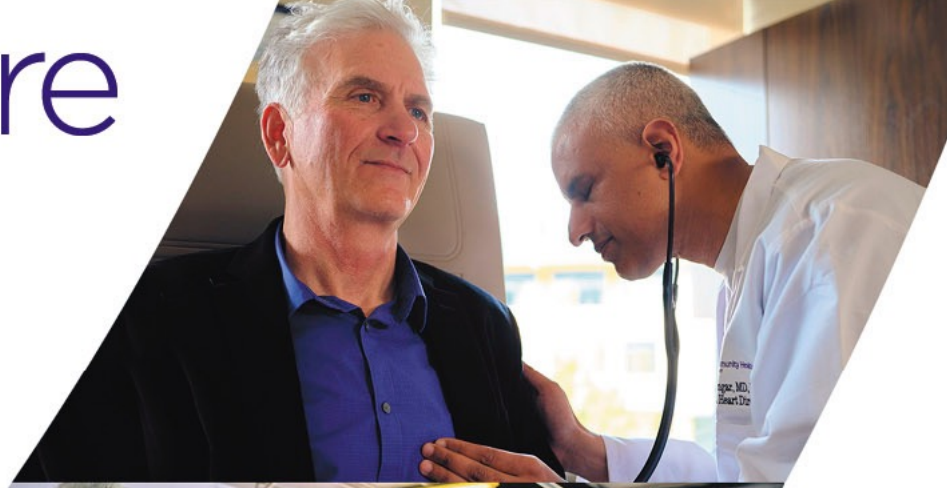


ONLINE PUBLIC MEETING

Your health, our future

**BCH's Community Health
Needs Assessment**



Welcome!



Grant Besser

Vice President of Public Affairs and
President of BCH Foundation

Boulder Community Health

Partnering to create and care for the healthiest community in the nation



Services at Foothills Hospital, Erie Medical Center and Community Medical Center, including:

181
Inpatient beds

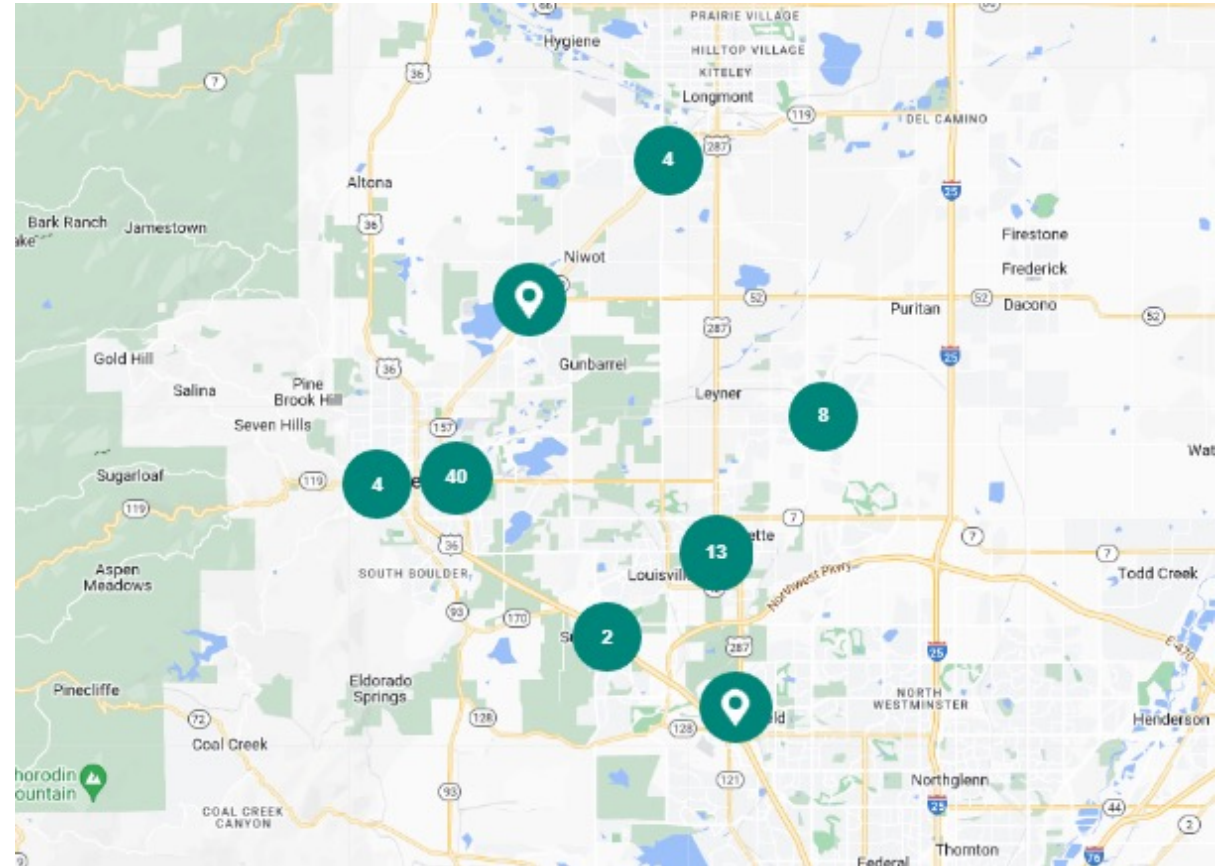
25
Emergency dept. &
level II Trauma beds

2
Emergency dept.

1
Urgent care clinic

9
Primary care
clinics

31
Specialty care
clinics



Helping patients who are unable to afford their care:

- \$3,667,413 - Charitable care
- \$96,092 – Infectious disease unreimbursed care
- \$21,331,059 - Medicaid unreimbursed costs

What we'll cover this evening

1

Overview of progress BCH is making on its 2023-2025 **Community Health Needs Assessment and Implementation Plan**

2

Updates on **the Hospital Transformation Project**

3

Questions and Feedback

Ben Keidan, MD

Vice President and
Chief Medical Officer of Boulder Community Health

2023-2025 CHNA process



Identify our community's needs through data analysis



Solicit community feedback



Develop and Document implementation plan



Implement plans to improve the health of the community

4 Priorities for 2023-2025

1

Mental (behavioral) health, chronic pain management and substance abuse

2

Wellness, preventative health and access to care
(Focus on health equity and women's health)

3

Chronic disease management
(Focus on aging)

4

BCH and provider workforce

Priority #1: Mental (behavioral) health, chronic pain and substance abuse



Service line transformation



Treatment resistant mood disorders



Medically monitored withdrawal management



Behavioral Health Navigator



Integrated Behavioral Health in Primary Care Clinics



Community Support Through BCH Foundation



Partial Hospitalization and Intensive Outpatient Programs

BCH's financial commitment to this priority

- **\$236,515** - Support groups and specialized educational programs provide access to information for addressing health behaviors and risks (including Social Determinants of Health)
 - \$177,386 - health behaviors or risk
 - \$59,129 - Social Determinants of Health
- **\$29,348** - Behavioral Health Navigator
- **\$103,639** - Sexual Assault Nurse Examiners unreimbursed costs
- **\$190,000** - Trans Cranial Magnetic Stimulation
- Community support through BCH Foundation
 - \$50,000 - Anchor Point Mental Health Endowment
- **\$65,000** – Capital investment to provide medical withdrawal management unit



ANCHOR POINT
MENTAL HEALTH ENDOWMENT

Mental (behavioral) health, chronic pain and substance abuse



- PILLAR (Prevention & Intervention for Life-Long Alternatives and Recovery) program
- Medication-Assisted Treatment (MAT): The PILLAR Program also serves as a referral networking system and has partnered with both BCH and neighboring MAT programs to enhance access to addiction treatment.
 - MAT programs offer Buprenorphine, Methadone, or Vivitrol to treat opioid use disorder across the continuum (ED/inpatient, outpatient)
- We are seeking approval from the State for an inpatient Substance Use Disorder (SUD) unit.

Amanda Wroblewski, LCSW

PILLAR PROGRAM COORDINATOR

- The Need
- How PILLAR Addresses the Gaps
- Participant Testimonials

The Need



What we are seeing

- Lack of access
 - Cost
 - Geographic location/lack of transportation
 - Limit of options
- Stigma
 - Patients that are seen for use-disorder-related diagnoses are treated poorly by medical staff
 - Use disorders may go unnoticed or ignored if not primary presenting issue
 - People are unfairly judged if there is a history of a use disorder in the medical chart
- Underlying mental health conditions
 - More clinicians needed in the field (not enough individual therapists)
 - Lack of mental health safety net
- Lack of support and infrastructure for peers

How PILLAR addresses the gaps

A BCH –Specific Program



Prevention & Intervention for Life-Long Alternatives and Recovery



- Resource navigation for the entire continuum of care for the treatment of substance use disorders.
- Short-term case management.
- Limited scholarship dollars to cover treatment related costs.
- Education for patients/participants, staff, and the community.
- Uber Health partnership with Denver Recovery Group.
- Collaboration with CoB Open Space & Mountain Parks to provide free, peer-lead, nature-based, sober programming throughout the year.

Accounts from those that have worked directly with
the PILLAR Program

Creating safe spaces to talk about use and accessing help



“Hello y’all,

I just got off the phone with a patient given the information about the DBT IOP by Taylor and wow I just wanted to share how highly she speaks of PILLAR and specifically of you Taylor. She was so grateful for the support, time, and resources you provided and kept repeating how grateful she was that PILLAR exists and that Taylor was so on top of things and so supportive.”

~Brandon Powell, Licensed Therapist and Care Coordinator, BCH Counseling Center

PILLAR Social Worker met with patient admitted to Foothills Hospital to discuss alcohol resources. Pt was not ready to quit completely but was open to learning about resources. Patient was very thankful for nonjudgmental approach and for the resources: “thank you for not judging me today”

~Patient interaction, October 2023

Reflection from Recovery & Wellness Series



“I just wanted to say thank you for such a great outing on Saturday - the feedback has been so positive. One of the Flatirons participants said Saturday's (Wellness & Recovery Series, 7/9/22) event was the best thing he's experienced since he came to treatment in Colorado. That's something for us all to celebrate!

Thanks so much for all you do!”

~Brian, Peer Facilitator of Recovery & Wellness Series

Transportation dollars creating access to care



“Hi Amanda and Taylor - just wanted to share some positive news since we forget to take in those moments sometimes in this craziness we live in. Thanks to the grant funding and support of your program, two Boulder patients were able to get an Uber to Colfax to see the provider today and get started in treatment! Another win, wohoo!”

~Jessica Zehm, Manager of Administrative Operations & Coordinator of Program Services, Denver Recovery Group

Live in chat:

Will be answered at the end of the presentation

Submit online:

bch.org/chna

Email for post-event questions:

chna@bch.org

Larry Novissimo

Vice President of Ambulatory Services

Priority #2: Wellness, preventative health, and access to care



BCH's financial commitment to this priority



- \$24,591 - Cardiovascular Community Outreach Coordinator
- Community Support through the BCH Foundation:
 - Cardiology
 - \$50,000 - Heart to Heart Fund
 - \$24,000 - Heart Scan Promotion
 - Case Management
 - \$12,500 - Elaine Myers Fund for Neurological Injury
 - \$155,135 - Project HEALS for Complex Patients
- Oncology access-to-care funds
 - \$160,000 - Center for Integrative Care supported by the Complimentary Alternative Medicine Fund
 - \$125,000 - Breast Cancer Treatment Fund
 - \$100,000 - Red Lipstick Fund
 - \$61,334 - Oncology Support Grants
 - \$30,000 - Bonnie Tebo Chemotherapy Fund

Priority 2: Wellness, preventative health, and access to care

- Identified priorities in current CHNA:
 - Health Equity
 - Social Determinants of Health
 - Population outreach for preventative care services
 - Women's health

- During last year's CHNA process, BCH heard from participants that Women's Health Services needs better attention. As a result, BCH added Women's Health Services as a health need.
 - Enhanced focus on caring for women throughout all phases of life



- **Gap Analysis** - Complete gap analysis of BCH Women's Health Services
 - Assess missing medical services
 - Assess access, care coordination, and care continuity
- **Education** - Establish cost effective and efficient ways to educate our community about our services and how to access them
 - Community lectures for the public
 - Provider lectures and CME
- **Care coordination** - Determine what additional resources may be needed to ensure the Community can have an efficient and patient centered experience at BCH
- **Navigation**
 - Care Coordination
 - Care Management
- **Best practices**
 - Who are the model health systems

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Priority #3: Chronic disease management (focus on aging)



Priority #3: Chronic disease
management (focus on aging)



Elizabeth Lycett, MD

BOARD-CERTIFIED GERIATRICIAN AND INTERNIST

Focus on aging population

- Geriatric clinic expansion
- Palliative care program development (with hiring of double boarded palliative care and trauma surgery)
- Enterprise-wide focus on Advanced Care Planning and understanding our patients' goals of care

Dr. Lycett's slides

Madelyn Hunt

MANAGER, CASE MANAGEMENT

Health Equity in Achieving Long-Term Solutions



Hospital Led-initiative supported by BCH Foundation

Strategy for complex population health management;
Aimed to reduce health inequities by increasing access to
continuity of care services



Strong Transitions of Care

Ensuring individuals have the ability to reach their
highest potential for health



Gap Bridging

Establish programs & partnerships to seamlessly connect
BCH patients to necessary care

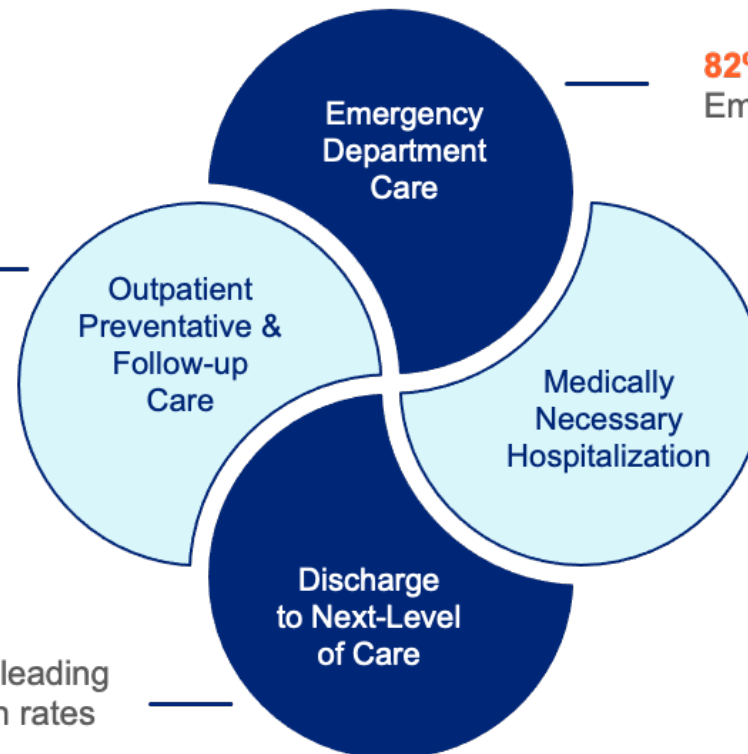


Hospital and housing collaboration



- Partnership with the Boulder Shelter for the Homeless to address complex social issues
- Focus on stable housing solutions for vulnerable patient populations with highest risk for adverse health outcomes

- **With housing secured**, the prioritization of health shifts, as basic survival is no longer a primary concern
- One's ability to adhere to medication and treatment regimens increases



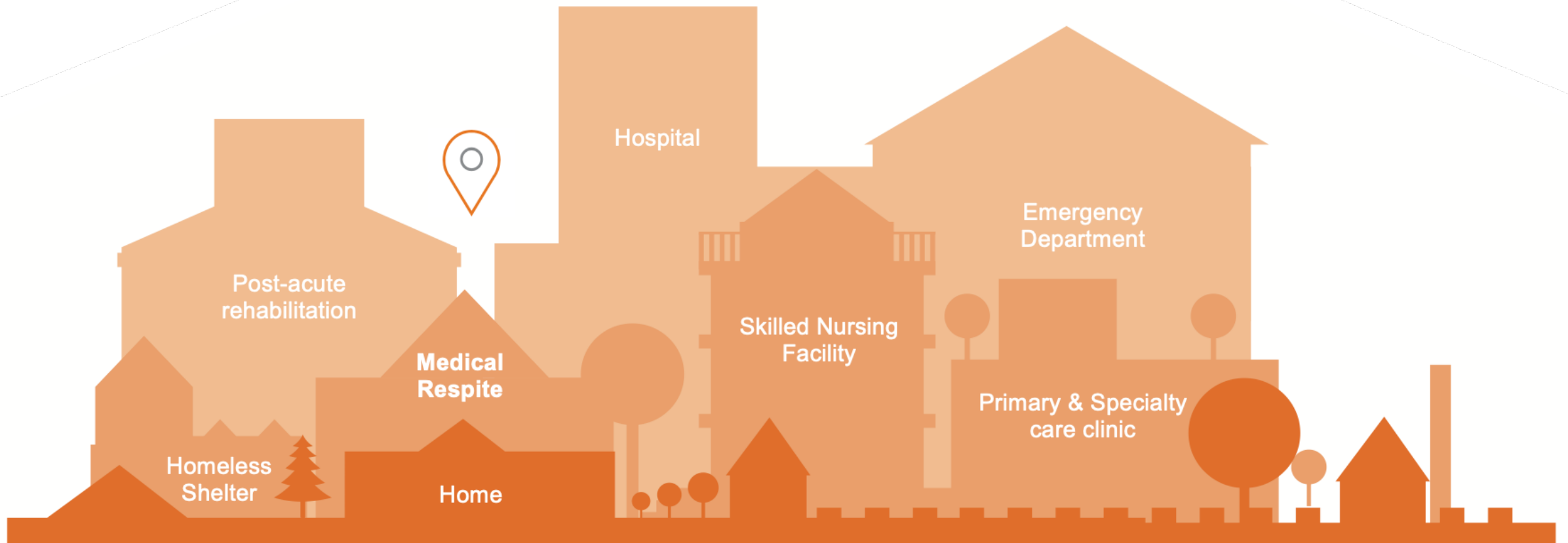
82% reduction to medically unnecessary Emergency Department visits

63% decrease to all-cause hospitalization, including chronic illness, substance use disorders, mental health crisis, and injuries associated with homelessness

Access to care recommendations increased, leading to a significant reduction in Medicaid readmission rates from **18% in Q1 2022** to **4% in Q4 2023**

Medical respite partnership

- Project HEALS partners with Colorado Coalition for the Homeless for medical respite services
- Allows for increased access to post-acute care services along with intensive case management
- Resulted in a 46% reduction in excess hospital stays for unhoused individuals from 2022 to 2023



- Bridges underinsured patients to post-acute services, ensuring safe transitions of care and filling critical coverage gaps



63-year-old with cerebral palsy

Home Caregiver Partnership

- Tailored for those living marginally in the community
- Services ensure consistent caregiver support, essential for safety and daily life activities



42-year-old with history of stroke

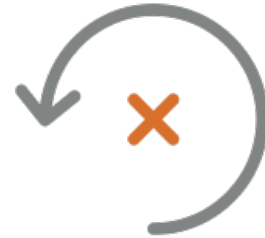
Facility Care Partnership

- Assists patients who cannot return to their former living arrangements
- Bridges patients to essential post-acute services, filling gaps left based on underinsured coverage



Increase

adherence with discharge recommendations and outpatient follow-up care



Decrease

medically unnecessary utilization of Hospital services



Improve

population health and long-term health outcomes for vulnerable adults

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chna@bch.org

Ben Keidan, MD

Vice President and
Chief Medical Officer of Boulder Community Health

Priority #4: BCH and provider workforce



Multi-year collaborative effort focused on **improving and streamlining workflows and developing high functioning teams** as we continue to address increased labor shortages.

Financial Commitment to workforce programs:

- \$934,998 in 2023
- \$66,265 for 2024

 Optum Boulder
Community
Health

- Hoover Family Center for Education Excellence: Expanded education assistance
- BCH Ambassador Scholarships
- BCH Staff and Physician DEI (Diversity, Equity and Inclusive) Training

Creating a culture of belonging at BCH with all staff training on courses including:

- Social Identity, Power and Privilege
- Racism and the 4 I's of Oppression
- Sex, Gender, Gender Expression, and Sexual Orientation
- Allyship, Cultural Humility/ Responsiveness, and Belonging
- Sustaining DEI Practices in Organizations

Employee wellness & support

- Employee and provider health and wellness team
- Wellness director and programming
- BetterUp 1:1 coaching for providers and staff
- Career growth through tuition reimbursement



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Hospital Transformation Program

Improving the quality of care to Medicaid patients from the hospital to the community



The Hospital Transformation Program (HTP) aims to improve the quality of hospital care for individuals enrolled in Health First Colorado (Colorado's Medicaid Program).

HTP asks hospitals to...

- Improve patient outcomes and experiences through enhanced care coordination
- Identify vulnerable patient populations, and implement initiatives to improve the health of those patients
- Engage with community organizations to address the unique health needs of their core patient populations
- Lower Medicaid costs by reducing avoidable hospital care

Focus areas

Reducing
Hospital
Readmission

Addressing
Social Needs

Behavioral
Health

Operational
Inefficiencies

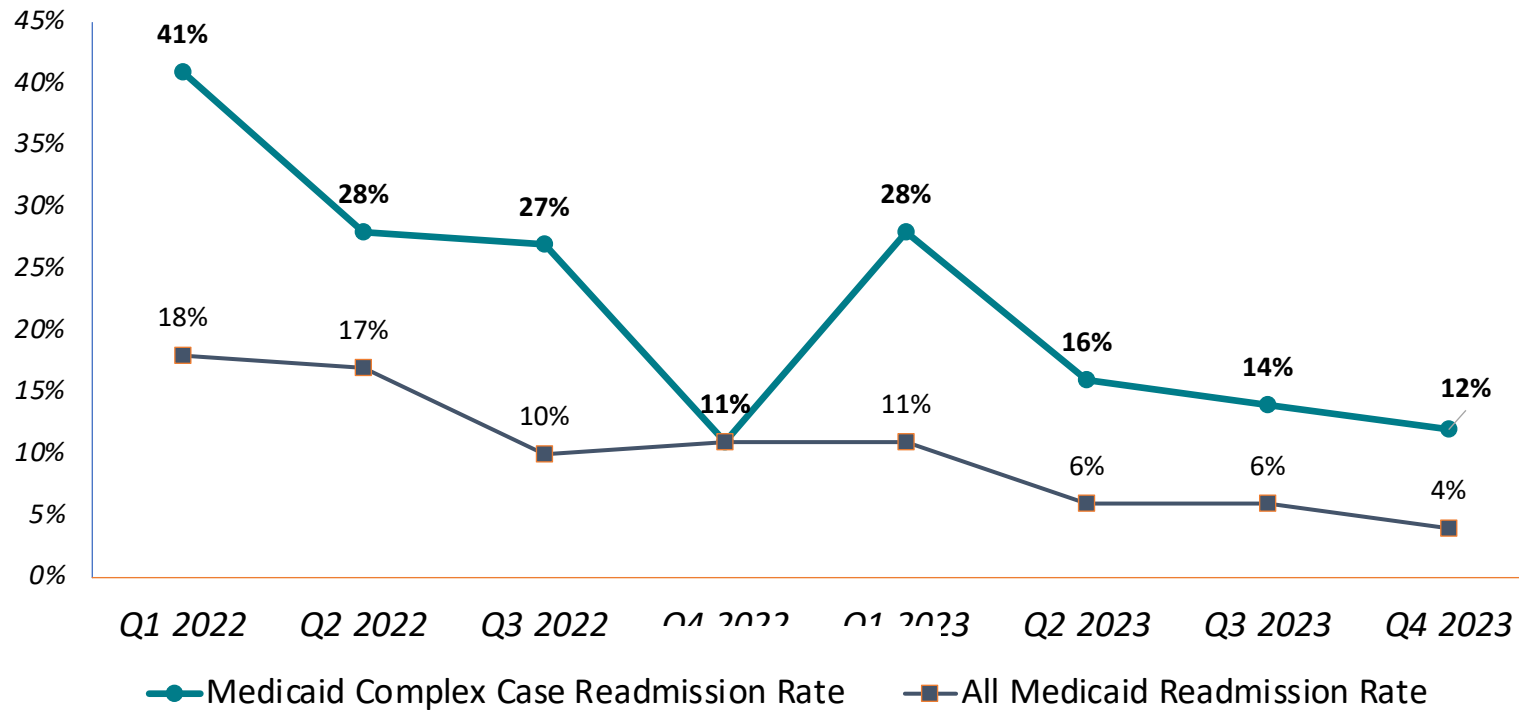
Promote Opioid
Reduction



HEALTH EQUITY

Reducing hospital readmissions

Enhanced access to post-acute care services is pivotal to the marked improvement in quality outcomes for BCH patients, as demonstrated by the downward trend in the readmission rates.



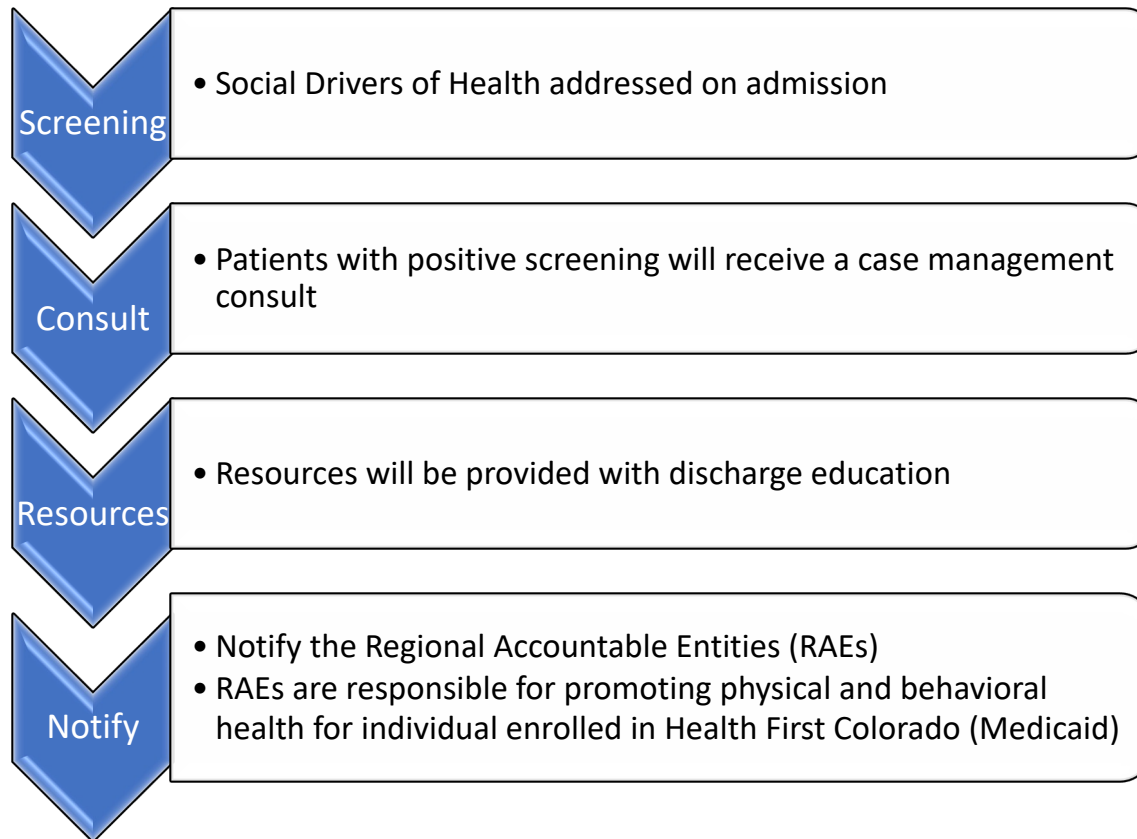
Readmission Cost Savings

| Year | Readmits | Discharges | Total LOS (Days) | Total Charges | Cost of Charges (10%) | Total Actual Reimbursement | Contribution to Margin-Actual |
|------|----------|------------|------------------|----------------|-----------------------|----------------------------|-------------------------------|
| 2022 | 181 | 1172 (15%) | 1403 | \$23.6 Million | \$2.3 Million | \$1.6 Million | (\$691,069) |
| 2023 | 71 | 939 (7.5%) | 784 | \$15.1 Million | \$1.5 Million | \$1.2 Million | (\$282,723) |

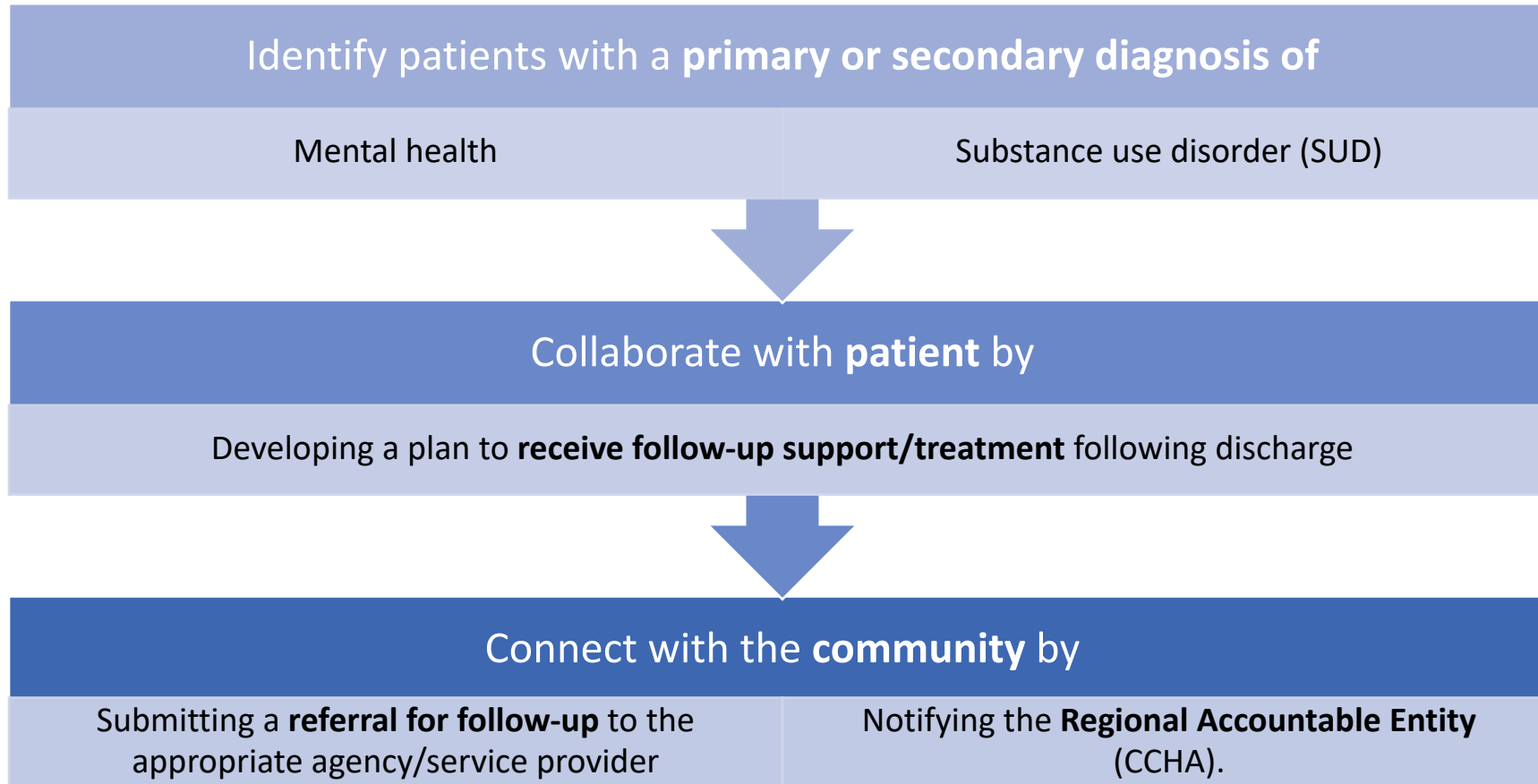
- Medical Respite: Contract for 1 bed beginning mid-May; In Aug 2023 increased to 2 beds; Total cost for medical respite in 2023 = \$37,719 (\$99/day for 381 bed days)
- 56% annual reduction to Excess Days at an estimated cost-savings of \$550 per bed day = \$444,950

Social needs screening and notification

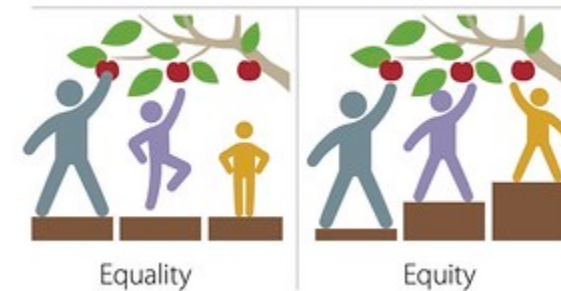
Implemented a social determinants (or drivers) of health (SDOH) screening tool to identify social needs that may negatively affect health outcomes.



Behavioral health discharge plans



- Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health (CDC)
- HTP promotes hospitals to identify vulnerable patient populations, and implement initiatives to improve the health of those patients



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BCH values community input

Questions:

- How can BCH promote Health Equity?
- How can BCH best serve behavioral health needs of our patients?

Questions about HTP

Live in chat:

Will be answered at the end of the presentation

Submit online:

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