Cover Page

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AdventHealth Porter

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

Portercare Adventist Health System dba AdventHealth Porter will be referred to in this document as AdventHealth Porter or "The Hospital." AdventHealth Porter in Denver, Colorado conducted a community health needs assessment from May 2024 to March 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 2026-2028 Community Health Plan based on the needs prioritized in the assessment process.

The Collaborative

To ensure broad community input, AdventHealth Porter took part in a Collaborative which included two subcommittees (the Denver Department of Public Health and Environment (DDPHE) Steering Committee and the DDPHE Assessment Design Team to help guide the Hospital through the assessment process. The Collaborative included representation from the Hospital, public health experts and community members. This included intentional representation from low-income, minority and other underserved populations.

The Collaborative met 16 times in 2024-2025. They reviewed primary and secondary data and helped to identify the top priority needs in the community.

See Prioritization Process for a list of Collaborative members.

Hospital Health Needs Assessment Committee

AdventHealth Porter also convened a Hospital Health Needs Assessment Committee (HHNAC) through the participation of the Sustainability Council. The purpose of the HHNAC was to select the needs the Hospital would address due to the findings in the assessment. The HHNAC made this decision by reviewing the priority needs that were selected by the Collaborative and by the internal hospital resources available. With this information, the HHNAC was able to determine where the Hospital could most effectively support the community.

See Prioritization Process for a list of HHNAC members.

Data

AdventHealth Porter in collaboration with the DDPHE Assessment Design Team collected both primary and secondary data. The primary data included a residential community survey, focus groups, and community led town-hall meetings. 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 2023-2024. 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 ten 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 Collaborative and the HHNAC understand the existing community efforts being used to address the ten 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 Collaborative identified the top ten significant health needs of the community. The HHNAC then prioritized the top three needs, discussing each one, assessing available community resources, and considering the Hospital's own resources and strategies. Through this discussion, the Hospital determined the top three 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
2. Drug and Alcohol Use
3. Neighborhood and Built Environment: Food Security

See Priorities Addressed for more.

Approval

On May 15, 2025, the AdventHealth Porter board approved the Community Health Needs Assessment findings, priority needs and final report. A link to the 2024 Community Health Needs Assessment was posted on the Hospital's website by May 15, 2025.

Next Steps

AdventHealth Porter will work with the Collaborative 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, board approved and posted on the Hospital's website by May 15, 2025.

About AdventHealth

AdventHealth Porter 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 Porter

Caring for Our Community

AdventHealth Porter is a 368-bed facility in the heart of Denver, Colorado. Previously known as Porter Adventist Hospital, AdventHealth Porter 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 80,000 employees, 52 hospitals, and hundreds of care sites across nearly a dozen states.

With the mission of Extending the Healing Ministry of Christ, AdventHealth Porter supports our community with expert medical care and uncommon compassion. We have proudly served the Denver and surrounding communities for 90 years and counting, specializing in advanced surgical procedures, life-saving emergency care, and much more.

Services

- Orthopedic and Spine
- AdventHealth Porter Transplant Institute
- Gastrointestinal / Digestive Health

Behavioral Health

- Cancer Care
- Heart and Vascular
- Emergency and Trauma Care
- Sports Medicine and Rehabilitation
- Wound Care
- Hospice Care

Awards & Recognition

AdventHealth Porter has been Magnet designated since 2009, placing it among the approximately 10% of US hospitals with Magnet designation. Magnet hospitals demonstrate excellence in nursing practice, quality patient care, and interprofessional collaboration for ongoing improvement and innovation.

AdventHealth Porter is one of ten hospitals in Colorado that have achieved both a CMS 5-Star Rating and Leapfrog A.

AdventHealth Porter was named as a 2024 top cardiology hospital for Medicare members.

Community Programs

AdventHealth Porter offers their community and patients with a wide variety of support groups for people of all ages. Support groups include breast cancer support, grief support, and KidsAlive supporting kids of parents who are battling cancer.

Additionally, AdventHealth Porter offers a Hospitality House which provides a safe, comfortable place for patients and families with short or extended hospital stays. This Hospitality House is primarily medical housing for a patient and their caregiver.

Community Overview

Community Description

Located in Denver Colorado, AdventHealth Porter defines its community as the Primary Service Area (PSA), the area in which 75-80% of its patient population lives. This includes 53 zip codes across Denver County.

According to the 2020 United States Census, the population in the Primary Service Area has grown 19.2% in the last ten years to 715,522 people in 2020.

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 is reported for Denver County, 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

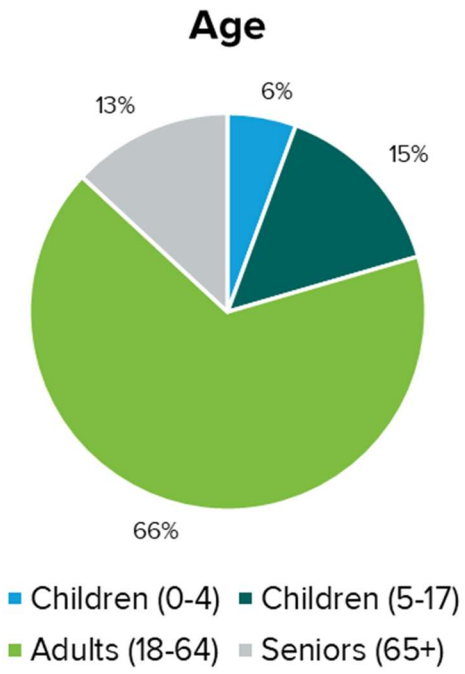
Age and Sex

The median age in the Hospital's community is 36.2, slightly lower than that of Colorado which is 37.5 and the US, 38.2.

Males are the majority, representing 50.2% of the population. Men, 18-64 are the largest demographic in the community at 33.9%.

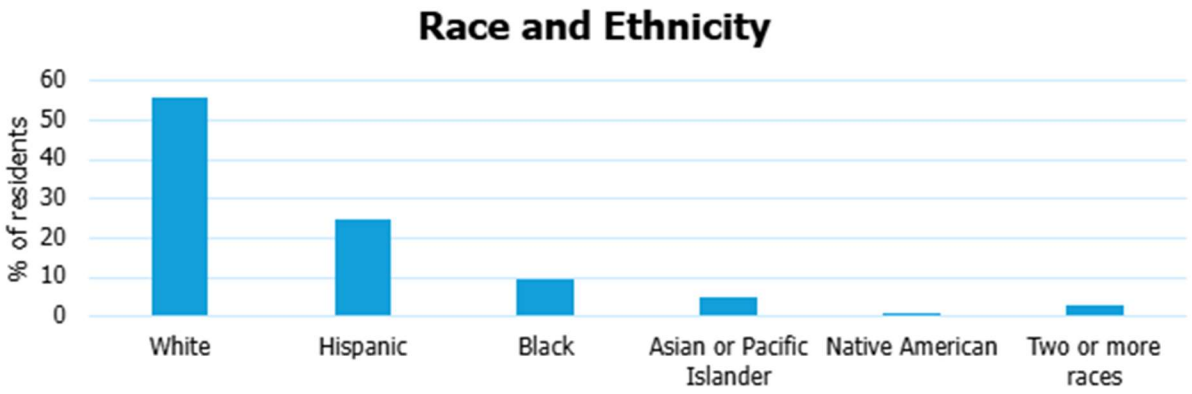
Children make up 20.5% of the total population in the community. Infants, those zero to four, are 5.6% of that number. The community birth rate is 46.4 births per 1,000 women aged 15-50. This is lower than the U.S. average of 51.6, and lower than that of the state, 48.2. In the Hospital's community, 13% of children aged 0-4 and 14% of children aged 5-17 are in poverty.

Seniors, those 65 and older, represent 13.1% of the total population in the community. Females are 56.2% of the total senior population.



Race and Ethnicity

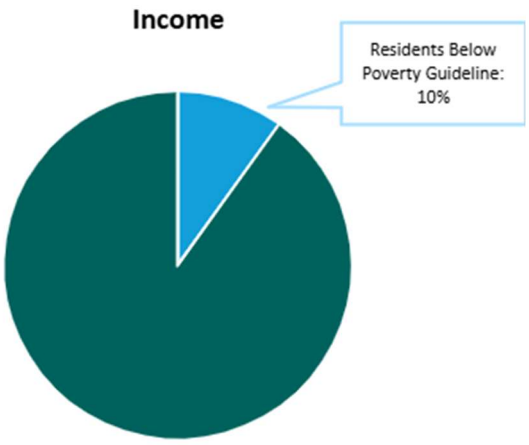
In the Hospital's community, 55.7% of the residents are non-Hispanic White, 9.5% are non-Hispanic Black and 24.8% are Hispanic or Latino. Residents who are of Asian or Pacific Islander descent represent 4.9% of the total population, while 0.3% are Native American and 2.9% are two or more races.



Economic Stability

Income

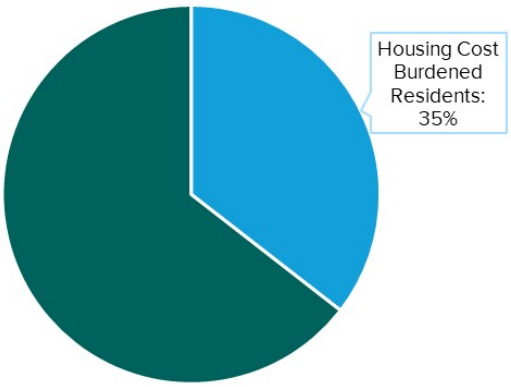
The median household income in the Hospital's community is $86,758. This is above the median for both the state and the US. Although above the median, 9.9% of residents live in poverty, including large percentages of infants 0-4 and children under 18.

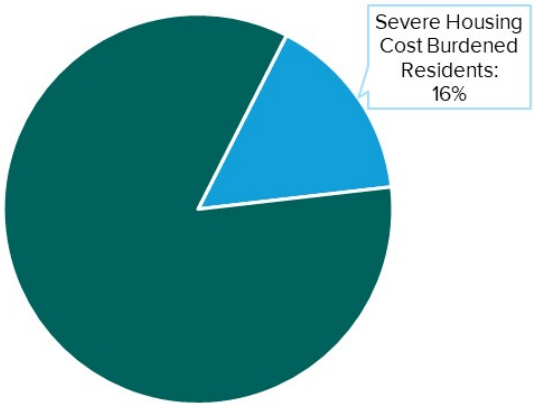


Housing Stability

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%.

[1] Severe housing cost burden* | County Health Rankings & Roadmaps





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.

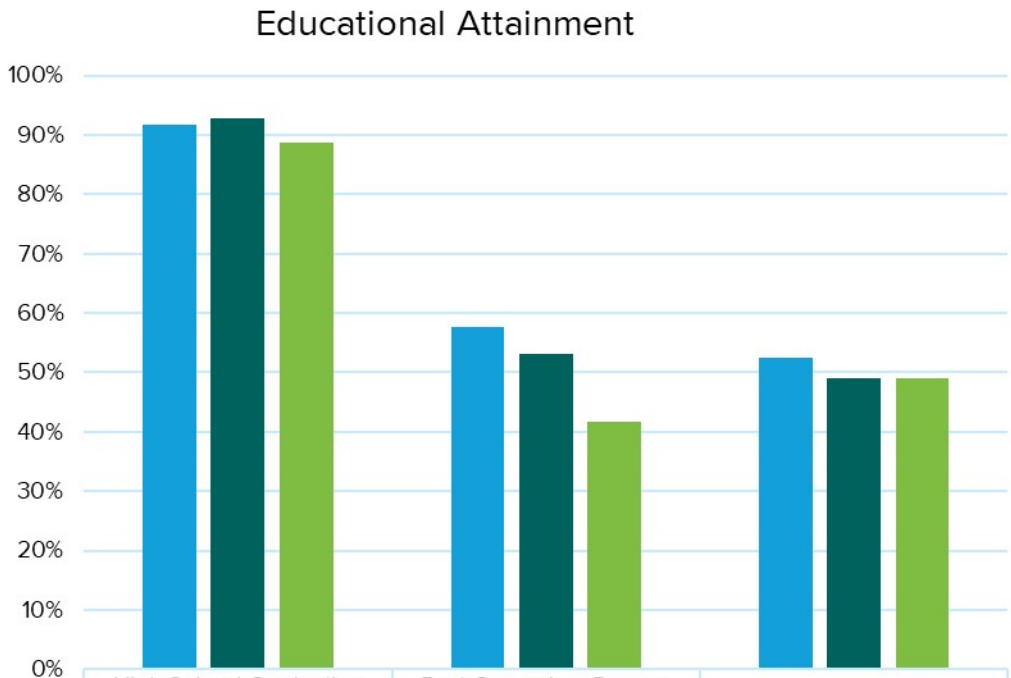
In the Hospital's community, there is a 91.7% high school graduation rate, which is lower than the state, (92.8%) but higher than the national average (88.6%). The rate of people with a post-secondary degree is also higher in the Hospital's PSA than in both the state and nation.

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

[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)

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, 52.4% of three- and four-year olds were enrolled in preschool. Although higher than both the state (50.0%) and the national (48.9%) averages, there may still be a large percentage of children in the community who are not be receiving these early foundational learnings.



	High School Graduation Rate	Post-Secondary Degree Rate	Preschool Enrollment Rate
Hospital's PSA	91.7%	57.6%	52.4%
Colorado	92.8%	53.1%	49.1%
United States	88.6%	41.7%	48.9%

Health Care Access and Quality

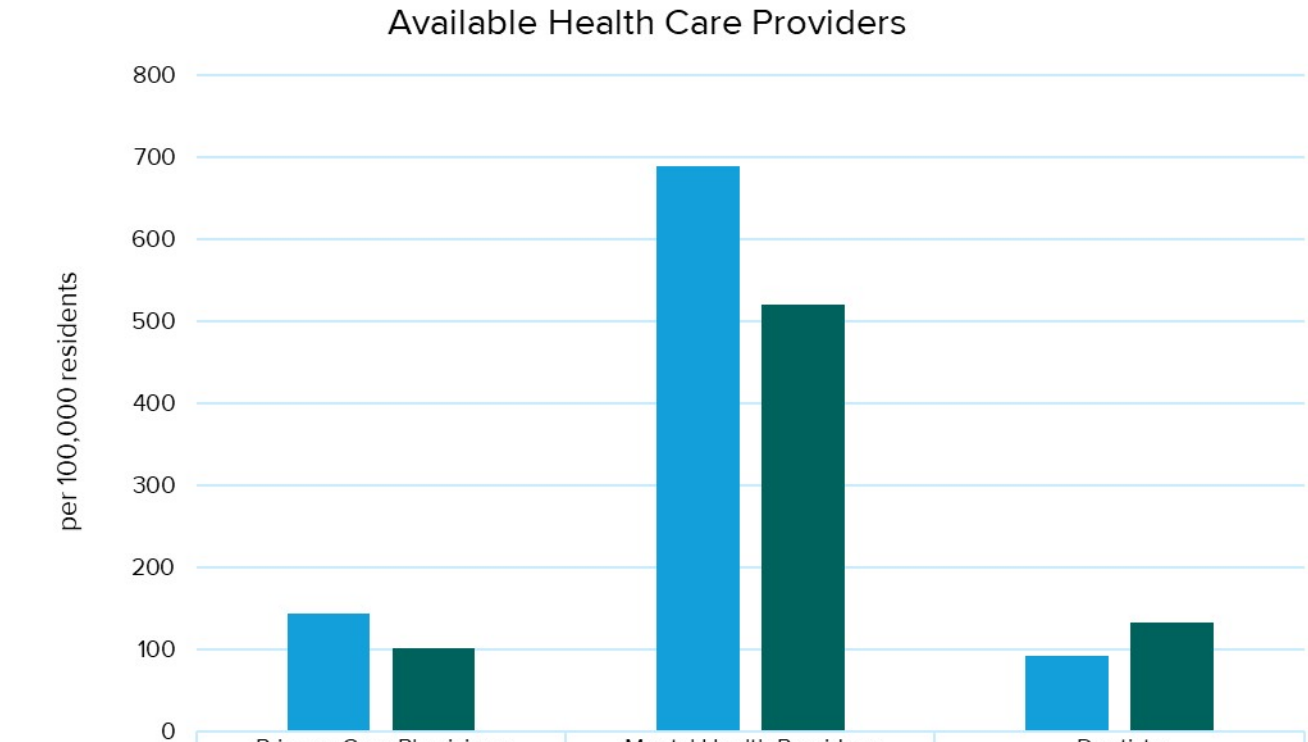
In 2022, 10.46% of community members aged 18-64 were found to lack health insurance. Without access to health insurance, these individuals may experience delayed care, resulting in more serious health conditions and increased treatment costs. Although health insurance coverage levels can be a strong 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. Denver

[3] Early Childhood Education| Health Impact in 5 Years | Health System Transformation | AD for Policy | CDC
[4] Health Insurance and Access to Care (cdc.gov)

County has more primary care physicians and mental health providers per capita than the state average, but fewer dentists.

Routine checkups can provide an opportunity to identify potential health issues and when needed develop care plans. In the Hospital's community, 67.3% of people report visiting their doctor for routine care.



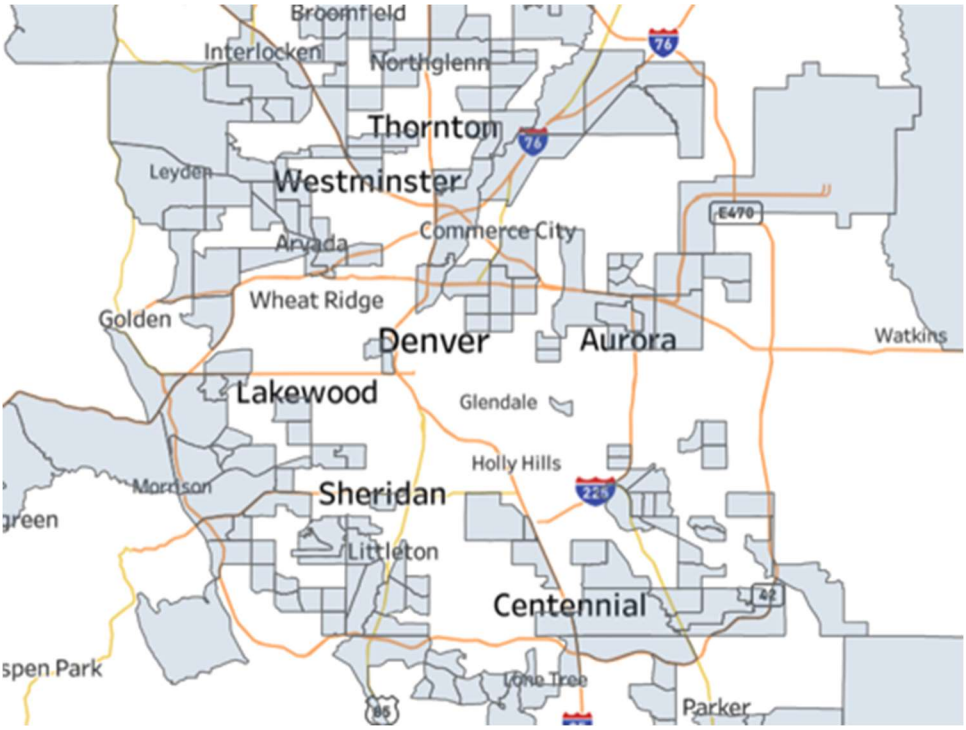
	Primary Care Physicians	Mental Health Providers	Dentists
Denver County	144.5	688.7	92.2
Colorado	101.7	519.8	132.9

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 Denver County, many neighborhoods live in an area defined as low food access – depicted in grey on the map below.

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



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 2022[7], showed the food insecurity rate in the Hospital's community as 12.5%.

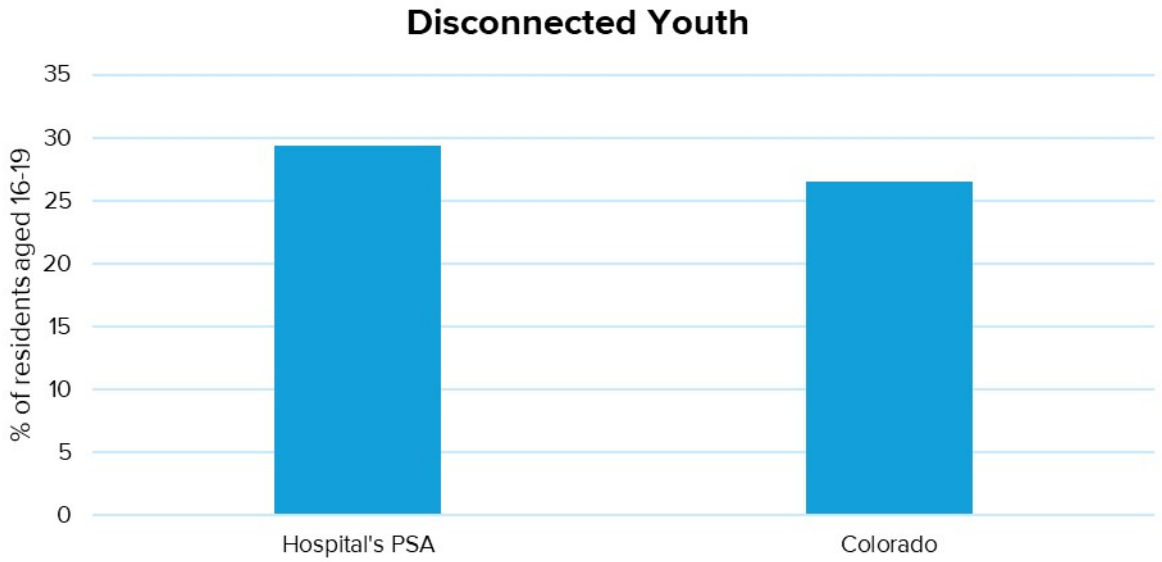
Access to public transportation is also an important part of a built environment. For people who do not have cars, reliable public transportation can be essential to access health care, healthy food and steady employment. In the community, 7.9% of the households do not have an available vehicle.

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

[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

In the community, 29.4% of youth aged 16-19 were reported as disconnected, meaning they had not participated in any community or school-led activity outside of academics in the last 12 months.



Also, in the community 31.8% of seniors (age 65 and older) report living alone and 9.1% 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 inequities 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, 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 the DDPHE Steering Committee, 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 Collaborative also collected publicly available and internal hospital utilization data for review.

The Hospital partnered 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, to participate in a Collaborative to guide the assessment process.

The Collaborative is made up of two sub-committees. The DDPHE Steering Committee is a collective of public health experts and representatives from a diverse group of community organizations in Denver. The purpose of the Steering Committee is to guide the health assessment process by determining how to involve community and by utilizing the broad representation of organizations to prioritize and select health needs.

The DDPHE Assessment Design Team is a small group of individuals with data assessment experience. This team includes epidemiologists, data scientists, and survey design experts. The purpose of this group is to design data collection tools and assess data gathered from community surveys and focus groups in order to create a broad and significant understanding of the needs of the community. This data was used to guide decisions from the Assessment Design Team. Both the DDPHE Steering Committee and Assessment Design Team form the Collaborative.

During data review sessions, community members of the DDPHE Steering Committee provided insight on how health conditions and areas of need were impacting those they represented. The Collaborative 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 Collaborative 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 the community health survey, focus groups, and town halls.

Residential Community Health Survey

- Denver Department of Public Health's Assessment Design Team created the Thrive in the Mile High Community Survey that was distributed in November of 2024.

- The survey was distributed via two waves of postcard outreach, digital outreach on city social media, through the Denver City Council, partner community organizations, and Public Service Announcements. The survey was also distributed in the Hospital's internal and external newsletters.
- A total of 2,154 (2,083 useable) responses were received, with 1,157 of those responses including the optional geo-tag to indicate census tract.
- The survey asked community members three questions:
    - What do you think being "healthy" means? For example, good physical health, good mental health, access to healthcare, safe and healthy places to live work and play, healthy social and community relationships, quality education, economic stability, or something else.
    - What do you need to achieve a healthy life in Denver? Please choose your top five.
        - Top results: Access to Healthcare, Clean Environment, Food Access, Access to Mental Health Care, Crime and Violence
    - What does your community(s) need to ensure everyone can achieve a healthy life? Please choose your top five. Your answers may be the same or different from Question 2.
        - Top results: Access to Healthcare, More Affordable Housing, Access to Mental Health Care, Food Access, Crime and Violence

Focus Groups

Denver Department of Public Health and Environment (DDPHE) partnered with community organizations to host 10 focus groups with 84 total participants in specific target populations in Denver from December 2024 – January 2025.

Target Population	Date of Interview	Focus Group Summary
Trans Youth and Parents of Trans Youth	12/11/2024	This focus group highlighted themes of centering LGBTQIA+ experiences in health settings, practicing attentive listening to life experiences, and increasing health literacy.
Latin(e) Community in North Denver	12/12/2024	This focus group brought up challenges with job opportunities and financial security, affordable healthcare, proximity to healthcare services, and financial struggles due to inflation.
Women in Community Corrections Programs	12/12/2024	This focus group highlighted the importance of attentive listening to life experiences, availability of reintegration programs, and concerns with participating in family life from a correctional setting.
Men in Community Corrections Programs	12/12/2024	This group brought up the need for reintegration resources and programs, as well as the need for affordable housing and clothing.

Lower Socioeconomic Households	12/17/2024	This group spoke about concerns with affording medication and experiencing or fear of experiencing homelessness, along with the need for increased resource navigation and communication.
People Experiencing Homelessness	1/2/2025	This focus group brought up the need for hygiene education and access to hygiene services, as well as increased resource communication and prioritizing the emotional health of those experiencing homelessness.
Young Black, Indigenous, People of Color (BIPOC) Men in East Colfax - Communities Experiencing Violence	1/3/2025	This group spoke to a resounding need for mentorship and emotional health resources, as well as a focus on the prevalence of gun violence experienced by this group.
People with Substance Use Disorders	1/6/2025	This focus group highlighted the need for affordable housing, free public resources to support substance use treatment or harm reduction, and resources for emotional health.
Older Adults	1/7/2025	This group listed health literacy and aging services/education as important needs, as well as increasing health communications.
American Indian and Alaskan Natives	1/7/2025	This group spoke to a need for aging services and resources, as well as increased understanding of spirituality as it relates to health choices and healthcare experiences. In addition to this, the group spoke about the need for health communications and reducing medication costs.

Community Led Town Halls

Three community members who form a Community Advisory Group (CAG) within the Denver Steering Committee hosted two community town hall meetings in January of 2025. These town hall meetings focused on learning together, mapping resources, tracking community needs over time, and strengthening connections with DDPHE.

- Saturday, January 25 in Five Points
- Sunday, January 26 in Montbello

Public and Community Health Experts Consulted

A total of 25 stakeholders provided their expertise and knowledge regarding their communities, including:

Name	*Organization*	*Services Provided*	*Populations Served*
Nathan Keffer	*Department of Public Health and Environment*	*Public Health Services for Denver Residents*	*All Denver Residents*
Paige Andrews	*Department of Public Health and Environment*	*Public Health Services for Denver Residents*	*All Denver Residents*
Agnes Markos	*Department of Public Health and Environment*	*Public Health Services for Denver Residents*	*All Denver Residents*
Julian Wolff	*Department of Public Health and Environment*	*Public Health Services for Denver Residents*	*All Denver Residents*
Eric Ortiz	*Department of Public Health and Environment*	*Public Health Services for Denver Residents*	*All Denver Residents*
Mallory Roybal	*City and County of Denver*	*Environmental Health Services*	*All Denver Residents*
Kelsey Clark	*City and County of Denver*	*Community Impact Policy Management*	*All Denver Residents*
Midori Higa	*City and County of Denver*	*Homelessness Reduction Services*	*Denver Residents Experiencing Homelessness*
Lisa Piscopo	*City and County of Denver*	*Executive Strategy and GIS Services*	*All Denver Residents*
Lori Laurita	*Denver Housing Authority*	*Housing Affordability Services*	*Denver Residents Experiencing Housing Instability*
Greta Hartmann	*Denver Housing Authority*	*Housing Affordability Services*	*Denver Residents Experiencing Housing Instability*
Chuck Ault	*St. Joseph Intermountain Health*	*Hospital and Healthcare Services*	*Denver Metro Residents*
Amanda Scates-Preisinger	*YMCA of Metro Denver*	*Wellness and Nutrition Services*	*Denver Metro Youth*

Gerald Hamel	*Community Outreach Service Center*	*Community Wraparound Support and Income Support*	*Denver Metro Residents*
Jenny Loth Hill	*Colorado Village Collaborative*	*Mental Health Support Services*	*Denver Residents in Need of Mental Health Services*
Cuica Montoya	*Colorado Village Collaborative*	*Mental Health Support Services*	*Denver Residents in Need of Mental Health Services*
Maureen Reid	*Denver Early Childhood Council*	*Early Childhood Support Services*	*Denver Families with Children Under 5 Years Old*
Dora Esparanza	*Denver Early Childhood Council*	*Early Childhood Support Services*	*Denver Families with Children Under 5 Years Old*
Alex Floyd	*One Colorado*	*LGBTQIA+ Support Services*	*LGBTQIA+ Denver Residents*
Jason Vitello	*Colorado Criminal Justice Reform Coalition*	*Criminal Justice Support Services*	*Denver Residents in the Criminal Justice System*
Nikki Collins	*City and County of Denver*	*Environmental Health Services*	*All Denver Residents*
Mariana del Hierro	*RE:Vision*	*Community Improvement and Job Creation*	*All Denver Residents*
Ricardo Gonzalez	*Servicios de la Raza*	*Human Services and Support for Spanish-Speaking Residents*	*Spanish-Speaking Denver Residents*
Gabriella Walters	*Tepeyac Community Health Centers*	*Health and Mental Health Services for Underserved and Spanish-speaking Populations*	*Spanish-Speaking Denver Residents*
Jessica Lagoni	*City and County of Denver*	*Human Services*	*All Denver Residents*

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)
- Colorado Coalition for the Homeless - The State of Homelessness 2024
- Colorado Health Information Dataset (COHID) Deaths Dashboard

Hospital utilization data for uninsured or self-pay patients who visited the Hospital for emergency department, inpatient or outpatient services in 2023-2024 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 Collaborative analyzed the data collected across all sources. At the conclusion of the data analysis, there were ten 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:

Child and Adolescent Development: LGBT

High school students who identify as transgender are at a high risk of bullying, misgendering, and discrimination from peers, family members, and school staff. Transgender children and teenagers may develop self-harming or suicidal ideations/behaviors in response to feeling ostracized, citing an overall and dramatic decrease in mental health unrelated to personal identity, but rather, related to how they are treated by others.

Drug and Alcohol Use

Among people experiencing homelessness who experience a substance use disorder, opioid and fentanyl use are listed as the leading cause of death by overdose. In addition to increased use of substances, there is limited access to harm-reduction and overdose prevention materials such as clean needle programs or Narcan kits. Substance use may disqualify people experiencing homelessness from some housing programs and resources, enforcing the cycle of homelessness.

Violence Prevention: Focus on Men

Firearm violence is much higher in the Hospital's service area than in the remainder of Colorado, with homicide by firearm listed as the second leading cause of death for men of color. Normalization of gun violence in some areas of Denver, as well as a decreased ability to report due to tension between police and people of color result in increases in deaths by gun violence.

Transportation

A lack of transportation access makes it more difficult to access social services and healthcare services. In addition to limiting access, utilizing inefficient public transportation increases commute time and may make it difficult to be on time for health appointments.

Economic Stability: Housing

Housing is a key indicator of health. Having access to safe and stable housing permits individuals to stay safe from weather events and provides a space to sleep and prepare food. In addition to this stable housing allows for access to nearby providers and for the building of community in the area where housing is located.

Economic Stability: Unemployment or Low Income

Individuals who are low-income or who are experiencing periods of unemployment may be unable to pay for needed health services for themselves or those they are supporting. In addition to gaps in healthcare due to an inability to pay for services, these circumstances may place individuals at risk of food insecurity or losing their stable housing. Experiencing prolonged unemployment or living with a low income can have profound effects on mental health and self-confidence. This effect is worsened by factors such as disability and limited English proficiency that may create additional challenges for job-seeking or system navigation.

Education Access and Quality: Children and Adolescents

School dropout is strongly associated with an increased risk of experiencing violence, housing instability, and financial instability. Some groups of youth are at a higher risk of school dropout than others, including youth who are experiencing homelessness, newcomers and migrant youth, and especially youth in the foster care system. In addition to less ideal health outcomes associated with school dropout, youth who leave school also leave behind resources and health services that are offered within the school system.

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 significant 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 that are 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.

Neighborhood and Built Environment: Food Security

Access to healthy food is a massive predictor of health and health outcomes. Individuals who are unable to feed themselves or their families healthy and nutritious food on a regular basis are more likely to have poor health outcomes and to experience additional health challenges. Many of the programs offered to close the food gap offer only shelf-stable foods and it is difficult to access fresh produce, dairy products, and meat products. In addition to this, there is a shortage of culturally appropriate foods and foods that accommodate allergies or sensitivities. Those with medically required diets may also face barriers in accessing these foods if they are unable to buy them outright due to cost or access issues (i.e. living in food deserts or lack of transportation).

Social and Community Context: Racism

The far-reaching impacts of structural racism affect almost every area of health and wellbeing. With well-documented examples like red lining, which decreases safe and affordable housing for people of color, and medical racism impacting pain management and safe childbirth rates for non-white individuals, racism is an urgent threat to all parts of a community's wellness and quality of life.

Priorities Selection

The Collaborative, through data review and discussion, narrowed the health needs of the community to a list of ten. Community partners within the Collaborative represented a broad range of interests and needs, from public health to the economic struggles of underserved, low-income and minority people in the community. Between January and March of 2025, the Collaborative met to review and discuss the collected data and select the top community needs.

Members of the Collaborative included:

Community Members:

- Three Denver residents were selected by the DDPHE Steering Committee to form the Community Advisory Group (CAG). CAG members are not named to protect their privacy.

AdventHealth Team Members:

- Bryan Trujillo, Regional Director of Community Health Improvement
- Monica Kneusel, Community Benefit Coordinator

Public Health and Community Experts (DDPHE Steering Committees):

- Nathan Keffer, Denver Department of Public Health and Environment, Senior Public Health Analyst
- Paige Andrews, Denver Department of Public Health and Environment, Senior Population Health Epidemiologist
- Agnes Markos, Denver Department of Public Health and Environment, Public Health Professional
- Julian Wolff, Denver Department of Public Health and Environment, Manager of Health Equity Engagement and Planning,
- Eric Ortiz, Denver Department of Public Health and Environment, Community Engagement Specialist
- Mallory Roybal, City and County of Denver, Senior Environmental Justice Administrator
- Kelsey Clark, City and County of Denver, Policy Manager
- Midori Higa, City and County of Denver, Director of Homelessness Resolution Programs
- Lisa Piscopo, City and County of Denver, Strategic Advisor
- Jessica Lagoni, City and County of Denver, Management Analyst Specialist
- Nikki Collins, City and County of Denver, Community Health Section Manager
- Lori Laurita, Denver Housing Authority, Program and Operations Manager
- Greta Hartmann, Denver Housing Authority, Program and Grants Administrator
- Chuck Ault, Intermountain Health, Community Health Manager
- Amanda Scates-Preisinger, YMCA of Metro Denver, VP Community Wellbeing
- Gerald Hamel, Community Outreach Service Center, BASIC Project Coordinator
- Jenny Loth Hill, Colorado Village Collaborative, Member
- Cuica Montoya, Colorado Village Collaborative, Senior Director of Homelessness Programs
- Maureen Reid, Colorado Early Childhood Council, Executive Leader

- Dora Esparanza, Colorado Early Childhood Council, Director of Business Services & Community Development
- Alex Floyd, One Colorado, Health Equity Director
- Jason Vitello, Colorado Criminal Justice Coalition, Equity and Community Development Manager
- Mariana del Hierro, RE:Vision, Executive Director
- Ricardo Gonzalez, Servicios de la Raza, Ventanilla de Salud Program Manager
- Gabriella Walters, Clinica Tepeyac, Director of Quality Risk and Compliance

Data Experts (DDPHE Assessment Design Team):

- Paige Andrews, Denver Department of Public Health and Environment, Senior Population Health Epidemiologist
- Agnes Markos, Denver Department of Public Health and Environment, Public Health Professional
- Elizabeth ter Harr, Colorado Coalition for the Homeless, Medical Director of Integrated Health Services
- Melissa Iwanowski, Colorado Coalition for the Homeless, Clinical Quality Improvement & Informatics Specialist
- Beth Gregory, Colorado Coalition for the Homeless, Director of Evaluation
- Ned Calogne, Colorado School of Public Health, Associate Dean of Public Health Practice
- Galena Rhoades, Thriving Families, Executive Director
- Gerald Hamel, Community Outreach Service Center, BASIC Project Coordinator
- Adonia Arteaga, Girls Inc., Center Programs Manager
- Tara Jae, Youthseen, Clinician
- Nizhoni Smocks, Youthseen, Finance Director
- Deanna Knight, Youthseen, Clinical Intern

Prioritization Process

To identify the top needs the Collaborative participated in a prioritization session on March 12th, 2025. During the session, the data behind each need was reviewed, followed by a discussion of the need, and the impact it had on the community. A modified Hanlon Method was used for prioritization, with Collaborative members asked to assign a “Seriousness of the Problem” rating for each of the 10 identified health issues.

Modified Hanlon Method

Variable Definitions	Modified Hanlon Method Equation
A = Size of the Problem B = Seriousness of the Problem D = Priority Score	**A + (2B) = D**

*All variables range from 0-10	

Collaborative members were asked to consider the following questions while assigning a *seriousness* ranking to each of the 10 identified health issues:

1. Does this health issue require urgent action?
2. Does it have a disproportionate impact on affected communities?
3. Are there risks if this issue is not addressed?
4. Does this issue influence other related (downstream) health outcomes?

In addition to the Collaborative, members of Denver Department of Public Health and Environment, the three members of the Community Advisory Group, and Denver's Health Board contributed their Seriousness ratings as well. The following weighting strategy was applied to continue to elevate the community voice:

Group	Size	Weight	Individual Vote Influence
DDPHE Steering Committee	18	0.325	1.81%
DDPHE Staff	150	0.3	0.20%
DDPHE Board of Health	9	0.05	0.56%
Community Advisory Group	3	0.325	10.83%

The top ten needs were ranked by the Steering Committee:

Ranking	Need
1	Economic Stability: Housing
2	Social and Community Context: Racism
3	Health Care Access and Quality
4	Economic Stability: Unemployment or Low Income
5	Neighborhood and Built Environment: Food Insecurity
6	Violence Prevention: Focus on Men
7	Education Access and Quality: Children and Adolescents
8	Transportation
9	Drug and Alcohol Use
10	Child and Adolescent Development: LGBT

The top ten health needs of the community were presented to the Hospital Health Needs Assessment Committee (HHNAC) on March 25, 2025. 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.

Members of the HHNAC included:

- Todd Folkenberg, Chief Executive Officer
- Dany Hernandez, Director of Mission Integration
- Michael Williams, Chief Medical Officer
- Anne Comeau, Quality Improvement Coordinator
- Brittney Johnson, Clinical Nursing Manager
- Sean Tracy, Director of Facilities
- Christina Kinhofer, Director of Supply Chain
- Brad Sjostrom, Director of Behavioral Health
- Carin Owen, Strategic Human Resources Director
- Chloe Dean, Communications Manager
- Monica Kneusel, Community Benefit Coordinator
- Bryan Trujillo, Regional Director, Community Health Improvement

The HHNAC narrowed down the list to three priority needs:

1. Drug and Alcohol Use
2. Health Care Access and Quality
3. 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 Hospital Programs	County and State Programs	Collaborative
Drug and Alcohol Use	• ALTO (Alternative to Opioids) Program • SBIRT (Screening, Brief Intervention & Referral to Treatment) Initiative • MOUD (Medication for Opioid Use Disorder) Treatments	• Own Path • Take Meds Back Program • Syringe Access Programs	• UnitedWay 211 • Servicios De La Raza • Mile High Behavioral Health • Colorado Health Network
Health Care Access and Quality	• Charity Care • Charity Lyft and Ambulance Rides	• Connect for Health Colorado	• UnitedWay 211
Neighborhood and Built	• Social Determinants of Health Screening	• Colorado Blueprint to End Hunger • Denver County WIC	• UnitedWay 211 • Denver and Arapahoe County

Environment: Food Security		• Denver County SNAP	Food Security Collaborative • Southwest Food Coalition • Nourish Colorado

Priorities Addressed

The priorities to be addressed include:

Icon Drug and Alcohol Use

Drug overdose deaths per year are on the rise in the Hospital's community, increasing from 370 to 467 from 2022 to 2023. Substance use is a prevalent health issue among people experiencing homelessness, with the Homeless Management Information System listing substance use as the fourth most common cause of homelessness and housing instability. Substance use in persons experiencing homelessness may exclude them from existing housing resources in addition to the health concerns created by unsafe substance use. With a 39% increase in homelessness in the last year, this health concern is rapidly growing in the Hospital's community.

Expanding services that prevent harmful substance use to persons experiencing homelessness has the potential to dramatically decrease deaths by overdose in this population, as well as open avenues to housing resources.

Icon Healthcare Access and Quality

Healthcare access continues to be a top priority for individuals in Colorado. In addition to the number of individuals who may not be able to access healthcare due to cost reasons (4.6% of Colorado individuals are uninsured), healthcare access issues can also be compounded by lack of transportation, prohibitive work schedules, lack of childcare, and limited English proficiency. Only 65% of individuals visited a general care provider for a routine checkup in the last year.

Expanding healthcare access has wide-reaching impacts for the Hospital's community, including reducing mortality rates, increasing use of preventive care services, and reaching populations that struggle to access healthcare services.

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 12.5% of individuals report an inability to afford food. For newcomers, food is one of the basic needs that they struggle to meet. Older adults also 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:

Child and Adolescent Development: LGBT

In the Hospital's community, 37% of high schoolers identify as transgender have considered suicide in the last 12 months, compared to 7.6% of cisgender high schoolers. The difference in mental health and stress in this population is dramatic, although these individuals make up a small overall portion of the population. The Hospital elected not to pursue this health issue, as AdventHealth Porter has robust anti-suicide programming in place, including ample resources and warm hand-offs to local organizations who can provide support to this group. The City of Denver also has resources for providing clinical and social care coordination services to this group.

Violence Prevention: Men

Men of color in the Hospital's community experience high levels of gun violence, making it the second leading cause of death for this group. Although this is a pressing and worsening issue, the Hospital is not well-positioned to make a significant impact on gun violence. AdventHealth Porter will continue to pursue a safe environment on its campus, and work with community organizations to understand the health needs of this population.

Transportation

In the Hospital's community, 8% of families do not have access to a vehicle, compounding concerns about transportation and healthcare accessibility. The Hospital provides transportation options for appointments as needed, along with Charity ambulance rides for those in need. While transportation continues to be a need for this community, the Hospital and community will need to collaborate further to identify scalable solutions that will impact this health priority.

Economic Stability: Housing

Access to safe and affordable housing continues to be a concern in this community. The second most frequently reported reason for experiencing homelessness is an inability to pay rent or a mortgage. Despite this, the Hospital did not select this as a priority since there are existing resources in the Denver community that are working to decrease rent costs and increase access to affordable housing. Social determinants of health are already screened for in the Hospital, including resource navigation for housing as needed.

Economic Stability: Unemployment or Low Income

Unemployment and low income are significant predictors of health and healthcare access. In the Hospital's PSA 9.9% of the community lives under the federal poverty line, compared to the state average of 16%. However, the unemployment rate in Denver County has decreased and is currently at 4%, mirroring the state's unemployment rate. In addition to this, the average yearly salary in the Hospital's community is $107,000 per year, compared to Colorado's $95,800. Compared to the other top needs that arose during the assessment process, the rates of employment and average income are not factors that the Hospital has a high level of impact on.

Education Access and Quality: Children and Adolescents

Education access for adolescents is an important predictor of health and wellbeing. Certain groups are more likely to leave school without attaining a high-school certificate, including children of migrant families, newcomers, and foster youth. The high school graduation rate in the Hospital's community is high at 91%. The Hospital did not select this as a priority since it does not have impactful influence over school attendance or enrollment.

Social and Community Context: Racism

Racism is a deeply rooted systemic issue that significantly affects access to and quality of healthcare for marginalized communities. This is reflected in a lower life expectancy for people of color in the Hospital's community, especially those who are Non-Hispanic Black with a life expectancy that is six years less than Non-Hispanic White individuals, and Native American individuals who have a life expectancy of 10 years less. Addressing its impact is crucial. While the Hospital recognizes this challenge, it will concentrate on strengthening evidence-based programs targeted at at-risk populations. By focusing on this approach, the Hospital can directly improve health outcomes for these marginalized groups without explicitly categorizing racism as a specific priority in our Community Health Needs Assessment (CHNA). This targeted strategy will enable the Hospital to create meaningful change and foster a healthier, more equitable community for everyone.

Next Steps

The Hospital will work with the Collaborative and other community partners to develop a measurable Community Health Plan 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 by 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 and 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 Porter 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

Advent Health Porter 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 Porter reports 26 MOUD interventions between January 1, 2024 – December 31, 2024. In addition to the MOUD program, Advent Health Porter 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 Porter reported 360 SBIRT encounters from January 1, 2024 - December 31, 2024.

Priority 3: Food Security

AdventHealth Porter is exploring a collaboration with Food Bank of the Rockies, with the goal of introducing their Food for Health program with the hospital as a pilot site. This program provides 6 months of medically tailored meals and nutrition education to individuals who meet certain health criteria. 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.
SDOH (Social Determinant of Health) screenings assessing food, housing, transportation, utilities, and safety are universally administered at all inpatient encounters. Porter reported 258 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, 2023-2025 Community Health Plan on our hospital website as well as on AdventHealth.com prior to May 15, 2023 and have not received any written comments.

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Portercare Adventist Health System dba AdventHealth Porter

CHNA Approved by the Hospital board on: May 15, 2025

For questions or comments, please contact: AdventHealth Rocky Mountain Region Community Health (rmr.communityhealth@adventhealth.com)