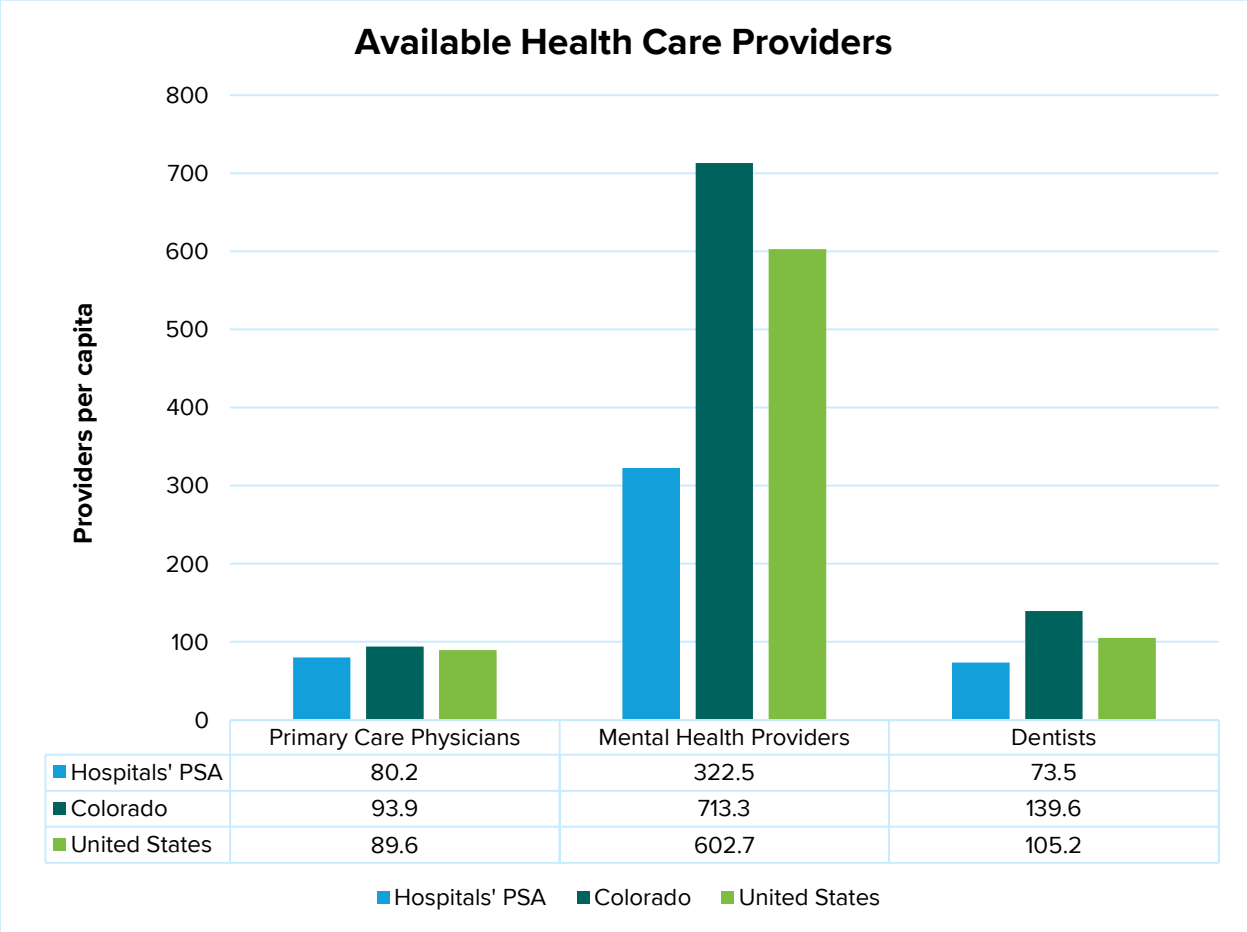
Health Care Access and Quality

In 2023, the Colorado Health Institute reported that 2.4% of uninsured community members aged 18-64 were found to lack health insurance. Without access to health insurance, these individuals may experience delayed care, resulting in more serious health conditions and increased treatment costs. Although health insurance coverage levels can be a strong indicator of a person's ability to access care, there are other potential barriers that can delay care for many people.[4]

Accessing health care requires more than just insurance. There must also be health care professionals available to provide care. When more providers are available in a community, access can be easier, particularly for those experiencing transportation challenges. The Hospitals' PSA has slightly lower primary care providers available, 80.20 per capita, compared to the state which is 93.90 per capita.

[4] Health Insurance and Access to Care (cdc.gov)

Routine checkups can provide an opportunity to identify potential health issues and when needed develop care plans. In the Hospitals' community, 84.5% of people reporting visiting their doctor for routine care.

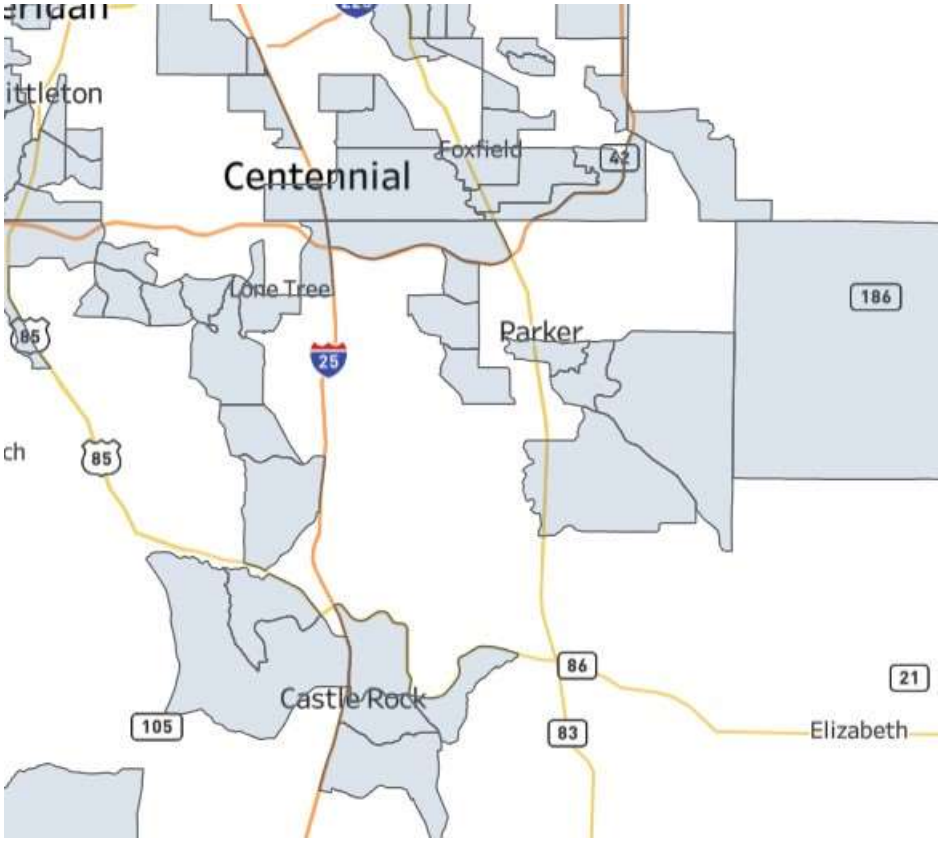


Neighborhood and Built Environment

Increasingly, a community's neighborhoods and built environment are shown to impact health outcomes. If a neighborhood is considered to have low food access, which is defined as being more than ½ mile from the nearest supermarket in an urban area or ten miles in a rural area, it may make it harder for people to have a healthy diet. A very low food access area is defined as being more than one mile from your nearest supermarket in an urban area or 20 miles in a rural area.

A person's diet can have a significant impact on health, so access to healthy food is important. For example, the largest contributors to cardiovascular disease are obesity and type 2 diabetes, both of which can be impacted by diet.[5] In the Hospitals' community, 5.6% of the community lives in a low food access area, impacting around 19,600 people.

[5] A Neighborhood's Built Environment May Have Numerous Effects on Its Residents' Health - RWJF



Food Insecurity

People who are food insecure, who have reduced quality or food intake, may be at an increased risk of negative health outcomes. Studies have shown an increased risk of obesity and chronic disease in adults who are food insecure. Children who are food insecure have been found to have an increased risk of obesity and developmental problems compared to children who are not.[6] Feeding America estimates for 2023[7], showed the food insecurity rate in the Hospital's community as 8.4%.

Access to public transportation is also an important part of a built environment. For people who do not have cars, reliable public transportation can be essential to access health care, healthy food and steady employment. In the community, 3.5% of the households do not have an available vehicle. This is a lower rate compared to the state, which is 5.5%.

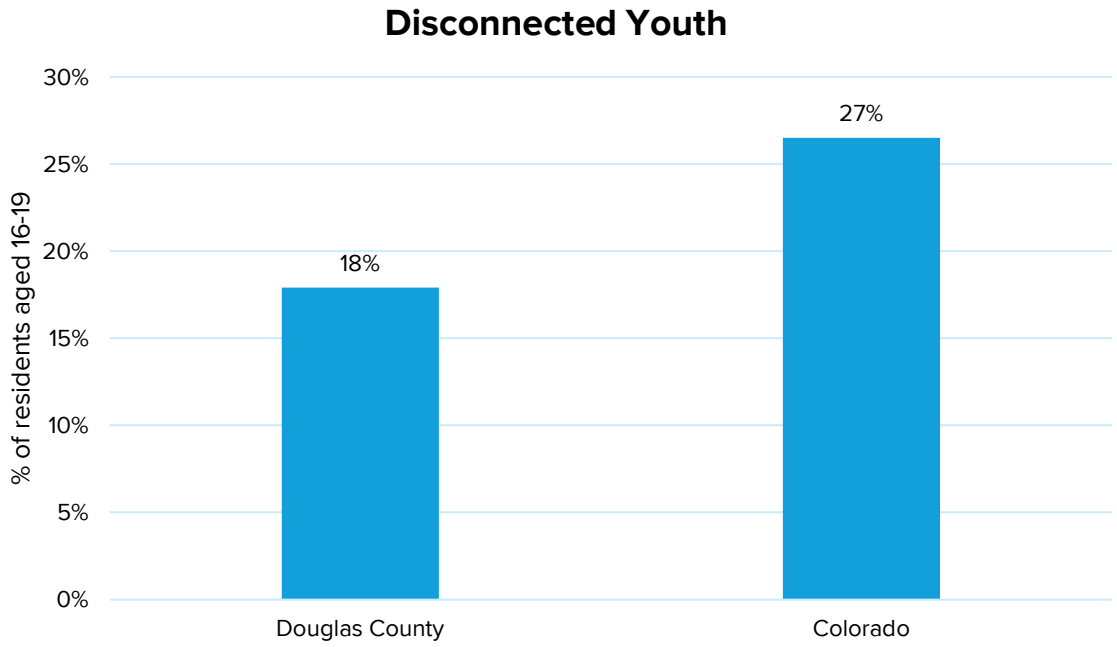
Social and Community Context

People's relationships and interactions with family, friends, co-workers and community members can have a major impact on their health and well-being.[8] When faced with challenges outside of their control, positive relationships with others can help reduce negative impacts. People can

[6] Food Insecurity - Healthy People 2030 | health.gov
[7] Map the Meal Gap 2020 Combined Modules.pdf (feedingamerica.org)
[8] Social and Community Context - Healthy People 2030 | health.gov

connect through work, community clubs or others to build their own relationships and social support. There can be challenges to building these relationships when people don't have connections to create them or there are barriers, like language.

In the community, 17.9% of youth aged 16-19 were reported as disconnected, meaning they were neither enrolled in school nor working at the time. The percentage of disconnected youth is lower than the state which is 26.5%.



Also, in the community 18% of seniors (age 65 and older) report living alone and 24% of residents report having limited English proficiency. All these factors can create barriers to feeling connected in the community.

Call out box: Social Determinants of Health

According to the CDC, social determinants of health (SDOH) are the conditions in the places where people live, learn, work and play that affect a wide range of health risks and outcomes. Social determinants of health are increasingly seen as the largest contributing factor to health outcomes in communities throughout the country.

The Hospital categorized and analyzed SDOH data following the Healthy People 2030 model. This approach was chosen so the Hospital could align its work with national efforts when addressing social determinants of health when possible. For the purposes of CHNA, the Hospital will follow this model for reporting any related data.

The Healthy People 2030 place-based framework outlines five areas of SDOH:

Economic Stability

Includes areas such as income, cost of living, food security and housing stability.

Education Access and Quality

This framework focuses on topics such as high school graduation rates, enrollment in higher education, literacy and early childhood education and development.

Health Care Access and Quality

Covers topics such as access to health care, access to primary care and health insurance coverage.

Neighborhood and Built Environment

Includes quality of housing, access to transportation, food security, and neighborhood crime and violence.

Social and Community Context

Focuses on topics such as community cohesion, civic participation, discrimination and incarceration.

Process, Methods and Findings

Process and Methods

The Process

The health of people living in the same community can be very different, because there are so many influencing factors. To understand and assess the most important health needs of its unique community and the people in it, the Hospital in partnership with AdventHealth Castle Rock and the Douglas County Health Department solicited input directly from the community and from individuals who represent the broad interests of the community. A real effort was made to reach out to all members of the community to obtain perspectives across age, race and ethnicity, gender, profession, household income, education level and geographic location. The Hospital and its' partners also collected publicly available and internal hospital utilization data for review.

The Hospitals and the Douglas County Health Department contracted with OMNI, a social research firm to collaboratively conduct a Community Health Needs Assessment. This partnership made it possible to partner with local community organizations and stakeholders, including those in public health and those who represent the interests of medically underserved, low-income and minority community members. Together they formed a Community Health Needs Assessment Committee (CHNAC) to guide the assessment process. The CHNAC is a regional effort through which the Hospitals and health department spanning Douglas County work to improve community health by leading outcome driven initiatives addressing the needs found in the assessment. The CHNAC includes representation from the Hospitals, Douglas County Health Department, the Douglas County Regional Health Connector Steering Committee, and leaders from various community-based organizations that address social determinants of health risk.

During data review sessions, community members of the CHNAC provided insight on how health conditions and areas of need were impacting those they represented. The CHNAC used the data review and discussion sessions to understand the most important health needs and barriers to health the community was facing and to guide the selection of needs to be addressed in the 2025 CHNA.

Community Input

The CHNAC collected input directly from the community and from community stakeholders, including individuals working in organizations addressing the needs and interests of the community.

Input was collected through community leader interviews, a pre-prioritization meeting, key informant interviews and focus groups.

Community Leader Interviews

- Three background interviews were conducted on the 2/20/25, 2/25/25, and 2/27/25. Nine AdventHealth team members participated, representing chaplains, care management, patient experience, directors, and hospital CEOs.
- Participants were presented with a general overview of the county, including questions on priorities, strengths, assets, and vision for the county. The discussion questions are listed below.

1. From your perspective, what do you see as the top two priorities for improving health in the county over the next 3-5 years?
    - (Public Health Focus) How do social determinants of health (e.g., economic, social, or environmental) affect these priorities?
    - (County Focus) How do recent events (e.g., economics, housing, COVID) affect these priorities?
2. Where do you see gaps in services or resources in the public health/county infrastructure?
    - What barriers prevent community members from accessing services or resources?
3. Have recent funding changes have affected existing Douglas County health services or programs?
    - How have these funding changes affected your ability to sustain health services or programs?
    - What solutions or strategies have you considered to address these gaps?
4. What are the county's greatest strengths or resources that promote health and well-being?
5. (Public Health Focus) What partnerships (e.g., hospitals, schools, community organizations) have been most effective in improving public health?
6. (County Focus) What local events, organizations/coalitions, or initiatives unite the community and support their health and well-being?
7. What is your vision for the county's future of health and well-being?
8. Of the various topics we discussed today, is there anything we missed that you feel is important to share on improving health in the county?

Pre-Prioritization Meeting

- On 3/13/25 a pre-prioritization process meeting was held to review background materials and community leader interview results for Douglas County health priorities. The purpose of the meeting was to identify initial health needs to focus additional primary data collection.
- A total of 23 public and community experts attended the pre-prioritization meeting, and they were asked three questions to consider while reviewing initial health issues presented from the data crosswalk.
    - Do the data align with your experience in the community?
    - Are there trends you see that are not showing up in the data?
    - What do you think are the most important health needs and opportunities facing Douglas County?
- After discussing these questions, an initial ranking exercise took place which asked attendees to rank the health issues from 1 (most important) to 10 (least important). The results showed the following rankings:
    1. Mental Health
    2. Substance Use
    3. Essential needs/Affordability/Economic Stability
    4. Access to Care
    5. Senior Population Needs
    6. Food Security
    7. Injury Prevention
    8. Health Equity
    9. Management and Prevention of Disease

10. Public Transportation

- These results informed how to structure the key informant interviews and focus groups to better understand the community's assets that would impact these health needs.

Key Informant Interviews

The key informant interview process involved eight participants, representing areas and organizations such as SECOR Cares, Douglas County Health Department, Douglas County Housing Partnership, NAMI, the police department, and schools.

- Participants discussed the needs ranked in the pre-prioritization meeting and the top populations impacted by each need. They also assessed the strengths of current county programs addressing the identified needs.
- Participants identified the actions, policies and funding which currently exist to support the health and well-being of county residents. At the end, participants identified opportunities to improve collaboration among the county health department and the hospitals.

Focus Groups

- Three focus groups were conducted by OMNI on the 4/18/25, 4/22/25, and 4/24/25. Each lasted 90 minutes, to delve deeper into the insights gathered from the key informant interviews. The focus groups included community-based organizations, community members receiving services, and Spanish-speaking community members.
- During these sessions, participants engaged in discussions centered around the findings from the key informant Interviews, allowing for a richer exploration of perspectives and themes. The focus groups aimed to clarify and expand upon the pre-prioritization meeting data, fostering an environment where participants could share their thoughts, experiences, and reactions to the information presented. This approach helped to ensure a comprehensive understanding of the actions and policies needed for a healthier county.

Public and Community Health Experts Consulted

A total of 27 stakeholders provided their expertise and knowledge regarding their communities, including:

Name	*Organization*	*Services Provided*	*Populations Served*
Mike Goebel, CEO	*AdventHealth Parker*	*Health Care, Support Services*	*Douglas County*
Michelle Fuentes, CEO	*AdventHealth Castle Rock*	*Health Care, Support Services*	*Douglas County*
Harmony Furlong, Chief Development Officer	*AdventHealth Castle Rock & AdventHealth Parker*	*Health Care, Support Services*	*Douglas County*
Matthew Mundall, Director, Mission	*AdventHealth Castle Rock*	*Health Care, Support Services*	*Douglas County*
Leeroy Coleman, Director, Mission	*AdventHealth Parker*	*Health Care, Support Services*	*Douglas County*
Scott Bartel, Director Multiple Service Lines	*AdventHealth Parker*	*Health Care, Support Services*	*Douglas County*
Jene Dunn, Director Nursing Services	*AdventHealth Parker*	*Health Care, Support Services*	*Douglas County*
James Sandoval, Director Nursing Services	*AdventHealth Parker*	*Health Care, Support Services*	*Douglas County*
Isheanesu Mazani, Director Strategic Human Resources	*AdventHealth Parker*	*Health Care, Support Services*	*Douglas County*
Bryan Trujillo, Regional Director Community Health	*AdventHealth Rocky Mountain Region*	*Health Care, Support Services*	*Douglas County*
Kate Suter, Director Strategic Human Resources	*AdventHealth Castle Rock*	*Health Care, Support Services*	*Douglas County*
Tealia McCune, Director Supply Chain	*AdventHealth Castle Rock*	*Health Care, Support Services*	*Douglas County*
Erica Beard, Manager Clinical Nursing	*AdventHealth Castle Rock*	*Health Care, Support Services*	*Douglas County*
Kevin Neu, Supervisor Care Management	*AdventHealth Castle Rock*	*Health Care, Support Services*	*Douglas County*

Victor Maldonado, Systems Engineer	*AdventHealth Castle Rock*	*Health Care, Support Services*	*Douglas County*
Sarah Zadigan, Director Nursing Excellence	*AdventHealth Castle Rock*	*Health Care, Support Services*	*Douglas County*
Andrew Catlett, Chaplain	*AdventHealth Castle Rock*	*Health Care, Support Services*	*Douglas County*
Stacy Farmer, Patient Experience Manager	*AdventHealth Castle Rock*	*Health Care, Support Services*	*Douglas County*
Laura Larson, Assistant Director for Community Health	*Douglas County Health Department*	*Public Health*	*Douglas County*
Michael Hill, Executive Director	*Douglas County Health Department*	*Public Health*	*Douglas County*
Richard Miura, Public Health Accountant Supervisor	*Douglas County Health Department*	*Public Health*	*Douglas County*
Chris Burnett, Quality Improvement Coordinator, Accreditation Coordinator	*Douglas County Health Department*	*Public Health*	*Douglas County*
Holen Hirsh, Vice President	*OMNI*	*Social Research Firm*	*Statewide*
Lindsay Houston, Research Manager	*OMNI*	*Social Research Firm*	*Statewide*
Puspanjali Gurung, Research Fellow	*OMNI*	*Social Research Firm*	*Statewide*
Ivonne Parra, Researcher	*OMNI*	*Social Research Firm*	*Statewide*
Andrea Trewartha, Researcher	*OMNI*	*Social Research Firm*	*Statewide*

Secondary Data

To inform the assessment process, the Hospital collected existing health-related and demographic data about the community from public sources. This included data on health conditions, social determinants of health and health behaviors.

The most current publicly available data for the assessment was compiled and sourced from government and public health organizations including:

- VISION: Visual Information System for Identifying Opportunities and Needs
- Colorado Hospital Association 2022 Hospital Utilization Report
- CDPHE Drug Overdose Dashboard
- Colorado Blueprint to End Hunger Data Dashboard
- Colorado Health Access Survey (CHAS) Data Dashboard 2023
- Healthy Kids Colorado Survey Dashboard
- Colorado Motor Vehicle Problem ID Dashboard — Colorado Department of Transportation (codot.gov)
- Metopio Data System
- Colorado Coalition for the Homeless - The State of Homelessness 2024
- Colorado Health Information Dataset (COHID) Deaths Dashboard
- 2024 March of Dimes Report Card for Colorado

Hospital utilization data for uninsured or self-pay patients who visited the Hospital for emergency department, inpatient or outpatient services in 2024 was also used in the assessment. The top ten diagnosis codes were provided by the AdventHealth information technology team.

The Findings

To identify the top needs, the Hospital analyzed the data collected across all sources. At the conclusion of the data analysis, there were 10 needs that rose to the top. These needs were identified as being the most prevalent in the community and frequently mentioned among community members and stakeholders.

The significant needs identified in the assessment process included:

Icon Mental Health: Substance Use Prevention

Mental illnesses are conditions that affect a person's thinking, feeling, mood or behavior, such as depression, anxiety, bipolar disorder or schizophrenia. Such conditions may be occasional or long-lasting (chronic) and affect someone's ability to relate to others and function each day. Mental health includes our emotional, psychological and social well-being. It affects how we think, feel and act. It also helps determine how we handle stress, relate to others and make healthy choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood.

Icon Injury Prevention

In the United States, unintentional injuries are the leading cause of death in children, adolescents, and adults younger than 45 years.1 Healthy People 2030 focuses on preventing intentional and unintentional injuries, including injuries that cause death.

Many unintentional injuries are caused by motor vehicle crashes and falls, and many intentional injuries involve gun violence and physical assaults. Interventions to prevent different types of injuries are key to keeping people safe in their homes, workplaces, and communities.

Icon Preventive Care

Getting preventive care reduces the risk for diseases, disabilities, and death — yet millions of people in the United States don't get recommended preventive health care services. Healthy People 2030 focuses on increasing preventive care for people of all ages.

Children need regular well-child and dental visits to track their development and find health problems early, when they're usually easier to treat. Services like screenings, dental check-ups, and vaccinations are key to keeping people of all ages healthy. But for a variety of reasons, many people don't get the preventive care they need. Barriers include cost, not having a primary care provider, living too far from providers, and lack of awareness about recommended preventive services.

Teaching people about the importance of preventive care is key to making sure more people get recommended services. Law and policy changes can also help more people access these critical services.

Icon Older Adults

By 2060, almost a quarter of the U.S. population will be age 65 or older.1 Healthy People 2030 focuses on reducing health problems and improving quality of life for older adults.

Older adults are at higher risk for chronic health problems like diabetes, osteoporosis, and Alzheimer's disease. In addition, 1 in 4 older adults fall each year, and falls are a leading cause of injury for this age group.2 Physical activity can help older adults prevent both chronic disease and fall-related injuries.

Older adults are also more likely to go to the hospital for some infectious diseases — including pneumonia, which is a leading cause of death for this age group. Making sure older adults get preventive care, including vaccines to protect against the flu and pneumonia, can help them stay healthy.

Icon Transportation

Every year in the United States, more than 30,000 people die from motor vehicle crashes.1 Healthy People 2030 focuses on keeping people safe in motor vehicles and promoting the use of other types of transportation.

Interventions to increase seat belt and car seat use can reduce deaths from motor vehicle crashes. Similarly, treating substance use disorders and conditions like sleep apnea is critical for preventing people from driving when they shouldn't be.

In addition, getting people to use motor vehicles less often can help improve their health. Mass transit options, like buses and trains, produce far less air pollution than cars — and people who walk and bike places get more physical activity. Communities that invest in mass transit and promote active transportation can help protect the environment and improve health.

Icon Economic Stability

People with steady employment are less likely to live in poverty and more likely to be healthy, but many people have trouble finding and keeping a job. People with disabilities, injuries, or conditions like arthritis may be especially limited in their ability to work. In addition, many people with steady work still don't earn enough to afford the things they need to stay healthy.

Employment programs, career counseling, and high-quality childcare opportunities can help more people find and keep jobs. In addition, policies to help people pay for food, housing, health care, and education can reduce poverty and improve health and well-being.

Icon Health Care Access and Quality

Accessible healthcare – particularly preventative services – can save lives and prevent suffering. Access to regular health screenings and physician services can catch life-threatening conditions early, increase knowledge of individual health risks, and provide much-needed education on healthy life practices.

Affordable healthcare is the other side of healthcare access. A substantial number of Colorado individuals are uninsured, and this group has a disproportionate representation of people of color, individuals who are low-income, and newcomers. Health issues unable to be addressed quickly due to cost will compound and create significantly worse health outcomes. This also extends to dental care and medication access.

Icon Health Care Access and Quality: Maternal Health

Access to comprehensive healthcare is especially crucial during maternal health. Ensuring that pregnant individuals have access to regular prenatal care can lead to early detection and management of potential complications, ultimately improving outcomes for both the parent and the child. Prenatal care includes routine check-ups, screenings, and educational resources that promote healthy behaviors and address any health concerns early on.

Moreover, postpartum care is equally important. Support for new parents can help manage physical recovery and mental health, preventing conditions such as postpartum depression. Programs that provide access to affordable healthcare, nutrition assistance, and mental health resources are essential in nurturing the well-being of both the parent and the child during this critical period.

Additionally, communities can play a significant role by creating supportive environments that provide resources and social support for families. By prioritizing maternal health and access to care, we can contribute to the overall health and resilience of our communities.

Icon Neighborhood and Built Environment: Food Security

Food security exists when all people have physical and economic access to sufficient safe and nutritious food that always meets their dietary needs and food preferences. A lack of food security has been linked to negative health outcomes in children and adults, as well as potentially causing trouble for children in schools.

Icon Social and Community Context: Health Equity

Healthy People 2030 focuses on five overarching goals aimed at achieving health equity. These goals are to ensure that everyone can live healthy, thriving lives free from preventable diseases and disabilities, eliminate health disparities while promoting health literacy, create supportive social and economic environments that foster well-being, encourage healthy development and behaviors throughout all stages of life, and engage leadership and the public across various sectors to implement policies that enhance the health and well-being of all individuals.

Priorities Selection

The CHNAC, through data review and discussion, narrowed down the health needs of the community to a list of ten. Community partners on the CHNAC represented the broad range of interests and needs, from public health to the economic of underserved, low-income and minority people in the community. During the spring of 2025, the CHNAC met to review and discuss the collected data and select the top community needs.

Members of the CHNAC included:

Community Members:

- Savannah Becerril, Assistant Program Director, YANA
- Matthew Lakin, Market Director of Business Development, Centennial Peaks Hospital
- Julia Mecklenburg, Senior Community Engagement, Colorado Access
- Jennifer Hutchings, Douglas County School District RE-1

AdventHealth Team Members:

- Conchetta Armstrong, Information Analyst, AdventHealth Parker
- Harmony Furlong, Chief Development Officer, AdventHealth Castle Rock and AdventHealth Parker
- Leeroy Coleman, Director Mission, AdventHealth Parker
- Andrea Carlett, Staff Chaplain, AdventHealth Castle Rock
- Matthew Mundall, Director Mission, AdventHealth Castle Rock
- Tealia McCune, Director Supply Chain, AdventHealth Castle Rock
- Bryan Trujillo, Regional Director of Community Health Improvement, AdventHealth Rocky Mountain Region
- Monica Kneusel, Community Benefit Coordinator, AdventHealth Rocky Mountain Region

OMNI Team:

- Holen Hirsh, Vice President
- Lindsay Houston, Research Manager
- Puspanjali Gurung, Research Fellow
- Ivonne Parra, Researcher
- Andrea Trewartha, Researcher

Public Health Experts:

- Michael Hill, Executive Director, Douglas County Health Department
- Laura Larson, Assistant Director for Community Health, Douglas County Health Department
- Richard Miura, Public Health Accountant Supervisor, Douglas County Health Department
- Chris Burnett, Quality Improvement Coordinator, Douglas County Health Department
- Jaclyn Moeller, Regional Health Connector for Douglas County
- Kelly Caldwell, Maternal and Child Health Coordinator, Douglas County Health Department

- Ellie Furata, Community Health Educator, Douglas County Health Department

Prioritization Process

To identify the top needs the CHNAC participated in a prioritization session. During the session, the data behind each need was reviewed, followed by a discussion of the need, the impact it had on the community and the resources available to address it. CHNAC members then ranked the needs via Menti, an online survey tool.

The CHNAC, (n=16) were asked to select the three needs they thought the Hospital should address in the community.

The following criteria was considered during the prioritization process:

1. Does the data align with your experience in the community?
2. Are there trends you see that are not showing up in the data?
3. What do you think are the most important health needs and opportunities facing Douglas County?

The needs were rated based on order of importance with 1 being most important and 10 being least important. The following needs rose to the top during the CHNAC's discussion and prioritization session.

After a list of the top 10 health needs of the community had been voted on by the CHNAC, they were presented to the Hospital Health Needs Assessment Committees (HHNAC). The HHNAC met and reviewed the data behind the selected needs and the available resources to address them in the community. The HHNAC also considered the Hospital's current resources and strategies to find ways to most effectively address the needs. Through these discussions the Hospital selected the needs it is best positioned to impact.

The following criteria was considered during the prioritization process:

A. **Impact on Community**: What are the consequences to the health of the community of not addressing this issue now?

B. **Resources:** Are there existing, effective interventions and opportunities to partner with the community to address this issue?

C. **Outcome Opportunities:** Do interventions addressing this issue have an impact on other health and social issues in the community?

The HHNACs also considered the following strategies during the prioritization process:

• **Existing Efforts** • **Partners/Groups to Engage** • **Potential Measures** • **Resources Available**	**A. Importance: Addressing this problem should be elevated by being in the plan.** B. **Feasibility: Work can be done to address the problem (e.g., there is funding/programming, staffing, community, and political will, etc.)** **C. Alignment: Addressing the problem would be in alignment with existing efforts** **D. Impact: Addressing the problem would impact the root cause of the issue**

Members of the HHNAC included:

- *Mike Goebel, CEO, AdventHealth Parker*
- *Harmony Furlong, Chief Development Officer, AdventHealth Castle Rock & AdventHealth Parker*
- *Leeroy Coleman, Director Mission, AdventHealth Parker*
- *Scott Bartel, Director Multiple Service Lines, AdventHealth Parker*
- *Jene Dunn, Director Nursing Services, AdventHealth Parker*
- *James Sandoval, Director Nursing Services, AdventHealth Parker*
- *Isheanesu Mazani, Director Strategic Human Resources, AdventHealth Parker*
- Bryan Trujillo, Regional Director Community Health, AdventHealth Rocky Mountain Region

The HHNAC narrowed down the list to three priority needs based on the proposed criteria and strategies:

- Health Care Access and Quality: Maternal Health
- Mental Health: Substance Use Prevention
- Neighborhood and Built Environment: Food Security

Available Community Resources

As part of the assessment process, a list of resources or organizations addressing the top needs in the community was created. Although not a complete list, it helped to show where there were

gaps in support and opportunities for partnership in the community when the CHNAC chose which priorities to address.

Top Needs	Current Community Programs	Current Hospital Programs
Health Care Access and Quality: Maternal Health	• You Are Not Alone (YANA) Strong Mamas Thriving Babies • Douglas County Public Health, Nutrition Program for Women, Infants, and Children Office (WIC) • Healthy Families Partnership of Douglas County • Douglas County Early Childhood Council • Douglas County School District • Douglas County Health Department Resource Navigation Help	• YANA Strong Mamas Thriving Babies • Healthy Families Partnership of Douglas County • Douglas County Health Department Free Diapers program • Douglas County Health Department Resource Navigation Help
Mental Health: Substance Use Prevention	• Douglas Physician Group • Region 12 Opioid Abatement Council • All Health Network • Valley Hope of Parker • Hard Beauty Foundation • HEART • Sky Ride Colorado • Douglas County School District • SE2 Campaigns to reduce opioid stigma and substance use disorders; and increase awareness of recovery and treatment services • The Crisis Response Team • The Juvenile Assessment Center (JAC) • The Regional Opioid Abatement Council for Douglas County	• The psych assessment team • ED physicians and pharmacy for ALTOs
Neighborhood and Built Environment: Food Security	• Colorado Blueprint to End Hunger • SECOR Cares • Parker Task Force • We Don't Waste • Family Connects • Hunger Free Colorado • United Way 211 Colorado	• United Way 211 • SECOR Cares • Parker Task Force

Priorities Addressed

Icon Health Care Access and Quality: Maternal Health

Maternal health data in the hospital's community reflects a generally positive outlook, with indicators such as low rates of infant mortality which 4.5 compared to the US rate of 5.6. The death rate of birthing people from complications of pregnancy or childbirth that occur during the pregnancy or within 6 weeks after the pregnancy ends in Colorado is 16.0 per 100,000 births, which is lower than the US rate of 23.2. Most pregnant mothers in the county receive timely prenatal care, which is essential for early identification and management of potential health concerns. Additionally, there tends to be a high prevalence of health insurance coverage among expectant mothers, contributing to better health outcomes. However, disparities exist within different demographic groups, highlighting the need for targeted support and resources. The percent of women who received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age in Colorado is 14.7 percent compared to the US of 15.7. This indicates that are opportunities to improve on adequate prenatal care.

Icon Mental Health: Substance Use Prevention

Substance use prevention and intervention are critical issues in Douglas County, Colorado, given the increasing trends in substance abuse among adolescents and adults. Data from recent years show a concerning rise in reported substance use, particularly among young people. According to the Colorado Department of Public Health and Environment, approximately 29% of high school students in Douglas County reported using marijuana in the past 30 days, a statistic that underscores the need for effective prevention programs. Furthermore, opioid overdose rates, while lower than the state average, have drawn attention as even a small increase can significantly impact community health. Addressing substance use not only promotes individual well-being but also enhances community safety and economic stability. By prioritizing education and support systems, Douglas County can work towards reducing substance-related harm and fostering healthier lifestyles among its residents.

Icon Health Care Access and Quality: Maternal Health

Maternal health data in the hospital's community reflects a generally positive outlook, with indicators such as low rates of infant mortality which 4.5 compared to the US rate of 5.6. The death rate of birthing people from complications of pregnancy or childbirth that occur during the pregnancy or within 6 weeks after the pregnancy ends in Colorado is 16.0 per 100,000 births, which is lower than the US rate of 23.2. Most pregnant mothers in the county receive timely prenatal care, which is essential for early identification and management of potential health concerns. Additionally, there tends to be a high prevalence of health insurance coverage among expectant mothers, contributing to better health outcomes. However, disparities exist within different demographic groups, highlighting the need for targeted support and resources. The percent of women who received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age in Colorado is 14.7 percent compared to the US of 15.7. This indicates that are opportunities to improve on adequate prenatal care.

Icon Neighborhood and Built Environment: Food Security

Food insecurity is on the rise in Colorado, as indicated by an 8% increase in SNAP benefits claimed from 2020 – 2022, representing an additional 41,829 individuals who could not afford food without SNAP benefits. In the Hospital’s community 10% of individuals report an inability to

afford food. This concern was highlighted by the Spanish-speakers focus group, who indicated that rising food prices increase their stress and – for newcomers – are one of the basic needs that they struggle to meet. The older adult focus group report struggles to accommodate rising grocery prices on a fixed income that has not expanded to meet that need. Addressing this priority can make a significant and life-changing difference for families and individuals in the community who struggle to meet the basic need of having adequate meals and nutrition. Increasing the number of people who can eat well and often will have far-reaching effects on the overall health of the community.

Priorities Not Addressed

The priorities not to be addressed include:

Icon Health Care Access and Quality

General access to care is not currently considered a high-priority health issue for the general population in the county, primarily because the community already possesses substantial resources to address healthcare needs. According to data from the Colorado Department of Public Health and Environment, Douglas County has a higher-than-average ratio of primary care physicians, with approximately 1,040 residents per physician compared to the state average of 1,200. Additionally, the county has significant resources that provide a wide range of services, from emergency care to specialized treatments. These factors collectively illustrate that the necessary infrastructure and resources are in place, alleviating the urgency of prioritizing general access to healthcare in the county. The hospital will focus on specific initiatives that improve the quality of care via targeted programs, such as substance use prevention and addressing maternal health, to improve health outcomes in the county.

Icon Social and Community Context: Health Equity

Health equity is often embedded within other health priorities rather than treated as a standalone issue because of its deep connection to various factors influencing health outcomes. Addressing priorities like access to healthcare and the social determinants of health allows us to combat the root causes of disparities effectively. For example, by improving access to essential services and creating healthier communities, we can significantly advance health equity. This collaborative framework not only ensures a comprehensive strategy but also enhances the impact of initiatives aimed at reducing disparities. By prioritizing health equity within the selected priorities, we can create sustainable, meaningful change that uplifts the health of entire populations.

Icon Preventive Care

In the Hospital's community, percentages of obesity amongst adults (24%), diagnosed diabetes (6%), high blood pressure (23%), and stroke mortality (26%) are all lower than the state's percentages of 24% for obesity, 7% for diagnosed diabetes, 25% for high blood pressure, and 36% for stroke mortality. There are already strong partnerships between the Hospital and trusted community organizations for disease management, therefore the Hospital did not select this as a priority.

Icon Injury Prevention

Not selecting injury prevention as a health priority in the Hospital's community is due to the lower incidence of injuries compared to chronic conditions like heart disease or mental health issues. The annual 2016 to 2020 average rate of injury-related deaths in Douglas County is lower than

Colorado. While injury prevention is important, the Hospital will allocate resources to other health priorities.

Icon Economic Stability

In the Hospital's community, the poverty rate for the general population is lower (4%) than the state's (7.5%). The rate of severely rent-burdened adults is also lower (22%) than the state's (25%). The HHNAC agreed that these are important issues, they also agreed that the Hospital is better positioned to focus on other issues based on current available resources.

Icon Transportation

In the Hospital's community, the percentage of households that do not have a vehicle is lower (3.5%) than the state's (5.5%). While public transportation is fragmented in the county, there are ongoing efforts to expand public transportation lines. The HHNAC agreed that this is an important issue that is being addressed via policy, therefore it was not selected as a priority to be addressed.

Icon Older Adults

In the Hospital's community, the percentage of seniors living alone is lower (19%) than the state's (27%). But, the social engagement index is dramatically decreasing in the county (77%) compared to the state's (85%). While this presents an opportunity to focus on outreaching seniors to strengthen a sense of community and belonging, the HHNAC agrees on not duplicating efforts from the local area agency on aging and other trusted senior organizations, therefore it was not selected as a priority to be addressed.

Next Steps

The CHNAC will work with the Hospital and other community partners to develop a measurable Community Health Plan for 2025-2027 to address the priority needs. For each priority, specific goals will be developed, including measurable outcomes, intervention strategies and the resources necessary for successful implementation.

Evidence-based strategies will be reviewed to determine the most impactful and effective interventions. For each goal, a review of policies that can support or deter progress will be completed with consideration of opportunities to make an impact. The plan will be reviewed quarterly, with an annual assessment of progress. A presentation of progress on the plan will also be presented annually to the Hospital board.

A link to the Community Health Plan will be posted on AdventHealth.com prior to May 15, 2025.

Community Health Plan

2023-2025 Community Health Plan Review

The Hospital evaluates the progress made on the implementation strategies from the Community Health Plan annually. The following is a summary of progress made on our most recently adopted plan. The full evaluation is available upon request.

Priority 1: Mental Health (Suicide Prevention)

In the 2022 CHNA, Mental Health and Suicide Prevention was identified as a priority. A comprehensive suicide prevention pathway has been developed at RMR hospitals, including the universal screening of patients with the C-SSRS tool. Low-scoring patients are assessed by a behavioral health practitioner using the Safe-T model. Depending on need, the patient is provided with resources (including a connection to Caring Contact and a RMCP Hospital Follow-Up program) or referred to the crisis assessment team for a full assessment (Safe-T, Audit C+ Two, SBIRT, CALM (Counseling Access to Lethal Means) and a Stanley Brown Safety Plan (if discharged)). Patients are either discharged home, sent to a crisis stabilization unit, an acute treatment unit, or inpatient behavioral health unit based on risk assessment.

Trainings provided to staff members at Parker Hospital from January 1, 2024 – December 31, 2024 include Institute of Reproductive Grief 8-hour training, The Birth Squad- Postpartum International Training, Access to Lethal Means Training (CALM) Training, C-SSRS Training Columbia Suicide Severity Rating Scale LEARN, LEARN for Perinatal Care. Community and caregiver trainings are on track to be offered during the remainder of the year. In addition to offering trainings throughout the year, RMR Behavioral Health has partnered with the local Veterans Association to stage an event focused on mental health care for veterans. This event provided free gun safes and education on safe weapons handling. Two articles on suicide prevention were published on the internal SharePoint site for hospital employees in Q3, including resources for suicide prevention.

In addition to this, the RMR Behavioral Health team published three articles on the hospital's internal SharePoint site. Two of the articles (The Year of the Squirrel | Suicide Prevention Awareness Month and The Subtlety of Suicidal Ideations | Suicide Prevention Awareness Month) were aimed at increasing awareness of how suicidal ideation can present itself in ourselves and people close to us. These articles included resources on navigating these thoughts as well as crises hotline numbers. The third article (You Are Not Alone (YANA) Offering Young Moms Hope and Community) detailed the impactful effects of the YANA program at AdventHealth Parker and Castle Rock. The YANA program is aimed at reducing maternal suicide rates in the first year after birth by offering wraparound social support for new mothers.

Priority 2: Substance Use Prevention

Advent Health Parker participates in MOUD (Medication for Opioid Use Disorder) counseling and treatment. The MOUD program provides patients in active opioid withdrawal with medication as a form of addiction treatment. Advent Health Parker reports 25 MOUD interventions between January 1, 2024 – December 31, 2024. In addition to the MOUD program, Advent Health Parker has implemented the ALTO (Alternative to Opioids) program. This program is focused on

providing pain management options that do not include opioids in order to prevent possible addiction and reduce the chance of relapse due to pain.

AdventHealth RMR has implemented the SBIRT (Screening, Brief Intervention & Referral to Treatment) initiative as a preventative approach for individuals who may be using substances at risky levels, or who are displaying substance use behaviors that may have negative impacts on their health and wellbeing. This intervention may be performed as a part of a full psychological evaluation, or separately if necessary. Advent Health Parker reported 421 SBIRT encounters from January 1, 2024 - December 31, 2024.

Priority 3: Food Security

Advent Health RMR continues to work with Hunger Free Colorado with the intention of establishing hospital staff as PEAS (Partners Engaging in Application Services) in order to provide SNAP and WIC sign-up services to patients in the surrounding community. This collaboration is contingent on the state budget and other funding sources that won't be fully realized until Q2 of 2025. AdventHealth Parker has partnered with the Parker Task Force - a crisis assistance center and food bank - to educate patients on food access points and encourage patients to join an advisory group.

SDOH (Social Determinant of Health) screenings assessing food, housing, transportation, utilities, and safety are universally administered at all inpatient encounters. Parker reported 129 positive SDOH screenings for food security between January 1, 2024 – December 31, 2024. These individuals are provided verified resources from United Way 211 and connected to local organizational partners. Advent Health RMR has built a collaboration with the Colorado Blueprint to End Hunger that has provided workgroup access to efforts around policy and food access and has partnered with Blueprint to support the RMR's needs assessment process by inviting the organization to speak at public community health improvement meetings across the RMR.

2022 Community Health Needs Assessment Comments

We posted a link to the most recently-conducted CHNA and the most recently adopted implementation strategy, 2023 Community Health Plan on our hospital website as well as on AdventHealth.com prior to May 15, 2025 and have not received any written comments.

Back Cover Page

Portercare Adventist Health System dba AdventHealth Parker

CHNA Approved by the Hospital board on: May 13, 2025

For questions or comments, please contact:
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