2021

Community Health Needs Assessment

An assessment of Children's Hospital Colorado, Colorado Springs licensed hospital facility.

Children's Hospital Colorado

Approved by the CHCO Board of Directors on December 16th, 2021.

Overview and Purpose

Overview of Children's Hospital Colorado

Founded in 1908, Children's Hospital Colorado has been a leader in providing the best health care outcomes for children for more than 100 years. Our mission is to improve the health of children through the provision of high-quality coordinated programs of patient care, education, research and advocacy. We also work hard to keep kids out of the hospital. Through medical research and advocacy efforts, we are committed to finding ways to keep kids safe and healthy. Children's Colorado is a not-for-profit pediatric health care network. We have more than 3,000 pediatric specialists and more than 5,000 full-time employees helping to carry out our mission. Children's Hospital Colorado's Colorado Springs Hospital opened May 28, 2019. The 294,000-square-foot, 115-bed facility is southern Colorado's first pediatric-only hospital. It provides more than 175,000 kids in southern Colorado and surrounding states with pediatric care closer to home. We have served more than 19,900 patients from 54 Colorado counties and 43 states and our Level 2 Emergency Department had more than 20,000 visits.

Children's Colorado is a not-for-profit pediatric healthcare network.

3,000+
Pediatric specialists

5,000+
Full-time employees helping to carry out our mission

Each year, the network has

15,000+
Inpatient admissions

600,000+
Outpatient visits

Purpose of the assessment

Children's Colorado embraces the opportunity to engage with our community to better understand their interests and concerns and to design programs and partnerships that directly respond to community needs. The primary purpose of this assessment is to help better inform how we fulfill our mission of improving the health of all Colorado children. We will also use the information gathered from this assessment to inform the work of the Division of Population Health and Advocacy. The Division of Population Health and Advocacy includes the teams of the Child Health Advocacy Institute (CHAI), Government Affairs, School Health, Partners for Children's Mental Health (PCMH), and the Office of Diversity, Health Equity, and Inclusion (DHEI). Our vision is to implement a model for whole child, whole health, which includes considering all clinical aspects as well as social determinants of health (SDoH).

This report is focused on identifying and quantifying community health needs and will be followed by a plan to address those needs. The Community Health Implementation Plan will guide the hospital's strategies for addressing identified needs. In addition, this report fulfills the requirements of the Affordable Care Act of 2010. Internal Revenue Service (IRS) Section 501(r) requires that nonprofit community hospitals conduct a community health needs assessment every three years. This is a report for the Children's Colorado Springs Hospital. Children's Colorado Springs Hospital opened in May 2019. IRS requires nonprofit community hospitals to complete a Community Health Needs Assessment (CHNA) within the first 2 years of being open. The IRS requires a newly licensed hospital to meet the CHNA requirement by the last day of the second taxable year.

Methods and Process

Children's Colorado used the following process to complete our assessment, which is in full compliance with IRS requirements and builds on approaches we have used for previous assessments.

Assess impact of the Community Health Implementation Plan

Review hospital data and determine geographic boundaries

Identify relevant secondary indicators

Collect community and public health input

Analyze data and identify health and social inequities and needs

Identify, validate, and select priorities

Write assessment report and disseminate widely

Defining the community

For purposes of this assessment, Children's Colorado Springs has defined community as all children aged 0 to 25 living in the El Paso County area from which most of the hospital's patient population resides and in which we have facilities.

Consistent with the Internal Review Service (IRS) guidelines, Children's Colorado considered three criteria to select the geographic area included in the assessment:

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

The hospital's mission is "to improve the health of children through the provision of high-quality, coordinated programs of patient care, education, research and advocacy." To understand the geographic area served by the hospital facility, we reviewed our patient population data and found that most inpatient admissions and outpatient visits are from children who live in El Paso County, which we ultimately decided to include in our definition of our community. In 2019, Children's Hospital Colorado in Colorado Springs saw 10,744 patients from El Paso ages 0 to 25 years old across inpatient, emergency department or urgent care (ED/UC) and outpatient settings, representing 87% of all patients seen that year.

Unique Patients Ages 0-25 Seen at Children's Hospital Colorado – Colorado Springs, By Setting, 2019

County	Inpatient, n (%)	Emergency / Urgent Care, n (%)	Outpatient, n (%)	Total, n (%)
El Paso, n	1,313	7,543	3,034	10,744
El Paso, % of Total Patients	80.6%	91.7%	80.7%	86.9%

Source: Children's Hospital Association (CHA), 2019

New data collection approach

Since this is the first assessment for the Children's Colorado Springs Hospital, we utilized feedback received on the Children's Hospital Anschutz Campus 2018 CHNA. Children's Colorado revised our prior data collection approach in two main ways: 1) gathered secondary data first to inform our primary data collection strategy and 2) developed a more dedicated approach to equity in our data collection process.[1]

More depth, less breadth

In prior assessments conducted for the Children's Colorado system, data was gathered simultaneously and then reviewed for analysis and prioritization. For our 2021 CHNA, Children's Colorado decided to gather and analyze secondary data first to inform what populations and topics we would focus on for our primary data collection approach. Children's Colorado used the Healthy People 2030 Social Determinants of Health Framework to identify focus health and social areas for our secondary data collection.[1] Once the secondary data were gathered and analyzed, Children's Colorado identified focus populations and topics for our primary data collection based on top needs from the secondary data (e.g., indicators with the greatest difference at the county level compared to the state) or where gaps in the secondary data could potentially be explored through our primary data (e.g., health and social indicators for youth in the Lesbian, Gay, Bisexual, Transgender, and Queer communities). Using this approach, the primary data collection process focused on the following populations and topics:

Populations:

- Families in the military
- Families who were born outside the US
- Families who identify as black, indigenous, or other person of color
- Families with diverse languages used at home
- Children with medical complexity
- Youth in the Lesbian, Gay, Bisexual, Trans, and Queer communities

Topics:

- Education and early childhood
- Housing
- Mental health and suicide prevention
- Respiratory health
- Intentional and unintentional injury

As part of this approach, our primary data collection tools included more in-depth and focused questions to deepen understanding of community needs in these populations and context behind the greatest needs identified in the secondary data. Please refer to Appendix A for our data collection instruments.

[1] Secondary data refer to data that has already been collected from another organization or source, such as public health surveillance data or patient health care utilization data. Primary data refer to data that a person or team gathered directly from a specific population, in the form of survey, interview, focus group, etc.

Applying a Data Equity Lens

A data equity approach aims to help change the status quo and utilization of data to advance equity and inclusion for the communities we serve. A data equity lens works to bring awareness to historical impacts, potential biases, and exploration of demographic data, such as race, ethnicity, sexual orientation, and the intersectionality of varying demographics. Based on prior assessments completed for Children's Colorado, we revised our assessment approach by identifying concrete and actionable ways to gather, analyze, and communicate our data more equitably. Below is a table that highlights some of the approaches we committed to ensure a more equitable approach to our CHNA work:

Equitable Approaches to Data and Children's Colorado Examples

	Equitable Approach	Children's Colorado Example
Data Collection	Design data collection tools with inclusive language, at the appropriate literacy level	Used person-first language to describe specific populations in our data collection tools and reviewed with diverse team members for literacy and culturally responsive language
	Translate data collection tools into community preferred languages	Offered caregiver survey in 8 languages: Amharic, Arabic, Burmese, French, Karen, Somali, Spanish, and English
	Partner with community organizations to gather data	Asked stakeholders to distribute surveys to community members to gather caregiver surveys
Data Analysis	Analyze data by multiple demographics (e.g., gender and race or ethnicity) to understand the intersection of multiple identities	Gathered demographic data for secondary sources, when available
	Include both individual- and system- level measures to limit internal bias	Individual-level: Analyzed data using our electronic medical records data (e.g., Epic) System-level: Analyzed big data from secondary sources
	Assess commonalities and differences in qualitative data using team-based approach which limits bias	Had data and evaluation team members review groupings and themes in the stakeholder interviews
Data Communication	Gather input on data from the community	Consulted and met with the organizational members of the Healthy Community Collaborative (HCC)* to gain feedback and input on health and social need priorities
	Provide relevant historical or cultural context for a more complete picture of the data	Discussed barriers such as language, discrimination and racism, stigma around accessing services, and culturally responsive education for providers
	Ensure information is presented with appropriate literacy and language	Used narratives, graphics, and 1-2 data points to describe the data rather than complex tables of numbers and percentages

**See the Community Engagement section for more information on the Healthy Community Collaborative*

The Child Opportunity Index

There are a number of measures that have been developed to help understand what type of social determinants a person may experience where they live (e.g., census tract, zip code, county). However, many of these measures do not have a child-specific focus. The Child Opportunity Index (COI) was developed by Diversity Data Kids in collaboration with the Kirwan Institute for the Study of Race and Ethnicity at Ohio State University in 2014 and measures the quality of resources and conditions that are essential for children to develop and thrive in the neighborhoods where they live. The COI is a composite index of 29 neighborhood-level indicators across three domains: education, health and environment, and social and economic.[2] The scale ranges from Very Low, Low, Moderate, High, and Very High child opportunity and can be calculated for a given geographic area.[2] As we start to describe our hospital data, we will reference the COI to help connect to the social and economic conditions of the patients we serve.

Child Opportunity Index Domains and Sub-domains

Education	Health & Environment	Social & Economic
Early childhood education	Healthy environments (e.g., walkability, green space)	Economic opportunities
Elementary education	Toxic exposures (e.g., hazardous waste dump sites)	Economic and social resources (e.g., poverty rate, employment)
Secondary and post-secondary education	Health resources (e.g., health insurance coverage)	
Educational and social resources		

Source: diversitydatakids.org

Data Sources

Our team identified relevant secondary indicators both internally and externally to identify health and social inequities and needs within our defined community. In total, we collected and analyzed data from over 30 data sources. For a list of specific data sources see Appendix B.

Stakeholder Interviews

Stakeholders provide critical insights regarding the root causes of community health needs as well as providing context and nuance that is often missed in secondary data. Our stakeholders were identified based on the community or communities they worked in and the population and topics outlined in the methods section of this report. Some stakeholders focused on our identified community (El Paso County), while others served the entire State of Colorado, including our county of focus. Hospital staff and leadership developed an initial list of stakeholders. Additionally, when we conducted stakeholder interviews, we solicited suggestions from the stakeholders for additional informants. In total, more than 30 organizations collaborated with Children's Colorado representing our diverse community members and assisted in our understanding of their priorities. For a detailed list of stakeholder names, roles, and organizations, please refer to Appendix C. We are deeply grateful to the many organizations who participated in the interviews:

- Catholic Charities
- City of Colorado Springs, Diversity and Community Outreach
- City of Colorado Springs, Office of Economic Development
- Colorado Department of Public Health & Environment (CDPHE), Office of Suicide Prevention
- Colorado Community Health Alliance (CCHA)
- Colorado Department of Education
- Colorado Department of Local Affairs, Division of Housing
- Colorado Springs Health Foundation
- Colorado Springs School District 11
- Colorado Trust
- Community Health Partnership
- Colorado Springs Fire Department Community and Public Health
- Culture of Wellness, Colorado School of Public Health
- Early Childhood Council Leadership Alliance
- El Paso County Public Health
- El Paso County Public Health, Fountain Valley Communities That Care
- First Visitor Program of Peak Vista Community Health Centers
- Homeward Pikes Peak
- Inside Out Youth Services
- Mt Carmel Veterans Center
- One Colorado
- Partners in Housing
- Peak Vista Community Health
- Pikes Peak Suicide Prevention
- Pikes Peak YMCA
- SafeCare CO by Lutheran Family Services
- Springs Rescue Mission
- The Colorado Health Foundation
- The Resource Exchange
- University of Colorado, School of Medicine
- Youth Move Colorado

Interviewees were selected based on the communities they serve (El Paso County) and included both state and local agencies. A total of 32 interviews were conducted. Some of the populations identified by stakeholders include but are not limited to families with diverse languages used in the home, families born outside of the U.S., families who identify as black, indigenous, or other person of color, LGBTQ+ youth, families in the military, and children with medical complexities.

Respondents were asked to identify the top needs of the populations they serve, barriers that these populations face, and COVID-19 impacts in addition to other organization-specific questions.

Surveys

In the caregiver survey that we administered, we asked respondents to rate a list of issues as not important, a little important, important, or very important. We then applied a weighting system, giving those issues rated as very important 4 points, important 3 points, a little important 2 points, and not important 1 point. The combined points for each issue were then compared to determine the top issues for each set of respondents.

We provided our survey in 8 different languages: English, Spanish, Somali, Burmese, Amharic, French, Karen, Arabic. We distributed the survey with the help of our stakeholders and partnered with Catholic Charities to gather caregiver surveys to gain representation for our diverse community members.

Limitations

Not surprisingly, the biggest barriers to community engagement and data collection during this assessment period were related to the many impacts of the coronavirus pandemic to everyday life. Due to safety concerns, Children's Colorado conducted most of their community outreach work virtually. This significantly limited our ability to reach important populations, including families who do not have reliable access to internet or technology, families who speak diverse languages, and populations who may prefer to engage in-person. Additionally, it was much more difficult to meaningfully engage community members and community organization leaders with shifting priorities during the pandemic, both personal and professional, such as accessing food, accessing COVID-19 tests, or managing remote learning for their children, or monitoring outbreaks and helping community members access COVID and non-COVID related resources, among many other pressing issues.

When gathering secondary data, it was often the case that the most recent data available was from 2019, prior to the pandemic. This data lag was more meaningful than prior assessments due to the substantial impacts the pandemic has had on community health and well-being, such as families' access to healthy food or youth mental health during the pandemic. To adjust for these limitations, Children's Colorado included questions in our surveys and stakeholder interviews that focused on the impact of COVID-19 on community needs and barriers to address those needs, and when available, included 2020 data in the assessment.

Summary Findings

Description of community served

The populations that are included in this assessment are the residents of El Paso County ages 0 to 25 years.

Child Population

Across Colorado, there are approximately 1.3 million children under the age of 18, representing 22% of Colorado's residents. Approximately 3 in 10 households in Colorado have children.[3]

Child Population, 2019

	Colorado	El Paso
Total Population Under 18 years (N, %)	1,256,320 (22%)	171,269 (24%)
% of households with one or more children under 18 years old	30%	33%

Source: American Community Survey 1-Year Estimate, 2019

Births and Deaths

There has been a steady decline in birth rates in Colorado since 2006. In 2020, there were 61,496 live births in Colorado.[4] While Colorado's birth rate has been declining for over a decade, there has been a positive net migration into Colorado, particularly among people of childbearing age.[5]

When looking at deaths in the less than 1 year age group, Colorado's infant mortality rate has hovered between 4.5 and 5.1 per 1,000 live births since 2012.[4] By race and ethnicity, infant mortality rates in Colorado are highest among Black and African American mothers: at 8.9 per 1,000 between 2017 and 2019.[4]

Strikingly, between 2015-2019, suicide was the leading cause of death among Colorado youth aged 10-17, exceeding motor vehicle and other transportation.[6] Among children under 10, sudden unexpected infant death (SUID) remains the leading cause for the less than 1 age group, child maltreatment for 1-4 year olds, and motor vehicle and other transportation for 5-9 year olds[6].

Leading Cause of Death by Age Group, 0-17 Years in Colorado, 2015-2019

All	Less than 1	1-4	5-9	10-14	15-17
Suicide	Sudden unexpected infant death	Child maltreatment	Motor vehicle and other transportation	Suicide	Suicide
Child maltreatment	Child maltreatment	Motor vehicle and other transportation	Child maltreatment	Firearm	Firearm
Sudden unexpected infant death	Unintentional drowning	Unintentional drowning	Unintentional drowning	Motor vehicle and other transportation	Motor vehicle and other transportation
Motor vehicle and other transportation	Other	Asphyxia	Firearm	Child maltreatment	Homicide
Firearm	Motor vehicle and other transportation	Fire	Fall or Crush	Homicide	Child maltreatment

Source: Child Fatality Prevention System, Colorado Department of Public Health and Environment, 2015-2019

Race and Ethnicity

While Colorado is predominantly White, 41% of the population identifies as a minority when looking at the 0–24 year old population.[7] The Hispanic or Latinx group is the largest minority population by a wide margin in El Paso County.

Race and Ethnicity Ages 0-24, 2019

	Colorado	El Paso
American Indian	0.8%	0.8%
Asian/Pacific Islander	4.0%	3.6%
Black	5.7%	8.9%
Hispanic	30.5%	23.9%
White	58.9%	62.8%

Source: Colorado Department of Local Affairs, 2019

Education

In school year 2018-2019, the average graduation rate for Colorado high school students was 81.1%.[8] When compared to the state and surrounding counties, El Paso had one of the lowest graduation rates at 75.3% in 2019.[8]

Graduation rate varies by race and ethnicity.[8] Additionally, the high school student population has diverse backgrounds and cultures, with 1% of Coloradan students identifying as immigrants and 14% English-Language Learners.[8] See Appendix D for details.

Graduation Rates by Race and Ethnicity, 2019

	Colorado	El Paso
American Indian or Alaska Native	64.9%	61.3%
Asian	89.9%	89.5%
Black or African American	74.4%	76.4%
Hispanic or Latinx	74.0%	62.4%
Native Hawaiian or Other Pacific Islander	76.0%	80.0%
Two or more races	80.6%	77.5%
White	85.9%	80.5%

Source: Colorado Department of Education, 2019

Children with a Disability

El Paso has a slightly higher percentage of children under 18 with a disability[2] (4.4%) compared to the state (3.5%).[9] When looking specifically at cognitive disabilities, El Paso also has a higher percentage (4.3%) of children living with a cognitive disability compared to the state (3.2%).[9]

Children with a Disability, 2015-2019

	Colorado	El Paso
% of children under 18 years old with a disability	3.5%	4.4%

Source: American Community Survey 5-Year Estimate, 2015-2019

According to the Colorado Department of Education, among children aged 6-21 years old with a disability in school year 2019-2020, 83% were non-English language learners and 17% were English language learners.[8] When looking at race and ethnicity among students with disabilities, White students comprise 49%, followed by Hispanic or Latinx at 38%, and Black or African American at 6%.[8]

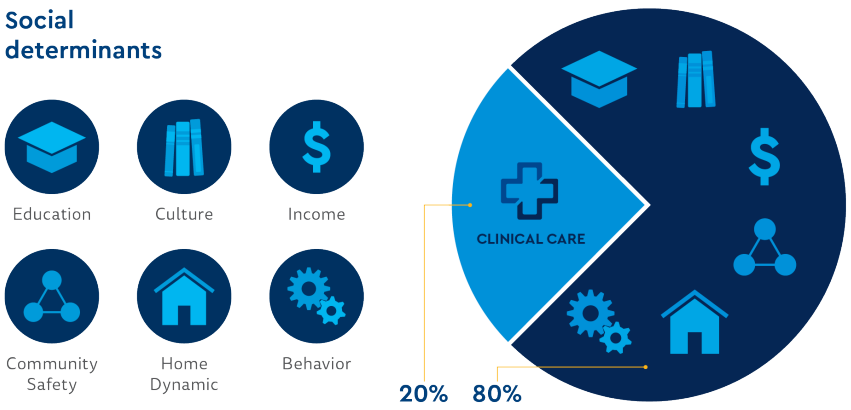
Social Determinants of Health

Social determinants of health (SDoH) are the social, economic, and physical conditions in which people are born and live in that impact their health.[10] Social determinants of health can range from families not being able to access medical care because of their immigration status to structural issues with their housing that impact their child's asthma.

When looking at a child's overall health, only 20% is impacted by clinical care while approximately 80% comes from other factors including education, income, and the home dynamic.

Below we will discuss the following SDoH topics:

- Socioeconomic status
- Access to benefits
- Housing
- Physical activity
- Food access



[2]Disability is defined as someone who has a serious difficulty with four basic areas of functioning – hearing, vision, cognition, and ambulation. https://www.census.gov/quickfacts/fact/note/US/DIS010219

Socioeconomic Status

While Colorado's median household income is about $95,000, more than 1 in 10 households with children live in poverty (10.9%), representing approximately 135,000 children.[3] For a family of four living in poverty, their annual household income would be $25,750 or less, according to the 2019 federal poverty guideline. For El Paso County, the rate of children living in poverty is 9.6%. Colorado median household income has increased in the last three years, and the percentage of children living in poverty between 2016 and 2019 has dropped 2.5 percentage points from 13.4% to 10.9%, with similar trends at the county level. Close to one-third of children in Colorado are being raised in single-parent households.[3] Like the distribution of income and poverty, these figures are slightly higher in more urban areas and notably lower in more suburban areas.[3]

Socioeconomic Indicators, 2019

	Colorado	El Paso
Total Population	5,758,736	720,403
Children (under 18) living in poverty	135,405 (10.9%)	16,162 (9.6%)
Median Household Income	$95,164	$86,411
% children (under 18) living in single-parent household	27%	27%

Source: American Community Survey 1-Year Estimate, 2019

Access to Benefits

Access to benefits—and health insurance in particular—can promote health at any age through routine check-ups, preventive screenings, and immunizations. Public insurance benefits, such as Medicaid, Child Health Plan Plus (CHP+), and Advance Premium Tax Credits (APTCs), provide no cost or low-cost options for health insurance for families with lower incomes, although many eligible families are not enrolled in these programs. At the state level, from ages 0 to 18 years old, the number of eligible but not enrolled individuals (EBNE) in Medicaid, CHP+, or APTCs is 7%.[11] This is the same at the county level for El Paso.[11] When looking at the data by race/ethnicity and income statewide, 49% of those who are eligible but not enrolled in any of the programs are Hispanic and 32% are under 139% of the federal poverty level.[11]

Eligible But Not Enrolled, Ages 0-18, 2018

	Colorado	El Paso
% EBNE*	7%	7%

Source: Department of Health Care Policy and Financing; Connect for Health Colorado; American Community Survey 2018; 2019 Colorado Health Access Survey; 2015 Medical Expenditure Panel Survey

**Eligible but not enrolled (EBNE) in Medicaid, CHP+, or APTCs*

Housing and Homelessness

Coloradans experiencing challenges with the lack of housing affordability and/or housing instability may also experience negative impacts on their physical health and may have trouble accessing health care.[12] Approximately 1 in 8 Coloradans are spending at or above 50% of their household income on housing.[3] Colorado ranks as the 8th least affordable state in the US when median income is compared to median home sales prices.[13] This is particularly true in urban settings across the Front Range. Across Colorado, 13.6% of households spend 50% or more of their household income on housing. This rate is slightly higher in El Paso (13.9%).[3] At the state level, approximately 1 in 3 units have monthly rent ranging from $1,000 to $1,499.[3]

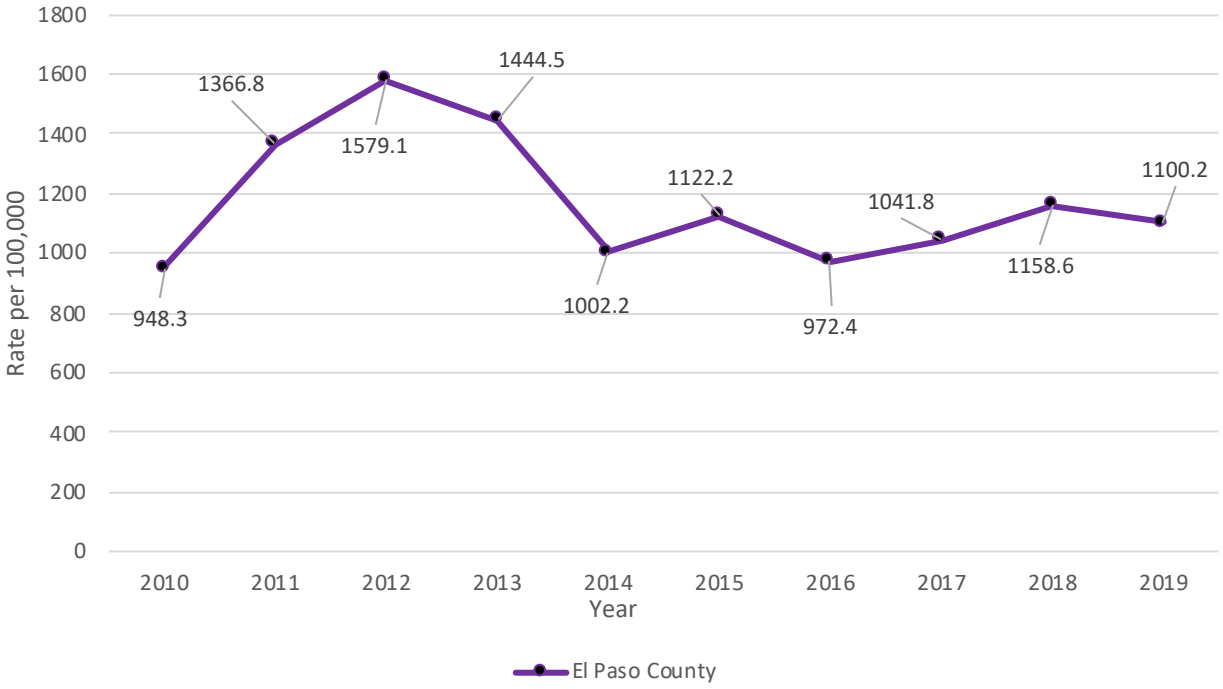
Housing Cost Burden, 2019

	Colorado	El Paso
Percent of households that spend 50% or more of their income on housing	13.6%	13.9%

Source: American Community Survey, 1-Year Estimate, 2019 following the County Health Ranking methodology for severe housing cost burden

Families spending the majority of their incomes on housing can lead to families experiencing more housing stability and homelessness. The rate of youth[3] experiencing homelessness in El Paso has shown an increase between 2010 and 2019 from 949 per 100,000 in 2010 to 1,100 per 100,000 in 2019.[8] For the 2018-2019 school year, the number of youth experiencing homelessness in El Paso was estimated to be 2,029.[8]

Youth Experiencing Homelessness, 2010-2019



Source: Kids Count, Colorado Department of Education; Colorado Department of Local Affairs, 2010-2019

[3]Number of PK-12 public school students served by the McKinney-Vento Homeless Education Program during the school year based on Colorado school district submissions

Physical Activity

The role of physical activity can affect both a child's physical and mental well-being. The benefits of physical activity can help reduce the risk of developing heart disease, type 2 diabetes, and high blood pressure.[14] It has also been shown that physical activity can be associated with lower symptoms for depression.[15] The Physical Activity Guidelines for Americans, by the U.S. Department of Health and Human Services (DHHS), recommends that children ages 6 to 17 should do 60 minutes or more of moderate-to-vigorous physical activity each day.[16]

In El Paso County, the percentage of students who are physically active for a total of at least 60 mins/day on five or more days in the past week is lower compared to the state.[17] Additionally, El Paso County (74.9%) reported higher video game play compared to the state (73.1%) in 2019 and higher television use (21.8%) in 2017.[17]

Physical Activity, 2017 and 2019

	Colorado	El Paso
% of students who were physically active for a total of at least 60 mins/day on five or more days in the past week	48.0%	46.4%
Among students who play video games, percentage who spend two or more hours per average school day playing video or computer games	73.1%	74.9%
% students who watched television for 3 or more hours per day on weekdays	16.7%	21.8%

Source: Healthy Kids Colorado Survey, 2017 and 2019

Lack of physical activity can also negatively impact a child's academic performance and may lead to lower levels of concentration and memory.[18] According to the 2017 Healthy Kids Colorado Survey, over half of Colorado youth (52.2%) spend an average of 3+ hours of total screen time on an average school day.[19]

Food Access

Children experiencing food insecurity can be at an increased risk for a variety of negative health outcomes, including obesity. They also face a higher risk of developmental problems compared with food-secure children. In addition, reduced frequency, quality, variety, and quantity of consumed foods may have a negative effect on children's mental health.[20] In 2019, about 12% of Colorado children 18 years and under experienced food insecurity.[21] In 2019, 41% of pre-kindergarten through 12th graders received free (33%) or reduced (8%) lunch.[8] More students who identify as Black or Hispanic were enrolled in the free or reduced lunch program than students of other races.[8]

The COVID-19 pandemic took economic tolls on many individuals and families and disrupted many food systems in place for children in Colorado, leading to increased food insecurity. Hunger Free Colorado conducted a quarterly survey across the state to determine the impact of Coloradans' access to food and financial security.[22] In December 2020, the third statewide survey in the series found that "almost 2 in 5 (38%) of Coloradans are food insecure."[22] This was found to be the highest incidence rate of food insecurity in the state since the Great Recession.[22]

When looking at the percentage of students who sometimes, most of the time, or always went hungry in the past 30 days because of a lack of food at home, El Paso County has a higher rate (18.2%) compared to the state (14.7%).[17] The majority of students who went hungry in the past 30 days in El Paso are either more than one race, followed by Black or African American, and Hispanic or Latinx.[17] See Appendix E for details.

Food Insecurity, 2019-2020

	Colorado	El Paso
2019 Child Food Insecurity Rate	12.2%	13.8%
2020 Projected Child Food Insecurity Rate	16.0%	18.4%

Source: Feeding America, 2019-2020

Health and health care indicators

After looking at how social factors can influence a child's well-being, the section below summarizes how some of the following health and health care indicators impact our county:

- Health Status
- Asthma and respiratory health
- Child abuse and neglect
- Unintentional injury
- Mental health and suicide prevention
- Nutrition
- Unhealthy weight
- Oral health
- Health access
- Health care utilization

Health status

Most parents in Colorado report that their children's health is either excellent (57.0%) or very good (31.4%).[23] Statewide, parent-reported health status varies slightly by race or ethnicity. Slightly fewer parents that identify as Hispanic report that their children's health is either excellent or very good (51.6% and 29.9% respectively) while a slightly higher percentage of parents that identify as non-Hispanic White reported excellent or very good health (60.6% and 31.4% respectively[4]). Parents of any race or ethnicity in El Paso County reported similar rates to the state (58.8% "excellent" and 31.2% "very good").[23]

Asthma and respiratory health

Children are more likely than adults to be seen in the emergency department or hospital for asthma and/or upper respiratory infections. In 2018, El Paso had a higher asthma hospitalization rate per 10,000 among 0-4 year olds (14.9) compared to the state (13.7).[24]

Asthma and Respiratory Health, 2018

	Colorado	El Paso
Asthma hospitalization rate per 10,000, 0-4 year olds	13.7	14.9
Asthma hospitalization rate per 10,000, 5-14 year olds	9.9	9.7

Source: Colorado Environmental Public Health Tracking, 2018

Children who identify as Black and children who live below 250% of the poverty line have greater health disparities in asthma prevalence, treatment, and outcomes.[25] Black and Latino children are less likely to receive preventive care and more likely to visit the ED and be hospitalized than White children.[26–28]

Barriers to asthma management may be related to the disease itself. However, national studies show that more than 50% of the patients of all ages whose asthma is uncontrolled have barriers that are not related to their disease or even their health care. Access to health care and medications are cited as barriers to asthma treatment, but U.S. families also report barriers such as poverty, stress, poor housing conditions, and increased exposure to environmental triggers. These factors are associated with increased asthma prevalence, worse control, and increased hospital admissions.[29–31]

[4]Differences are not statistically significant

Asthma and respiratory health

Joey has asthma. He currently lives in Colorado Springs in an older building and occasionally his family has pests in their home which can trigger asthma. At school, Joey must take his inhaler to the gym and sometimes he forgets it. Joey recently lost his inhaler. With his family's medical insurance, his parents can only pay for one inhaler for several months due to the amount that the insurance will cover for the prescription. This financial strain and concern about Joey's asthma creates added stress for their household. Without Joey's inhaler, he is more at risk of having to go to the emergency room to manage his asthma.

Child abuse and neglect

Child maltreatment is one of the leading causes of death among youth under 18 years in the state. Young children (under 1 year) experience higher rates of child maltreatment death compared to older children.[32] Across measures, El Paso County has had slightly higher rates of ED visits tied to abuse among children aged 0-18, child maltreatment deaths, and reported rates of child abuse and neglect compared to the state.[32]

Colorado infants, children and youth who are non-Hispanic Black are 3.8 times as likely to die by child maltreatment compared to non-Hispanic White infants, children, and youth.[6] In El Paso, Black or African Americans had the highest rate of child maltreatment deaths compared to other groups at 13.1 per 100,000.[32]

Child Abuse, Maltreatment, and Neglect, 2016-2019

	Colorado	El Paso
Crude rate of ED visits per 100,000 mentioning injuries due to child or adult abuse among Colorado residents under 18 years old[1]	62.1	64.0
Crude rate of child maltreatment deaths per 100,000 among Colorado residents under 18 years old[1]	3.7	4.8
Child Abuse and Neglect (rate per 1000)[2]	9.5	14.7

Source: [1]Colorado Department of Public Health and Environment, Child Fatality Prevention System, 2016-2019; Colorado Department of Public Health and Environment, Injuries in Colorado Dashboard, 2016-2019; [2]Kids Count, Division of Child Welfare Services, Colorado Department of Human Services, 2018

Unintentional injury

Unintentional injuries make up some of the top leading causes of death among youth in Colorado. Unintentional injuries can include motor vehicle accidents, unrestrained child seats, falls, or drownings. Motor vehicle and other transportation injuries are the fourth leading causing of death in Colorado for children less than 18 years.[6] Unintentional drownings are the third leading cause of death for children 9 years and under.[6]

When looking at motor-vehicle deaths per 100,000, El Paso had a higher rate compared to the state from 2016-2019 (3.5 compared to 3.1) for youth under 18 years.[33] Overall, El Paso also had higher rates of emergency department visits related to unintentional injuries compared to the state.

Unintentional Injuries, 2016-2019

	Colorado	El Paso
Average annual crude rate of deaths per 100,000 due to all traffic-related motor vehicle deaths among Colorado residents under 18 years old	3.1	3.5
Average annual crude rate of deaths per 100,000 due to unintentional injury among Colorado residents under 18 years old	7.5	9.4
Average annual crude rate of ED visits per 100,000 mentioning unintentional injuries among Colorado residents under 18 years old	7,659.4	8,335.6

Source: Colorado Department of Public Health and Environment, Injuries in Colorado Dashboard, 2016-2019

Mental health and suicide prevention

Mental health impacts emotional, psychological, and social well-being and is important at every stage of life, from childhood and adolescence through adulthood.[34] In El Paso, 40.7% of high school students felt sad or hopeless almost every day for 2 or more weeks in a row during the past 12 months in 2019. Despite the prevalence of mental health issues, access to mental health care continues to be a challenge for all Coloradans. According to the Colorado Health Access Survey, more than 1 in 10 Coloradans reported not getting needed treatment for mental health issues in 2019.

Mental health is also a risk factor for suicide. For several years, suicide has been the leading cause of death for Colorado youth aged 10-17.[35] In 2019, approximately 8% of Coloradan students attempted suicide one or more times in a 12 month period.[17]

Substance use and abuse can be a risk factor for suicide. Between 2014 to 2018, marijuana was present in 3 out of 10 (30.0%) suicide deaths among youth ages 15-19 compared to about 1 in 5 (19.8%) from 2009 to 2013. Furthermore, from 2014 to 2018 alcohol was present in 12.1% of suicide deaths among 15- to 19-year-olds . For these reasons, there are concerns over access to substances among youth.[36]

At Children's Colorado, patients are increasingly presenting with mental and behavioral needs as well as self-harm and suicide attempts, particularly since the start of the pandemic. Between January and May 2021, behavioral health emergency department visits across the Children's Hospital Colorado health system were up 73% compared to the same time period in 2019. During the spring of 2021, suicide continued to be a leading chief complaint in Children's Colorado Emergency Departments and Children's emergency transportation teams were receiving calls for 3-4 suicide attempts per week. Experts at Children's Colorado expect to see increases in other diagnoses, including disordered eating and substance use and abuse.

Mental Health Indicators, 2016-2019

	Colorado	El Paso
Percent of high school students who felt sad or hopeless almost every day for 2 or more weeks in a row so that they stopped doing some usual activities during the past 12 months[1]	34.7%	40.7%
Percent of high school students who actually attempted suicide one or more times during the past 12 months[1]	7.6%	9.7%
Percentage of high school students who had an adult to go to for help with a serious problem[1]	72.7%	69.5%
Average annual crude rate of ED visits per 100,000 mentioning self-harm injuries among El Paso County residents under 18 years old[2]	202.0	234.9
Average annual crude rate of ED visits per 100,000 mentioning self-harm injuries among El Paso County residents 18-24 years old[2]	329.8	378.6

Source: [1]Health Kids Colorado Survey, 2019; [2]Colorado Department of Public Health and Environment, Injuries in Colorado Dashboard, 2016-2019

Nutrition

Nutrition is vital to the development and growth of children and can help reduce risk for health conditions, such as obesity, poor oral health, and type 2 diabetes.[37] Nutrition serves as another health factor that needs to be addressed in El Paso County. When compared to the state, El Paso had higher rates of youth who drank sweetened beverages (47.2% compared to 42.6%) and lower rates of consumption of fruits and vegetables in 2019.[17]

Nutrition, 2019

	Colorado	El Paso
Percentage of students who drank a can, bottle or glass of another sweetened beverage one or more times in the last week	42.6%	47.2%
Percentage of students who ate fruit one or more times per day in the past week	33.6%	26.2%
Percentage of students who ate green salad one or more times per day in the past week	12.6%	10.8%

Source: Healthy Kids Colorado Survey, 2019

Unhealthy weight

People who are obese are at a higher risk for many serious health conditions. Furthermore, those who experience childhood obesity are more likely to be obese and experience more severe risk factors into adulthood.[38] Approximately 1 in 4 high schools students in El Paso County (25.4%) are overweight or obese.[17]

Unhealthy Weight, 2019

	Colorado	El Paso
% of students who are overweight or obese	21.6%	25.4%
% of students who are overweight	11.9%	14.0%
% of students who are underweight	4.6%	5.2%

Source: Healthy Kids Colorado Survey, 2019

Oral Health

Oral health is essential to a person's overall health and well-being. However, not everyone has access to preventative care, such as visiting a dentist or dental hygienist, which can lead to greater rates of oral diseases. Individuals with lower incomes or education levels are less likely to access oral health services.[39] In El Paso County, around 2% parent-reported child's teeth condition is fair or poor.[40] In addition, the level of children aged 0 to 18 who did not visit the dentist or dental hygienist in the past year is around 20%.[41]

Oral Health, 2017-2019

	Colorado	El Paso
Percentage of parent-reported child's teeth condition is Fair or Poor[1]	6.8%	2.3%
Children age 0 to 18 who did not visit the dentist or a dental hygienist in the past year[2]	20.4%	19.5%

Source: [1]Child Health Survey, 2018-2019; [2]Colorado Health Access Survey, 2017-2019

Health Access

Statewide, the percentage of children enrolled in Medicaid was 32.0% in 2019.[3] In 2019, nearly 1 out of 3 children in Colorado and El Paso were on Medicaid (32.0% and 32.9% respectively). When looking at access to care, cost can be a contributing factor for families to not seek medical, specialty, and/or dental care.

Health Access and Affordability, 2019

	Colorado	El Paso
Access		
Uninsured children (under 19)[1]	5.5%	5.4%
% Medicaid (under 19)[1]	32.0%	32.9%
Affordability		
Did not fill a prescription for medication due to cost[2]	10.8%	9.3%
Did not get needed doctor care due to cost[2]	12.8%	9.9%
Did not get needed specialist care due to cost[2]	12.9%	9.5%
Did not get needed dental care due to cost[2]	20.6%	17.5%

Source: [1]American Community Survey 1-Year Estimate, 2019; [2] Colorado Health Access Survey, 2019

The health care workforce shortage remains a staggering issue, as there are not enough providers, especially for mental and behavioral health, compared to the population.

Health Care Workforce, 2018-2019

	Colorado	El Paso
Number of pediatric mental health providers[1]	n/a	344
Number of child psychiatrists[1]	n/a	24
Number of pediatric primary care providers[1]	n/a	340
Number of adult primary care providers[1]	n/a	303
Ratio of population to primary care physicians[2]	1,230:1	1,650:1
Ratio of population to dentists[2]	1,260:1	980:1
Ratio of population to mental health providers[2]	300:1	340:1

Source: [1]Colorado Community Health Alliance (CCHA), 2018-2019[5] ; [2] County Health Rankings & Roadmaps, 2019

[5]https://hcpf.colorado.gov/sites/hcpf/files/ACC%20RAE%207%20FY1819%20Network%20Adequacy%20Report%20Plan%202020.pdf

Health Care Utilization

When looking at our own patient volumes from El Paso County, the majority of patients across ED/UC, inpatient/observation, and outpatient settings were White, followed by Hispanic/Latinx, and either Black or African American or more than one race.

Health Care Utilization–Children's Hospital Colorado (El Paso), by Setting, by Race and Ethnicity, 2019

Clinical Setting	Race Ethnicity	Percent
ED/UC	American Indian/Alaska Native	<1.0%
	Asian	1.2%
	Black/African American	4.8%
	Hispanic/Latinx	20.2%
	More than one race	5.5%
	Native Hawaiian/Other Pacific Islander	<1.0%
	Other	2.0%
	White	62.3%
Inpatient/Observation	American Indian/Alaska Native	<1.0%
	Asian	1.3%
	Black/African American	7.4%
	Hispanic/Latinx	20.7%
	More than one race	6.9%
	Native Hawaiian/Other Pacific Islander	<1.0%
	Other	1.6%
	White	56.1%
Outpatient	American Indian/Alaska Native	<1.0%
	Asian	1.5%
	Black/African American	4.6%
	Hispanic/Latinx	20.1%
	More than one race	4.9%
	Native Hawaiian/Other Pacific Islander	<1.0%
	Other	2.4%
	White	56.0%

Source: Epic, 2019

The most common languages for Children's Hospital Colorado patients from El Paso were English, Spanish, and American Sign Language in 2019. About half of the patient population seen in 2019 used Medicaid as their primary insurance, followed by Tricare, and then private insurance.

Top Diagnoses by Clinical Setting

The top diagnoses for ED/UC encounters for patients from El Paso in 2019 included respiratory-related illnesses and viral infections. In 2020, respiratory-related illnesses remained a top diagnosis in the ED and injury was also in the top five diagnoses. Please see Appendix F for 2020 diagnoses by clinical setting.

Top 5 Diagnoses – ED/UC, 2019

Diagnosis Description	Percent
Acute upper respiratory infection, unspecified	9.1%
Acute obstructive laryngitis (croup)	3.6%
Viral infection, unspecified	2.9%
Influenza due to unidentified influenza virus with other respiratory manifestations	2.8%
Fever, unspecified	2.4%

Source: Epic, 2019

In the Inpatient or Observation settings, the top diagnoses in 2019 were similar to those of ED visits and included upper respiratory and viral infections. In 2020, additional top diagnoses included visits for bronchiolitis and Type 1 diabetes.

Top 5 Diagnoses – Inpatient/Observation, 2019

Diagnosis Description	Percent
Dehydration	2.8%
Viral pneumonia, unspecified	2.3%
Acute bronchiolitis due to other specified organisms	2.1%
Pneumonia, unspecified organism	1.9%
Acute obstructive laryngitis (croup)	1.8%

Source: Epic, 2019

In the Outpatient setting, the top diagnoses in 2019 included encounters for feeding difficulties, muscle weakness, and unspecified lack of coordination. In 2020, additional top diagnoses included visits for speech and language-related complications.

Top 5 Diagnoses – Outpatient, 2019

Diagnosis Description	Percent
Feeding difficulties	2.8%
Other symbolic dysfunctions	2.7%
Mixed receptive-expressive language disorder	2.5%
Muscle weakness (generalized)	2.4%
Unspecified lack of coordination	2.2%

Source: Epic, 2019

Emergency Department Utilization and the Child Opportunity Index

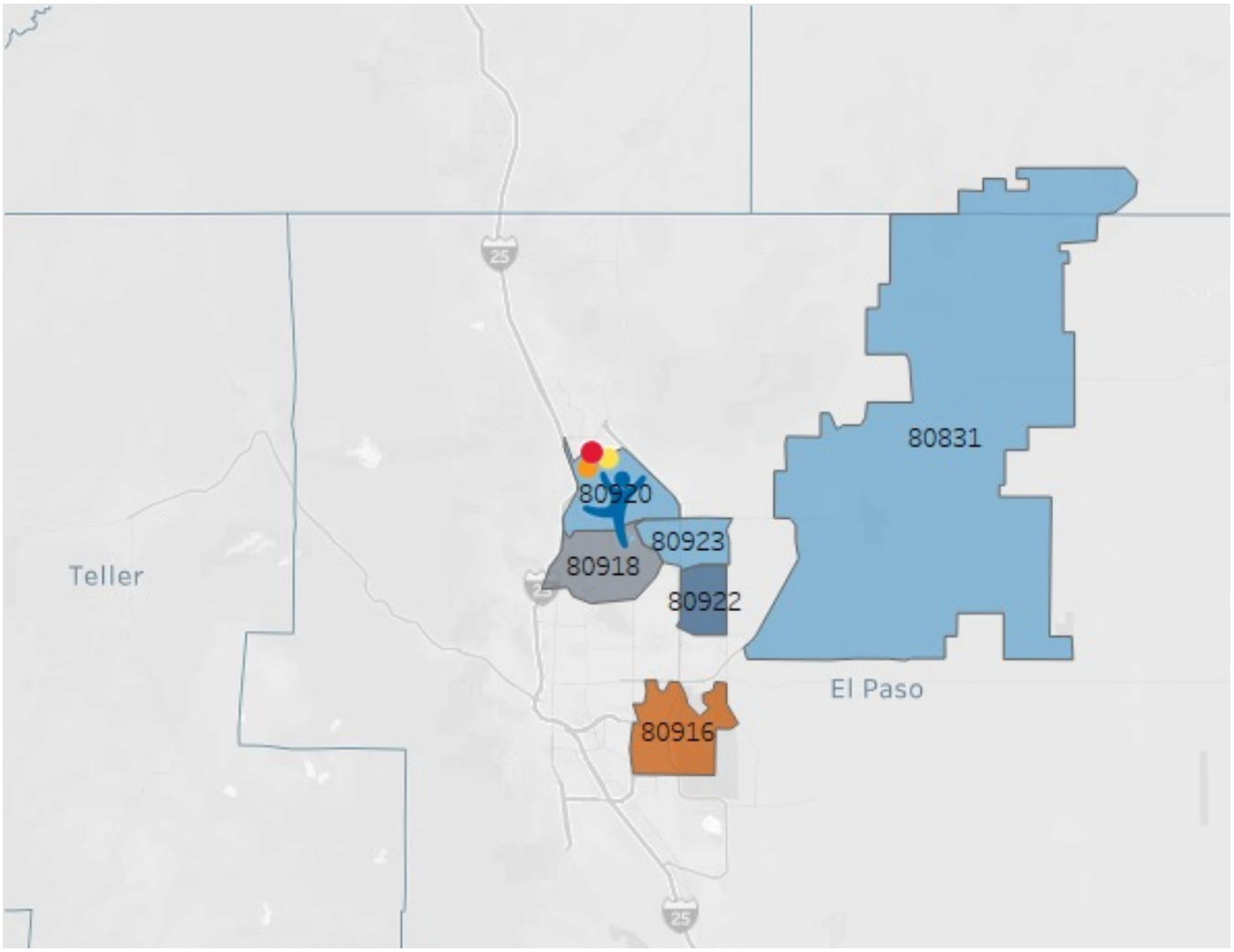
In order to gain a better understanding of where we see the highest patient volumes from our ED and the level of child opportunity in those respective zip codes, we looked at both the COI and ED utilization among our patient population.[42] When looking at the top zip codes where we see our highest patient volumes for ED/UC visits, there are areas of low opportunity in certain zip codes such as 80916.

Top Zip Codes by County – ED/UC Visits, 2019

County	ZIP	COI	% Total ED/UC Encounters
El Paso	80920	High	9.9%
	80918	Moderate	7.5%
	80923	High	6.3%
	80831	High	6.0%
	80922	Very High	5.5%
	80916	Very Low	4.9%

Source: Epic, 2019

Child Opportunity Index by Top ED/UC Zip Codes, 2019



Source: Epic 2019 and diversitydatakids.org

Community Engagement

To help prioritize our community engagement work, we identified focus areas for our primary data collection based on where there were health disparities and inequities when comparing El Paso to the state or within El Paso County populations (see Appendix A). As described in the methodology section of this report, Children's Colorado engaged in a significant community outreach process to assess the interests and concerns of caregivers in the neighborhoods and counties that the hospital serves. Through collaborations, surveys, interviews and community meetings, we were able to get the input of hundreds of people. We found both consistencies and differences in the issues that concerned those with whom we spoke.

Collaborations

Children's collaborated with several partners to inform our CHNA. Below is a brief description of the partnerships and collaboration approach.

Colorado School of Public Health (CSPH) – Children's Colorado partnered with a group of students enrolled in a Community Health Assessment course to assist with stakeholder interviews with organizations focused on food insecurity and to research existing and new, more holistic methods to screen for and measure food insecurity in a household.

Healthy Community Collaborative (HCC) – The HCC is a community stakeholder group formed in 2011 to address the health and social needs of El Paso county residents. The HCC consists of over 60 representatives from schools, hospitals and health systems, non-profit organizations, city and county government agencies, public health, medical providers, and interested citizens. We collaborated with the HCC in two ways: 1) to provide feedback on our secondary data collection process and 2) to prioritize the health needs of the children and young adults in the El Paso County community.

UCHealth – We partnered with UCHealth to prepare and collect stakeholder interviews. Our teams met weekly to strategize our stakeholder interview approach and outreach to shared stakeholders in El Paso County. We co-created data one-pagers for stakeholders to review prior to the interview.

Data Collection

Children's Colorado engaged in community outreach process to assess the interests and concerns of caregivers in the neighborhoods and counties that the hospital serves. Through our primary data collection such as surveys, interviews, and community meetings, we were able to gain the input of hundreds of people.

Survey

Of our 90 respondents, most completed the survey in English (98%), with the remaining in Spanish (2%). In addition, 10% identified as Hispanic/ Latinx, 59% as White, 3% as Black or African American, 27% as multiple races/ethnicities, and 1% as other. Furthermore, 38% families have children with complex medical needs, such as chronic physical, developmental, mental, emotional, or behavioral conditions.

In the caregiver survey, respondents ranked the following as top 5 health issues for children in their community:

Caregiver Survey- Top 5 Issues (in rank order)

1. Access to health care and mental health services
2. Mental health, including suicide
3. Child abuse and neglect
4. Access to or cost of child care
5. Affordable housing

Health care and mental health services were top concerns across all household incomes. Furthermore, mental health, including suicide, was also ranked as a concern for all household incomes.

Household Income	
$0 to $24,999	18%
$25,000 to $49,999	14%
$50,000 to $74,999	9%
$75,000 to $99,999	18%
$100,000 or more	36%
Don't know/prefer not to answer	6%

Income Distribution

	#1 Critical Need	#2 Critical Need	#3 Critical Need	#4 Critical Need	#5 Critical Need
$0 to $24,999	Access to Benefits	Access to health care and mental health services	Mental health, including suicide	Access to or cost of child care	Hunger or access to healthy food
$25,000 to $49,999	Access to health care and mental health services	Access to or cost of child care	Mental health, including suicide	Mother and infant health	Child abuse and neglect
$50,000 to $74,999	Access to health care and mental health services	Mental health, including suicide	Child abuse and neglect	Hunger or access to healthy food	Access to or cost of child care
$75,000 to $99,999	Access to health care and mental health services	Child abuse and neglect	Mental health, including suicide	Access to or cost of child care	Access to Benefits
$100,000 or more	Access to health care and mental health services	Mental health, including suicide	Child abuse and neglect	Affordable housing	Access to or cost of child care
Don't Know/ Prefer not to answer	Access to health care and mental health services	Mental health, including suicide	Child abuse and neglect	Access to Benefits	Obesity/ overweight

When asked about the impact of COVID on their children's ability to be healthy and thriving, the top three impacts including 1) feeling connected with family and friends who live outside their home, 2) changes in mood for their child(ren), and 3) accessing health care when needed.

Interviews

Stakeholders identified mental and behavioral health as the top needs for the populations they serve. This was followed by housing (lack of affordable and/or available housing) and access to care as the subsequent top needs. Food insecurity, economic issues, and access to culturally responsive and inclusive care were also identified as a top need.

Stakeholder Interviews- Top 5 Needs (in rank order)*

1. Mental and behavioral health
2. Housing
3. Access to care
4. Food insecurity
5. Economic issues

**Economic issues and access to culturally responsive and inclusive care had same number of votes*

When stakeholders were asked to identify the top barriers these populations face, transportation and lack of housing were the most frequently cited. Stakeholders mentioned that stable supportive housing that includes "wraparound" services to address individuals' medical, behavioral health, and social needs is needed for individuals with behavioral health and physical health concerns. Partners also described how there are challenges navigating the health and social system, how families often do not access services when they are eligible because they are unaware that this is a resource to them, as one partner described "knowing where to go first", and referral challenges when seeing different providers. Stigma around accessing services was also identified as a top barrier. Stakeholders described how many of the families they work with are reluctant or even ashamed to access services, especially mental and behavioral health. Language and literacy barriers have also resulted in gaps in care for families of diverse backgrounds. Partners mentioned that these families often face communication barriers and have a difficult time navigating the health system and accessing crucial resources. For example, partners noted that telehealth appointments have proven to be difficult if there is poor or lack of translation services available. Many of these barriers are connected and addressing at least one of these could impact others.

Stakeholder Interviews- Top 5 Barriers (in rank order)*

1. Transportation
2. Lack of housing
3. Need for more navigation support
4. Stigma around accessing services
5. Language barriers

**Navigation support and stigma around accessing services had the same number of votes; Language barriers and Lack of access to mental and behavioral services had same number of votes*

Community Meetings

After identifying top needs from our secondary data and primary data, we discussed the following for our community meetings:

We held one community partner meeting and to accommodate the public meeting requirement, we were invited by our partner, the El Paso County Health Department, to join monthly Healthy Community Collaborative (HCC) meetings. HCC members were presented with detailed information about data from internal and external sources as well as the results of interviews and surveys. Participants were also given an opportunity to ask questions and to advocate for issues that they found most compelling. They then were asked to vote for their top health and social issues -- the results of which would be shared with hospital leadership.

When asked what the top medical needs were, the #1 identified need was mental health. When asked what the top social needs were, the #1 identified need was access to health care and mental health services.

Medical Need

Category	Votes
Mental health	18
Child abuse and neglect	7
Nutrition	7
Unintentional injury	5
Unhealthy weight	3
Asthma and respiratory healthy	**1**

Social Need

Category	Votes
Access to health care and mental health services	19
Affordable housing	16
Not getting enough exercise	5
Not having enough food	2

This community meeting was then used to inform our final prioritization by the Population Health Committee.

Impacts of racism on health

The Centers for Disease Control and Prevention explains racism as "structures, policies, practices, and norms that assigns value and determines the opportunities based on the way people look or the color of their skin."[43] Racism is a public health issue as it negatively impacts mental and physical health and has led to health inequities. Racial and ethnic minority groups experience higher rates of illness and death from health conditions, including diabetes, obesity, hypertension, heart disease, and asthma, when compared to their White counterparts. Additionally, social determinants of health such as where one lives, learns, works, are crucial drivers of health inequities experienced by communities of color which can put these populations at greater risk for poor health outcomes.[43] This impact is critically important for us to acknowledge and understand as we work to enhance health equity in our communities.

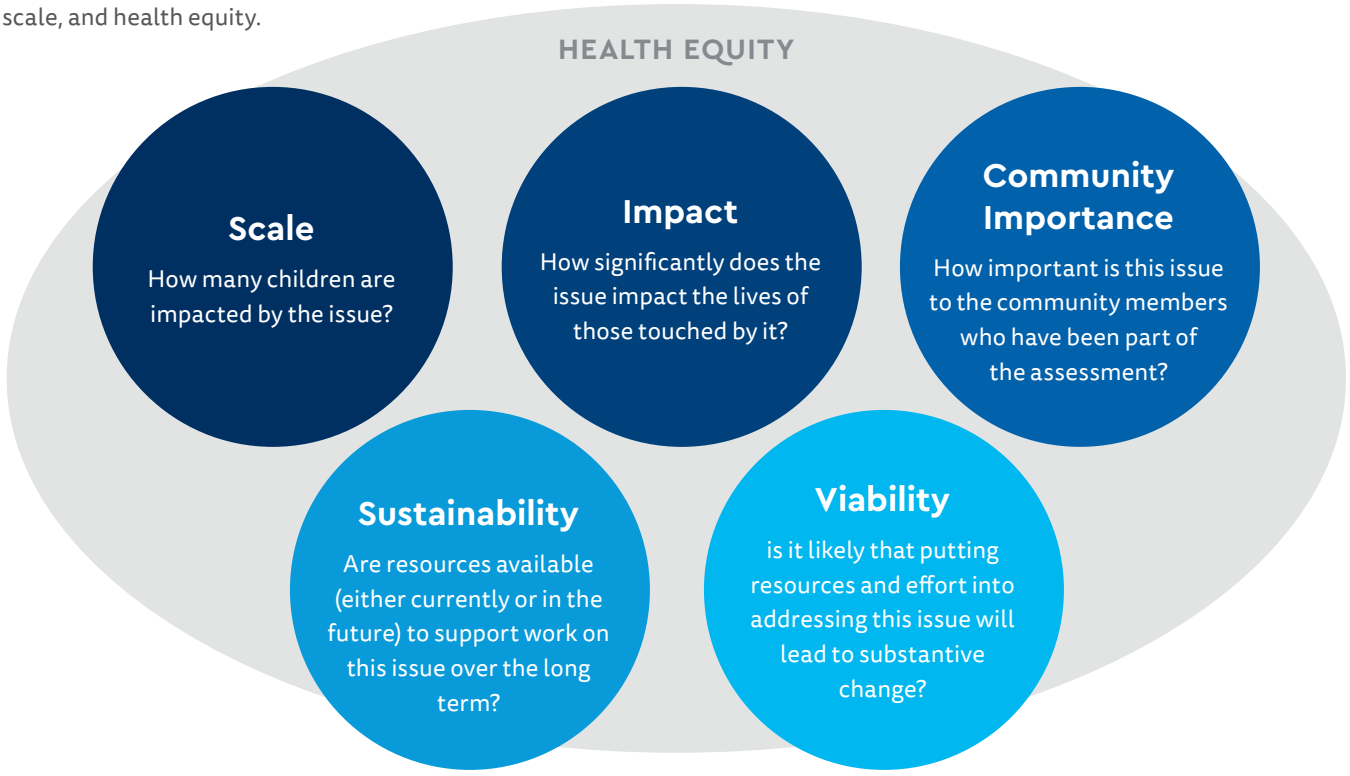
Impacts of COVID-19 Pandemic

The mitigation tactics for the COVID-19 pandemic inadvertently created inequities and implications which disproportionately affected racial and ethnic minority groups. As systems and policies were not created to be preventative for the most vulnerable populations, the Center for Disease Control (CDC) guidelines exuberated the underlying issues. The guideline to mitigate the spread had economic, social, and secondary health consequences. For instance, essential work setting increased exposure due to lack benefits such as paid sick days. Other unintended consequences may include lost wages, unemployment, increased exposure to older adults in multi-generational households, and stress and social isolation.[44]

From our interviews, when asked about COVID-19 impacts, stakeholders highlighted the following for the populations they serve: increased need for housing, increase in families experiencing homelessness, financial stressors (e.g., unemployment, loss of income, and lack of additional employment opportunities), delayed care (e.g. families were missing important appointments such as well-child check visits), and negative mental health impacts (e.g., increase in feelings of isolation, loneliness, and overall stress).

Prioritization

Once both secondary and primary data collection were completed, the final step of the assessment was to seek input on how to prioritize among the needs identified between the primary and secondary data. The Population Health committee, which is comprised of CHCO clinical and nonclinical leadership worked to select prioritization criteria and, after careful consideration, determined that the following six factors were most important: impact, community importance, viability, sustainability, scale, and health equity.



Description of Identified Priority Needs

Mental health emerged as the top community concern through every method of data collection included in this assessment. Caregivers, health care team members, and community leaders all share a belief that the mental health of children is a critical issue. Internal utilization data and public health surveillance data demonstrate a continued and increasing need for mental health and suicide prevention services for children and youth in Colorado, including services that address disparities in mental health outcomes within populations. Please see the Mental Health and Suicide Prevention section for details on the data.

Mental health has also long been identified as a health priority among our community stakeholders as persistent systemic challenges have prevented mental health parity from being achieved. As Children's Colorado joins our community partners in embracing whole child, whole health approaches to child health, we recognize the need to place a consistent intentional focus on mental health to meaningfully integrate mental health into our holistic approaches to care.

Moreover, during the COVID-19 pandemic, children's mental health needs have alarmingly intensified and further underscored the lack of mental health resources in our communities. In May 2021, Children's Colorado declared a "State of Emergency" for

youth mental health, highlighting the reality that mental health challenges facing kids have gone beyond crisis levels, and the organizations that serve kids are overwhelmed. Therefore, based on the data and feedback we heard from the community, our work toward holistic models of care, and reflecting the current crisis state of our mental health system for children and youth, mental health was selected as our primary priority.

Complementary priorities that will roll up under our primary priority, and include continuing priorities, will be determined as part of our implementation plan, which will outline the specific strategies and tactics we will employ to address mental health needs for children and youth. Further engaging our community stakeholders to identify more specific areas within the immense mental health needs in our communities will ensure the development of a meaningful implementation plan.

See Appendix G for resources available to address mental and behavioral health.

Children's Hospital Colorado knows that the needs and the concerns of the community are extensive and that our ability to address those needs is limited. While the selected priorities areas will be the focus of our community efforts for the next several years, we will also continue to listen to the community and to identify new opportunities to address public concerns. Some of the specific issues that the community raised through this process, but that were not selected as top priorities, will continue to be addressed through the work of the Division of Population Health and Advocacy.

Conclusion

This report is the culmination of an inclusive and far-reaching effort to gather input from a wide range of stakeholders. Children's Hospital Colorado is proud of our work with the community and the leadership role it plays in supporting the mental, emotional and physical health of every child in our great state. We wish to thank the hundreds of parents and community members who lent their voices to this assessment. Through surveys, community meetings and one-on-one conversations, we gathered important insights into the issues about which families are most concerned. Our promise is that we will act on what we learned by continuing to partner with the communities with which we serve and work collaboratively to improve the health and wellbeing of all children in Colorado.

As a first step, we will incorporate the findings of this assessment into an implementation plan that will guide our community-based efforts for the next three years. We will consult with our many partners in the development of that plan. We look forward to documenting ways that we can continue the successful programs we have already established as well as exploring new ways to effectively address the priority issues.

We also welcome continued feedback both on the content of this report and our strategies for addressing community health needs. Comments, questions, and suggestions can be sent to **communitybenefit@childrenscolorado.org**.

Appendix A: Data Collection Instruments

Caregiver Survey

Children's Hospital Colorado 2021 Caregiver Survey

Thank you for participating in the Children's Hospital Colorado Caregiver Survey. The goal of this survey is to hear from parents and caregivers of children about the most important community health needs for families in our surrounding community. This survey should take about 10 minutes. The results of the survey will be summarized into a report, called a Community Health Needs Assessment, and available on our website (www.childrenscolorado.org) by the end of December 2021. Your responses will remain confidential with others in the overall report.

1. In what language would you prefer to take this this survey?

□ Amharic	□ Burmese	□ French	□ Somali
□ Arabic	□ English	□ Karen	□ Spanish

Tell Us About Your Community

Please answer the following question about children in your community.

2. Thinking about what children in your community need to be healthy and thrive, please share how **important** you think it is to address the following needs for **children in your community:**

	Not important	A little important	Important	Very important
Access to benefits (e.g., Medicaid, WIC, food stamps, TANF)				
Access to health care and mental health services				
Access to or cost of child care				
Affordable housing				
Child abuse and neglect				
Dental care				
Hunger or access to healthy food				
Injury				
Mental health, including suicide				
Mother and infant health				
Obesity / overweight				
Respiratory health, including asthma				

Other (please specify): _____

Covid Impact

Please answer the following question about how much the Covid pandemic has impacted your family.

3. Please share how much you think the Covid pandemic has impacted the following areas for your **FAMILY**:

	Not impacted	A little impacted	Impacted	Very impacted
Accessing health care when needed (medical, dental, or mental health)				
Accessing stable child care				
Changes in mood for my child/children (sadness, fatigue, irritability, loneliness)				
Family member (including child) diag-nosed with Covid				
Internet access and technology				
Keeping health insurance for my child/children				
Being able to pay rent or mortgage				
Paying for basic needs, such as food or utilities				
Feeling connected with family and friends who live outside our home				

Other (please specify): _____

Tell Us About Yourself

Please answer the next set of questions about yourself and the children living in your home.

4. What county do you live in?
   - □ Adams
   - □ Arapahoe
   - □ Denver
   - □ Douglas
   - □ El Paso
   - □ Other – please specify
5. What ZIP code do you live in? (free text)
6. What language do you primarily use in your home?
   - American sign language
   - Amharic
   - Arabic
   - Burmese
   - English
   - French
   - German
   - Karen
   - Nepali
   - Russian
   - Spanish
   - Somali
   - Other – please specify
7. What age are the children living in your household? (Check all that apply)
   - □ Infant to 2 years
   - □ 3 to 5 years
   - □ 6 to 11 years
   - □ 12 to 14 years
   - □ 15 to 17 years
   - □ 18 to 24 years
8. Which racial and ethnic groups are the children in your home?
   - □ Asian
   - □ South Asian
   - □ East Asian
   - □ Pacific Islander
   - □ Black or African American
   - □ Hispanic/Latinx
   - □ Middle Eastern/Arab American
   - □ American Indian or Alaska Native
   - □ White
   - □ Other – please specify
9. Do any of your children have complex medical needs (chronic physical, developmental, mental, emotional, or behavioral conditions)?
   - □ Yes
   - □ No
10. What is your household income? Mark one response.
    - □ $0 to $24,999
    - □ $25,000 to $49,999
    - □ $50,000 to $74,999
    - □ $75,000 to $99,999
    - □ $100,000 or more
    - □ Don't know / Prefer not to answer

Stakeholder Interview Guide

Stakeholder Interview Introduction

Thank you for taking the time to speak with me today. As shared in the outreach email to you, the purpose of this interview is to inform Children's Colorado and UCHealth's Community Health Needs Assessments (or CHNAs for short).

Do you have any questions about the information provided in the consent form?

[Overview and purpose] As a reminder, CHNAs are conducted by non-profit hospitals once every three years in collaboration with other health care providers, public health departments and community organizations. Your input is an essential component to this process.

[About the interview and how information will be used] The interview will take up to 60 minutes and your participation is completely voluntary. We will keep your individual responses confidential. We will be aggregating the findings to report in our CHNAs. **As part of the CHNA process, we are required to include a list of all interviewees, including their name, role, and organization in the report. None of your individual responses will be attributed to you in the published report.** The results of the interview will be summarized into a report, and available on our website (**www.childrenscolorado.org**) by the end of December 2021.

UCHealth's report would be on our website (www.uchealth.org) in July 2021 and Children's Hospital's report would be available on our website (www.childrenscolorado.org) in December 2021.

Any questions before we get started?

Questions

*[Prior to starting the interview, review the stakeholder's pre-survey results. If they did not complete the survey, use the first part of the interview to complete **the survey**.]*

1. In our pre-interview survey, you indicated that your organization is most familiar with or primarily serves/outreaches to the following populations:
   - Population 1 _____
   - Population 2 _____
   - Population 3 _____

For most of today's discussion, we will focus on those populations. You may answer these questions for all the populations you included in your survey, or we can return to these questions if you feel your responses would differ by population.

Community Needs

2. What would you say are the top 2 or 3 health or social needs overall for **[name the Populations 1-3]**?

3. What are some of the barriers that this/these population(s) faces to address the needs you identified?

4. Covid has impacted different populations in different ways. How would you say Covid has impacted **[name the Populations 1-3]** in particular?

5. The next question focuses on the data one-pagers that were sent to you ahead of this interview. Among the adult and pediatric measures that were listed, are there any that stand out as impacting [name the Populations 1-3], that we haven't already discussed? If so, how?

6. Is there anything else that would help **[name the Populations 1-3]** achieve better health?

7. **[If interviewee listed more than one population, but in the interview only focuses on one population, proceed with this question]** Would you respond differently to any of these questions for the other populations you identified? [If yes, repeat questions 2-6 for populations 2 and 3.]

Existing work and collaboration opportunities

8. What is your organization already doing to address the top needs for these populations?

9. What are other organizations doing, that you're aware of?

10. What role do you see Children's playing, if any, to help address these top needs?

11. What role do you see UCHealth playing, if any, to help address these top needs?

12. **[Optional, if time]**: Do you have any other feedback or ideas about how to address these health and social needs?

Appendix B: Data Sources

American Community Survey, 1-Year Estimate, 5-Year Estimate, 2019

Centers for Disease Control and Prevention, 2020

Feeding America, 2019

Healthy Kids Colorado Survey, 2019

Hunger Free Colorado Survey, 2021

Division of Child Welfare Services, Colorado Department of Human Services, 2018

Colorado Department of Public Health and Environments (CDPHE), 2016-2019

Child Health Survey, 2018-2019

Colorado Health Access Survey, 2017-2019

Colorado Department of Education, 2018-2019

Vital Statistics, 2016-2019

Pregnancy Risk Assessment Monitoring System, 2019

Colorado Environment Public Health Tracking, 2018

Colorado Health Information Dataset, 2019

Colorado Health Observational Regional Service, 2019

KidsCount, 2019

County Health Rankings, 2018-2020

Colorado Body Mass Index Monitoring System, Children and Youth 2-17 years, 2014-2016

Colorado Health Institute, American Community Survey Estimates, 2018

Governor's Office of Information Technology, 2019

U.S. Census Bureau Household Pulse Survey, 2020

Children's Colorado Epic, 2020

Child Fatality Prevention System

Colorado Department of Local Affairs, 2019

Department of Health Care Policy and Financing, 2018

Connect for Health Colorado, 2018

Medical Expenditure Panel Survey, 2015

Child Opportunity Index

Colorado Environmental Public Health Tracking, 2018

Colorado Health Institute (CHI) Access to Care Index, 2018

Injuries Dashboard, CDPHE, 2016-2019

Colorado Hospital Association, 2019

Appendix C: Stakeholder List

Name	Role	Organization
Andy Barton	President & Chief Executive Officer	Catholic Charities
Lena Heilmann	Office of Suicide Prevention Strategies Manager	Colorado Department of Public Health & Environment (CDPHE), Colorado Office of Suicide Prevention
Danielle Summerville	Diversity and Community Outreach Programs Manager	City of Colorado Springs, Diversity and Community Outreach
Yemi Mobolade	Small Business Development Administrator	City of Colorado Springs, Office of Economic Development
Samantha Richardson; Jessica Zaiger; Megan Billesbach; Terri Ridgway	Supervisor, Pediatric Care Coordination, Region 7; Care Coordination Manager; Community Liaison; Supervisor, Care Coordination	Colorado Community Health Alliance (CCHA)
Christy Haas-Howard	Asthma Nurse Specialist	Colorado Department of Education
Zac Schaffner	Supportive Housing Services Manager	Colorado Department of Local Affairs, Division of Housing
Cari Davis	Executive Director	Colorado Springs Health Foundation
Cory Notestine	Executive Director of Student Success and Wellness	Colorado Springs School District 11
Mia Ramirez	Community Partner (Regional Manager)	Colorado Trust
Amber Ptak	CEO	Community Health Partnership
Steven Johnson	Community and Public Health Administrator	Colorado Springs Fire Department Community and Public Health
Erik Wallace	Associate Dean for Colorado Springs Branch	University of Colorado, School of Medicine
Deanna LaFlamme	Program Director	Culture of Wellness, Colorado School of Public Health
Maegan Lokteff	Executive Director	Early Childhood Council Leadership Alliance
Jamie Pfahl	Public Health Planner	El Paso County Public Health
Teresa Bassma	Youth Substance Use Prevention Planner	El Paso County Public Health, Fountain Valley Communities That Care
Mayra Apresa; Maria Garcia; Silvia Lara; Mikayla Fueshko	Ambulatory Care and Special Operations Manager; Family Support Care Manager; Family Case Manager	First Visitor Program of Peak Vista Community Health Centers
Beth Hall-Roalsted	Executive Director	Homeward Pikes Peak
Jessie Pocock	Executive Director	Inside Out Youth Services
Bob McLoughlin; Katie Travis	CEO; Director of Family Services	Mt Carmel Veterans Center

Marvyn Allen; Alexander Wamboldt	Health Equity and Training Director; Youth & Schools Program Manager	One Colorado
Cindy Wells	Child Enrichment Center and Program Support Specialist	Partners in Housing
Autumn Orser	VP of Medical Services	Peak Vista Community Health
Bill Lyons	Senior Vice President - Grants and HRSA Projects	Peak Vista Community Health
Cassandra Walton	Executive Director	Pikes Peak Suicide Prevention
Gloria Winters	Chief Medical Officer	Pikes Peak YMCA
Becky Huyge	Site Supervisor	SafeCare CO by Lutheran Family Services
Joel Sibersma	Senior Director of Health	Springs Rescue Mission
Chris Bui	Senior Program Officer	The Colorado Health Foundation
Amanda Reed; Lori Ganz	Early Intervention Manager; Director of Clinical Services	The Resource Exchange
Kippi Clausen	Project Director	Youth Move Colorado

Appendix D: Colorado Department of Education

		Colorado	El Paso
% Immigrants	**American Indian or Alaskan**	*	*
	Asian	*	10%
	Black	*	1%
	Native Hawaiian	*	*
	Latino	*	2%
	Multiple Races	*	1%
	White	*	0%
	All races	1%	*
% English Language Learners	**American Indian or Alaskan**	*	2%
	Asian	*	23%
	Black	*	2%
	Native Hawaiian	*	6%
	Latino	*	18%
	Multiple Races	*	1%
	White	*	1%
	All Coloradan Students	14%	*

*Source: Colorado Department of Education, 2019; * indicates suppressed or unavailable data*

Appendix E: Percentage of Students Hungry in the last 30 days, 2019

% of students who went hungry in the past 30 days sometimes, most of the time, or always because of a lack of food at home	State	El Paso
American Indian or Alaska Native, non-Hispanic	27.4	*
Asian, non-Hispanic	14.9	17.5
Black or African American, non-Hispanic	23.4	23.5
Hispanic Only or Hispanic White	17.8	21.5
Multiple Race or Hispanic Other Race	20.5	25.4
Native Hawaiian or Other Pacific Islander, non-Hispanic	22.7	*
White, non-Hispanic	11.7	14.9

*Source: Healthy Kids Colorado Survey, 2019; * indicates suppressed or unavailable data*

Appendix F: Top 5 Diagnoses by Patient Class, 2020

ED/UC, 2020

Diagnosis Description	Percent
Acute upper respiratory infection, unspecified	7.9%
Viral infection, unspecified	3.4%
Fever, unspecified	3.4%
Constipation, unspecified	2.6%
Unspecified injury of head, initial encounter	2.5%

Source: Epic, 2020

Inpatient/Observation, 2020

Diagnosis Description	Percent
Acute bronchiolitis due to respiratory syncytial virus	3.2%
Acute bronchiolitis, unspecified	2.9%
Type 1 diabetes mellitus with ketoacidosis without coma	2.1%
Respiratory distress syndrome of newborn	2.0%
Acute bronchiolitis due to other specified organisms	2.0%

Source: Epic, 2020

Outpatient, 2020

Diagnosis Description	Percent
Unspecified lack of coordination	2.7%
Feeding difficulties	2.7%
Mixed receptive-expressive language disorder	2.1%
Phonological disorder	2.0%
Other symbolic dysfunctions	1.9%

Source: Epic, 2020

Appendix G: Resources to Address Mental and Behavioral Health

Community stakeholders identified resources potentially available to address the identified community needs. This is not a comprehensive list of all available resources. For additional resources refer to Colorado 2-1-1 at **211colorado.org.**

Health Need	Resource
Behavioral Health	Aspen Point Mental Health Child Community Services Colorado Association for Infant Mental Health Colorado Community Health Alliance Colorado Crisis Line Colorado Department of Human Services, Office of Behavioral Health Colorado Department of Public Health and Environment, Office of Suicide Prevention Diversus Health El Paso County Public Health Family Care Center Peak Vista Community Health Centers Pikes Peak Mental Health Center The Follow-up Project The Suicide Prevention Coalition of Colorado Zero Suicide Colorado

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Children's Hospital Colorado

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