Denver Regional Accountable Health Community Gap Analysis

Gap Analysis – Year 3
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Executive Summary

The Denver Regional Accountable Health Community joins clinical and community-based partners to identify and address unmet health-related social needs and enhance overall health and well-being of residents across the Denver metro area. Demographic and socioeconomic analysis of neighborhoods served by the Denver Regional AHC suggests that the AHC is well-positioned to reach households that may benefit most from community-based services to meet health-related social needs. Food security persists as the No. 1 reported unmet need followed by housing security and quality, transportation, utility assistance and safety. While specific capacity and service gaps vary, accessibility of services is the universally reported barrier to meeting any health-related social need. The Denver Regional AHC advisory board aims to improve availability and accessibility of services through its collaborative work groups. Prioritized service gaps and barriers along with strategies for improvement are introduced in this gap analysis report. The Denver Regional Quality Improvement Plan follows this report and details corresponding work group activities, results and recommendations.
Introduction

Denver Regional Council of Governments, a quasi-governmental association of 58 local governments, serves 3.2 million people representing more than half of the state’s population. A board of directors comprising local elected officials guides DRCOG’s regional planning, transportation planning and Area Agency on Aging divisions to support the long-term growth, development and well-being of the region. DRCOG collaborates with local governments, regional stakeholders and the public to develop and implement Metro Vision, the region’s shared vision for its future. DRCOG also establishes guidelines, informs policies and allocates funding for transportation and personal mobility.

As the federally designated Area Agency on Aging, DRCOG coordinates community-based services for older adults across an eight-county region. The AAA allocates federal and state funding mandated by the Older Americans Act and the Older Coloradans Act to support 45 community-based services offered through 27 organizations. Services include nutritional support; transportation to appointments, minor home repairs and maintenance; personal care and legal assistance. As an AAA, DRCOG also provides older adults (60 and older) and individuals with disabilities (18 and older) with case management, transition services, options counseling, ombudsman services, Medicare counseling and an information and assistance phone line.

Through its AAA, DRCOG manages the Denver Regional Accountable Health Community (AHC). Funded by the Center for Medicare and Medicaid Innovation, the Accountable Health Communities model evaluates how systemically addressing health-related social needs (HRSNs) of Medicare and Medicaid beneficiaries affects health outcomes and health care costs. While often used interchangeably, social determinants of health (SDOH) and HRSNs are separate concepts. In the context of the Denver Regional AHC, SDOH are understood as the upstream factors that affect a community’s well-being such as the laws, policies and regulations that are part of the larger political, economic and social systems. HRSNs are the individual, nonmedical needs that affect a person’s overall health such as stable and safe housing, transportation, nutritious food and protection from violence or abuse.

Within the Denver Regional AHC, DRCOG functions as the bridge organization to convene a network of clinical and community-based partners, creating a clinical-community continuum of care to better address individuals’ HRSNs. Clinical partners in primary care, behavioral health, home health and hospital settings complete evidence-based screenings to identify housing, food, utility, transportation and safety needs, then navigate individuals to community-based organizations to meet their needs and support their overall well-being.
Background and Purpose

Screening and navigation activities implemented in person-centered approaches allow for people’s needs to be identified and addressed through community-based services. Community-based organizations have addressed HRSNs in local communities for decades, supporting significant numbers of individuals and households, yet gaps and barriers to service and capacity issues exist. This report presents a:

1. demographic overview of the people living in the Denver Regional AHC region to better understand individuals and households that may benefit from community-based services
2. summary of the Denver Regional AHC screening results, including the prevalence of types and numbers of identified HRSNs
3. summary of available community-based resources, gaps and barriers to service, and strategies and opportunities for improvement

This information guides the AHC advisory board to analyze existing community-based service gaps and barriers to care, prioritize gaps and develop possible solutions. Through work groups specific to each HRSN, the AHC advisory board develops small-scale and replicable projects to test proposed solutions. The AHC quality improvement plan reports on the outcomes and sustainability of these projects. In short, this gap analysis report is a foundational document to inform the direction of the Denver Regional AHC’s community-level quality improvement efforts to address gaps and barriers to using community-based services and HRSNs in the region.

Goals

Goals of the Denver Regional AHC include 1) to improve clinical-community alignment for screening and referral, and 2) to enhance community-level interventions to address HRSNs.

As part of a national effort funded by the Center for Medicare and Medicaid Innovation, the Denver Regional AHC aims to demonstrate the value and total cost savings of meeting Medicare and Medicaid beneficiaries’ HRSNs through community resources. By collecting data on identified needs, community services delivered and corresponding effects on health, the AHC model gathers evidence to inform future policy, allocation of funding and services to better address HRSNs and community health moving forward.

The Denver Regional Accountable Health Community’s mission and vision are:

Mission

Denver Regional Accountable Health Community improves health outcomes by aligning clinical and community service providers to address unmet social needs.
Vision

Barriers to health are removed so people in the Denver region can live healthier lives.

Clinical and Community Partners

Clinical partners previously and currently operating as part of the Denver Regional AHC include Aurora Mental Health Center, Centura Health, Denver Health Sam Sandos Westside Family Health Center, Denver Health Emergency Department, Doctors Care, Dominican Home Health Agency, Jefferson Center for Mental Health, STRIDE Community Health Center and Tri-County Health Department.

Community partners include Brothers Redevelopment, Energy Outreach Colorado, Hunger Free Colorado, Jewish Family Service, Seniors’ Resource Center, Violence Free Colorado and Volunteers of America. The Denver Regional AHC also thanks the additional organizations and individuals who volunteer their time and expertise in the AHC work groups to enhance its community-level quality improvement initiatives.

Timeline

During year one of operations (May 2017 through April 2018), the AHC advisory board established a strategic plan and prepared screening and referral workflows between clinical and community partners. Screening and referral commenced in year two (May 2018 through April 2019), and year three of AHC operations recently ended (May 2019 – April 2020). During year three, the AHC continued operations with existing partners, established new clinical and community partnerships, and launched its work groups as part of the community-level quality improvement plan to address gaps and barriers to community-based services. Year four will continue with screening and referral operations as well as community-level quality improvement initiatives.
Community Profile: Denver Regional Accountable Health Community Service Area

The Denver Regional AHC includes Adams, Arapahoe, Broomfield, Denver, Douglas and Jefferson counties. The greatest number of individuals served reside in the Denver metro area near clinical partner sites that initiate screening and navigation activities (Figure 1).

The density of households served is determined by the residential addresses of individuals completing health-related social need screenings. To protect privacy, screenings are displayed based on density in quartiles, meaning that 25% of screenings occur in the lightest shaded area, 25% occur in the next darker shaded and so forth.

The highest density of screened and navigated households resides in west Denver and east Lakewood, north of U.S. Route 6/6th Avenue and south toward U.S Route 285/Hampden Avenue (approximately 6,600 screenings, darkest purple shaded area). The remaining households reside across a larger area including Broomfield, Thornton, Aurora, Centennial, Morrison and Golden (approximately 15,000 screenings, three lighter purple shaded areas).
Figure 1. Denver Regional Accountable Health Community Service Area: Highest Concentrations of Screened Households. The Denver Regional AHC includes Adams, Arapahoe, Broomfield, Denver, Douglas and Jefferson counties (see inset). Most screened households reside proximal to Denver metro area clinical and community partner sites, with the highest density of screened households residing in west Denver and east Lakewood (see darkest shaded purple area).
Methods and Approach

Community Profile and Current State Assessments

Observations within this report, as well as supporting analyses, are informed by quantitative and qualitative data. Figure 1 depicts the six-county AHC region, populated based on the addresses of individuals who completed HRSN screenings at AHC clinical partner sites from the program model start-to-date (May 2018-February 29, 2020).

The American Community Survey 2018 demographic and socioeconomic data of the six-county AHC region and HRSN screening results of Medicare and Medicaid beneficiaries from the program model start-to-date (May 2018-February 29, 2020) comprise the “Current State Assessment of Population and Community Needs” (see page 13). More detailed methodology behind the community profile and current state assessment of population and community needs is provided in the Technical and Quantitative Data Appendix.

The “Current State Assessment of Service Availability and Accessibility” (see page 26) represents contributions from: 1) community-facing staff screening and navigating individuals and households for HRSNs and community-based services, and 2) the AHC advisory board and work groups comprised of clinical and community-based organization leadership with other subject matter experts, gathered through facilitated discussions. See Qualitative Data Appendix for more details on qualitative data sources.

Advisory Board and Work Groups

The Denver Regional AHC advisory board, comprised of leadership from clinical and community-based organizations involved in screening, navigation and delivery of services in the AHC region, meets on a quarterly basis to ensure commitment to the AHC’s mission and vision.

Further organized into four smaller work groups, advisory board members collaborate to address gaps and barriers to community-based services related to the following HRSNs: food security; housing security and quality; utilities; and safety. Work groups meet monthly to 1) prioritize gaps and barriers to community-based services, 2) brainstorm and prioritize solutions, 3) test solutions and 4) evaluate for sustainability with the overall goal to improve availability and accessibility of services. At least one clinical and community advisory board member sits on each work group along with other local subject-matter experts who volunteer resources and time.

Community-facing staff provide input to the advisory board and work groups at bimonthly meetings to ensure that efforts are informed by first-hand accounts of seeking community-based services. Before a
work group pursues a project to test a proposed solution, an environmental scan evaluates other promising practices to avoid duplication of existing efforts and maximize community benefit. Environmental scans are detailed in separate addendums to this report.

The AHC advisory board opted not to convene its own transportation work group, as there are several other transportation-related initiatives, projects and funding mechanisms already in place. Alternatively, the Coordinated Public Transit Human Services Plan is currently being developed by DRCOG’s transportation division. The coordinated transit plan will identify the transportation needs of individuals with disabilities, older adults and low-income individuals and families, provide strategies for meeting these needs, and prioritize transportation services for funding and implementation. The coordinated transit plan is completed approximately every five years to contribute to closing gaps in transportation services through informing future transportation and mobility investments in the Denver region.

Quality improvement

Throughout its screening, navigation and community-based service provision efforts, the Denver Regional AHC uses the Plan-Do-Study-Act quality improvement methodology. PDSA methodology allows the AHC to complete rapid-cycle improvements to continue evaluating progress toward its goals and remain responsive to the needs of its partners and the community.

Definitions

The following terms guide the understanding and work of the Denver Regional AHC:

**Social Determinants of Health (SDOH):** upstream factors that create conditions in communities which may support or hinder health, such as laws, policies and regulations

**Health-Related Social Needs (HRSNs):** individual, nonmedical needs that affect health outcomes, for example, stable and safe housing, nutritious food, protection from violence and transportation

The Denver Regional AHC uses an HRSN screening in clinical settings to refer individuals to community-based organizations to address these individual, nonmedical needs.

**High-Risk:** Per the national Accountable Health Communities model, individuals screened who report at least one HRSN and two or more emergency department visits in the last twelve months are considered

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high-risk and eligible for navigation services. Navigation services include a person-centered action plan, referral and follow-up to connect the individual to community-based resources.

The HRSN screening tool identifies needs in the following ways:\(^2\):

**Food Security:** Within the past 12 months, an individual worried that their food would run out before they got money to buy more; or the food they bought didn’t last and they didn’t have money to get more

**Housing Security and Quality:** An individual does not currently have a steady place to live or worries about losing their place to live in the future; or has problems with pests, mold, lead paint or pipes, lack of heat, a nonworking oven or stove, missing or nonworking smoke detectors or water leaks

**Utility Needs:** Within the past 12 months, an individual’s electric, gas, oil or water company threatened to shut off services; or already had these services shut off

**Safety Needs:** Screening questions are designed to identify instances of child abuse, older adult abuse or domestic violence. This includes reporting instances of anyone, including family and friends, physically harming an individual, insulting, or talking down to an individual, threatening an individual with harm or screaming or cursing at an individual.

**Transportation Needs:** Within the past 12 months, reporting lack of reliable transportation, keeping an individual from medical appointments, meetings, work or getting to things needed for daily life

Strengths and Limitations

To promote transparency, knowledge-sharing and improvements, the strengths and limitations of this report include:

**Strengths**

- The HRSN screening is based on validated tools to promote fidelity and reliability of results, assembled by a technical expert panel convened by the Centers for Medicare and Medicaid Services.
- The AHC convenes community and clinical partners in a coordinated effort to address community needs.
- Beyond its founding clinical and community-based partners, the Denver Regional AHC works with additional subject matter experts and service providers to identify and close gaps in community-based services to improve future availability and accessibility.
- The assessment of gaps and barriers to service is informed by community-facing staff who screen and navigate individuals and families on a daily basis to collect detailed insight into the persistent challenges of accessing services within existing systems.
- The American Community Survey 2018 demographic data used in this report’s “Current State Assessment of Population Characteristics and Community Needs” (see page 13) provides detailed demographic characteristics at the census tract level. American Community Survey data allows for comparisons between areas of the region with high percentages of at-risk households to areas with high screening density.

**Limitations**

- HRSN screening results are specific to the Medicare and Medicaid beneficiaries screened at AHC clinical partner sites.
- To promote person-centered and trusting care, people can leave questions unanswered on the HRSN screening tool, thus screening results are not complete in all cases. For example, in domestic violence situations, a person may not be ready to disclose information or access services at the time of screening due to extenuating and personal circumstances. Moreover, safety-related screening results are underreported. *
- No specific funding exists for the AHC to pay for community-based services or for work groups to invest in additional community-based service capacity which requires offering existing resources and time for improvement efforts.
- Primary input from Medicare and Medicaid beneficiaries is not collected in this report’s assessment of identified gaps and barriers to service. This is a planned improvement in next year’s report.

- The American Community Survey 2018 demographic data used in this report’s “Current State Assessment of Population Characteristics and Community Needs” (see page 13) uses a five-year average of survey data. This leads to a lag of two to three years in American Community Survey data. The 2018 American Community Survey uses data from 2014-2018. Additionally, the ACS survey questions do not match closely enough to AHC survey questions to allow for detailed comparisons.

*Note: Immediate safety-related needs are promptly addressed per mandatory reporting and medical reporting options policies.*
Results and Findings

Summary

This section comprises two assessments: the 1) Current State Assessment of Population and Community Needs; and the 2) Current State Assessment of Service Availability and Accessibility.

The “Current State Assessment of Population Characteristics and Community Needs” presents an overview of the demographic and socioeconomic characteristics of people living across the AHC region and of people living within the AHC’s highest-screened neighborhoods. Specifically, American Community Survey demographic and socioeconomic indicators of the AHC’s highest-screened areas are compared with indicators of at-risk areas and the overall six-county AHC region. This comparison evaluates whether the AHC serves neighborhoods that may benefit most from community-based services to address unmet needs, following the understanding that socioeconomic factors contribute to almost 40 percent of health outcomes.

Next, this report includes demographic and socioeconomic indicators collected during HRSN screenings. Some screening indicators are based on the individual (for example, education level or race) while others are based on the household (for example, household income or household size). To conclude, an overview of the types and numbers of needs identified by screenings depicts the prevalence of unmet HRSNs in the AHC service area.

The “Current State Assessment of Service Availability and Accessibility” details an assessment of programs and services available to address needs, gaps and barriers to these community-based services, contributing factors, strategies and key opportunities for improvement. Understanding residents of the Denver region and the gaps and barriers to seeking services informs the Denver Regional AHC’s community-level quality improvement efforts, which are further explained in the Quality Improvement Plan report submitted to the Centers for Medicare and Medicaid Services.

Current State Assessment of Population Characteristics and Community Needs

Population Characteristics

Complex, interacting factors influence a community’s overall health and well-being. When evaluated across systems, socioeconomic factors contribute to approximately 40% of health outcomes compared with only 30% from health behaviors, 20% from clinical care and 10% from physical environment (Figure
By adapting an understanding of hot-spotting⁴ and social vulnerability indexing⁵, this report evaluates the Denver Regional AHC’s effectiveness in reaching households that may benefit most from community-based services based on demographic and socioeconomic risk indicators collected in 2018 American Community Survey data. Furthermore, this evaluation informs whether the Denver Regional AHC clinical and community partners are well-positioned in the region to reach and serve households with potentially unmet HRSNs.

**Figure 2.** Modifiable Determinants of Health Outcomes, Source: Park, H., Roubal, A.M., Javaag, A., Gennuso, K.P. and Catlin, B.B, 2015.

In Table 1, demographic and socioeconomic indicators of AHC neighborhoods with higher screening rates are compared with a) neighborhoods that may be considered at-risk for higher unmet HRSNs based on their demographic and socioeconomic characteristics and b) neighborhoods across the entire six-county AHC region. These comparisons determine whether the Denver Regional AHC serves neighborhoods more similar to the general population or neighborhoods that may have increased risk of unmet HRSNs.

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Neighborhoods served by Denver Regional AHC with demographic and socioeconomic indicators that most closely match those of at-risk neighborhoods are shaded in green. Neighborhoods with characteristics more similar to the general population are shaded in yellow. Neighborhoods with characteristics that fall somewhere in between at-risk neighborhoods and the greater region are shaded in grey. For example, 16% of households in AHC high-screened tracts reported income less than the federal poverty level which is nearly identical to the 17% exhibited in at-risk tracts, compared with 9% in the general population.

This report does not claim that these characteristics define an individual or household as vulnerable or at-risk. People are capable and resilient. Multigenerational households can benefit families. Being an older adult or someone with a disability does not mean an individual is dependent. The demographic and socioeconomic indicators of Table 1 are included with the understanding that it is complex physical, social and economic factors interacting with individuals that affect access to basic resources and overall health. However, it is often people within these demographics or socioeconomic situations who experience more negative health outcomes\(^6\), and thus the Denver Regional AHC aims to better serve these community members in its efforts toward health equity.

<table>
<thead>
<tr>
<th>Demographic/Socioeconomic Indicator</th>
<th>High-screened tracts</th>
<th>At-risk tracts</th>
<th>General population (all tracts in AHC region)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population</td>
<td>634,426</td>
<td>711,630</td>
<td>2,792,364</td>
</tr>
<tr>
<td>Total households</td>
<td>240,812</td>
<td>244,289</td>
<td>1,070,570</td>
</tr>
<tr>
<td>Mean household size</td>
<td>2.6</td>
<td>2.9</td>
<td>2.6</td>
</tr>
<tr>
<td>Percent of households with families</td>
<td>59%</td>
<td>63%</td>
<td>65%</td>
</tr>
<tr>
<td>Percent of grandparents living with grandchildren under the age of 18</td>
<td>4%</td>
<td>6%</td>
<td>3%</td>
</tr>
<tr>
<td>Percent of single person households</td>
<td>31%</td>
<td>28%</td>
<td>27%</td>
</tr>
<tr>
<td>Percent of households with income below poverty level during last 12 months</td>
<td>16%</td>
<td>17%</td>
<td>9%</td>
</tr>
<tr>
<td>Percent of unemployed individuals</td>
<td>3%</td>
<td>4%</td>
<td>3%</td>
</tr>
<tr>
<td>Percent of employed individuals</td>
<td>65%</td>
<td>65%</td>
<td>69%</td>
</tr>
<tr>
<td>Percent of individuals born outside the U.S.</td>
<td>18%</td>
<td>24%</td>
<td>12%</td>
</tr>
</tbody>
</table>

---

<table>
<thead>
<tr>
<th>Demographic/Socioeconomic Indicator</th>
<th>High-screened tracts</th>
<th>At-risk tracts</th>
<th>General population (all tracts in AHC region)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of individuals who speak English less than “very well”</td>
<td>13%</td>
<td>19%</td>
<td>7%</td>
</tr>
<tr>
<td>Percent of Latinx/Hispanic individuals</td>
<td>40%</td>
<td>49%</td>
<td>22%</td>
</tr>
<tr>
<td>Percent of African American individuals</td>
<td>6%</td>
<td>11%</td>
<td>5%</td>
</tr>
<tr>
<td>Percent of rent-burdened households (30% or more of household income spent on rent in the past 12 months)</td>
<td>55%</td>
<td>57%</td>
<td>48%</td>
</tr>
<tr>
<td>Percent of individuals with Medicaid coverage</td>
<td>29%</td>
<td>34%</td>
<td>17%</td>
</tr>
<tr>
<td>Percent of individuals 60 and over</td>
<td>18%</td>
<td>14%</td>
<td>19%</td>
</tr>
<tr>
<td>Percent of individuals under 18</td>
<td>23%</td>
<td>27%</td>
<td>22%</td>
</tr>
<tr>
<td>Percent of individuals with less than a high school education</td>
<td>19%</td>
<td>24%</td>
<td>10%</td>
</tr>
<tr>
<td>Percent of individuals with a disability</td>
<td>12%</td>
<td>11%</td>
<td>10%</td>
</tr>
<tr>
<td>Percent of households with cash public assistance or Supplemental Nutrition Assistance Program (SNAP)</td>
<td>14%</td>
<td>18%</td>
<td>8%</td>
</tr>
</tbody>
</table>

Table 1. Demographic and socioeconomic indicators that may contribute to health-related outcomes compared across AHC-high screened tracts, at-risk tracts and the total AHC six-county region, American Community Survey, 2018. Green-shaded indicator represents neighborhoods served by the AHC have characteristics that most closely match those of at-risk neighborhoods. Yellow shaded indicator represents neighborhoods served by the AHC have characteristics more similar to the general population. Grey-shaded indicator represents neighborhoods served by the AHC have characteristics in between those of at-risk neighborhoods and of the general population in the AHC region. Detail on data methodology included in Appendix.
Result 1: This analysis suggests the Denver Regional AHC meets the goal of serving neighborhoods that may benefit most from community-based services to address HRSNs. Specifically, the Denver Regional AHC serves neighborhoods with a higher proportion of the following individuals and households, compared with the general population (Table 1):

- households with Medicaid health insurance;
- households who are rent-burdened;
- households receiving Supplemental Nutrition Assistance Program (SNAP) or other public benefits;
- households identifying as Latinx/Hispanic;
- individuals with less than a high school education;
- individuals with a disability;
- and households with income below the poverty level.

The poverty level does not relate to actual living expenses for a household. The 2019 federal poverty level for family of four was $25,750\(^7\), a meager income to support a household of any number of people in the Denver metro area. However, the DRCOG AHC team believes in the general utility of the poverty level indicator.

Compared with at-risk tracts, the Denver Regional AHC does not serve as many neighborhoods with grandparents living with grandchildren or households with individuals under 18 years of age, although the AHC serves neighborhoods with a slightly greater proportion of these households than the general population.

The Denver Regional AHC serves neighborhoods with a proportion of older adults similar to the general population (18% AHC and 19% general population). By comparison, the share of the population in at-risk tracts classified as older adults (age 60 and older) is only 14%. As the Area Agency on Aging for the Denver region, DRCOG is responsible for the establishment and continued support of a comprehensive, coordinated system of community-based services to meet the needs of the region’s older adults.

Result 2: Opportunities for greatest improvement to reach more:

- households identifying as black/African American
- people who were born outside of the United States
- and people who do not confidently speak English

While African American households make up 5% of the general population, these households make up 11% of at-risk tracts and only 6% of neighborhoods served by AHC. The AHC serves neighborhoods somewhere between at-risk tracts and the general population for those born outside of the United States or those who do not confidently speak English. Through new clinical partnerships and programs in the coming year, the AHC aims to improve and reach more of these individuals and households.

In addition to the American Community Survey’s five-year rolling average data, the HRSN screening tool collects demographic and economic information with corresponding HRSNs (Table 2). Demographic and economic information allows the Denver Regional AHC project team to better understand the characteristics of individuals and households screened with unmet needs.

In an effort toward person-centeredness, the Denver Regional AHC allows for individuals to refuse screening questions. For example, a person does not have to answer if they do not identify within the current binary gender responses or with the race/ethnicity categories provided. Therefore, demographic and economic data collected via HRSN screenings is not complete but provides a foundational overview.

<table>
<thead>
<tr>
<th>HRSN Screenings: Demographic/Socioeconomic Indicators</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age: Median (interquartile range)</td>
<td>13.7 years (7.1, 34.5 years)</td>
</tr>
<tr>
<td>Female</td>
<td>59%</td>
</tr>
<tr>
<td>Male</td>
<td>41%</td>
</tr>
<tr>
<td>Household size: mean (standard deviation)</td>
<td>4.0 (2.0) people</td>
</tr>
<tr>
<td>Race: Note screening allows multiple selections.</td>
<td></td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>5.4%</td>
</tr>
<tr>
<td>Asian</td>
<td>1.9%</td>
</tr>
<tr>
<td>Black or African American</td>
<td>8.5%</td>
</tr>
<tr>
<td>Native Hawaiian/Other Pacific Islander</td>
<td>0.4%</td>
</tr>
<tr>
<td>White</td>
<td>50.6%</td>
</tr>
<tr>
<td>Other</td>
<td>11.5%</td>
</tr>
<tr>
<td>No answer</td>
<td>25.7%</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
</tr>
<tr>
<td>Hispanic, Latinx or Spanish Origin</td>
<td>55.2%</td>
</tr>
<tr>
<td>No answer</td>
<td>11.7%</td>
</tr>
<tr>
<td>Education: Of those 18 and older</td>
<td></td>
</tr>
<tr>
<td>No school or only kindergarten</td>
<td>0.8%</td>
</tr>
<tr>
<td>Grades 1 through 8</td>
<td>3.8%</td>
</tr>
<tr>
<td>Grades 9 through 11 (some high school)</td>
<td>10.5%</td>
</tr>
<tr>
<td>Grade 12 or General Educational Development diploma (high school graduate, diploma or alternative credential)</td>
<td>32.8%</td>
</tr>
</tbody>
</table>
Table 2. Demographic and socioeconomic indicators collected via health-related social need screenings completed by Denver Regional AHC clinical partners, project-to-date (May 1, 2018-Feb. 29, 2020).

Table 2 presents project-to-date screening data (May 1, 2018-Feb. 29, 2020) to conclude that the Denver Regional AHC serves:

Result 3: More children than any other age group (13.7 median age).

Interquartile range explanation (Table 2): The median age of screened individuals is 13.7 indicating that half of screenings had an age younger than 13.7 and half had an age older than 13.7 years. The 25th percentile is 7.1 years, meaning that one quarter of screenings had an age younger than 7.1. The 75th percentile is 34.5 years, meaning that one quarter of screenings had an age older than 34.5. A median age of 13.7 years indicates that most screenings were completed for children. The interquartile range of 7.1 and 34.5 years further demonstrates the data set represents a younger population; half of screened individuals had an age between 7.1 and 34.5 years.

Result 4: More women than men (59% vs. 41%).

Result 5: An average household size of four people, indicating that multiple individuals within the household are likely affected by identified HRSNs such as food security, housing security and quality, transportation, utility and safety needs.

Result 6: A majority of individuals who identified as white or Hispanic/Latinx/Spanish (50.6% white; 55.2% Hispanic, Latinx or Spanish origin). 8.5% identify as black/African American while other minority communities are less represented: 5.4% American Indian/Alaska Native and 1.9% Asian. 25.7% and 11.7% did not respond to race and ethnicity screening questions, respectively, suggesting a fair amount of demographic information in not accounted for.
Result 7: A varied population in terms of education level (of those 18 and older). 15.1% report less than a high school education. 58.1% report educational attainment between a high school degree and some years of college (32.8% high school diploma/General Educational Development diploma (GED); 25.3% 1-3 years of college). Only 12.1% reported college of four years or more.

Result 8: A majority of households that have incomes lower than the poverty level (approximately 51.5%, at $25,750 per year assuming an average household of four). Only 4.1% of households reported annual income greater than $50,000.

Overall, the demographic and economic information during HRSN screenings indicates the AHC serves a majority of multi-person households; more white, Hispanic/Latinx individuals than other race/ethnicities; households with a variety of educational levels; and mostly households near or below the poverty level. In the next section, screening results depict the types and prevalence of needs identified for these individuals and households.

Community Needs: Prevalence of Health-Related Social Needs

The HRSN screening assesses food security, housing security and quality, utility, safety and transportation needs. Table 3 displays screening results by project year. Due to the publication date of this report, year one comprises screenings completed during a full 12-month period from May 1, 2018 through April 30, 2019. Year two comprises screenings completed during a 10-month project period (May 1, 2019 through Feb. 29, 2020). Clinical partners were onboarded at different times throughout project years; therefore, the number of screenings completed in project years varies. Despite the shorter reporting period, year two results include nearly as many screenings as during year one (13,002 and 12,756 screenings, respectively). As for the demographic questions, people may refuse questions due to any reason, meaning that screening results are informative but not complete in all cases.

In this section, written results represent screening data displayed in Table 3. Figures 3 and 4 display project-to-date data; Figures 5 and 6 compare data between project years.

Figure 3 depicts the prevalence of unmet HRSNs by number of needs reported. Prevalence is calculated based on screenings with identified needs (n=8,404) versus total screenings completed (N=25,758).

Figure 4 depicts prevalence of HRSNs by type. Prevalence is calculated based on screenings with identified needs (n=8,404) versus total screenings completed (N=25,758).
## Health-Related Social Need (HRSN) Screening Results Summary

<table>
<thead>
<tr>
<th>Health-Related Social Need (HRSN) Screening Results Summary</th>
<th>2018-2019</th>
<th>2019-2020</th>
<th>Project-to-Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>N = 13,002 total screenings</td>
<td>N = 12,756 total screenings</td>
<td>N = 25,758 total screenings</td>
<td></td>
</tr>
<tr>
<td>Screenings: zero needs</td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Screenings: one or more needs</td>
<td>8,625</td>
<td>66.3%</td>
<td>8,729</td>
</tr>
<tr>
<td>Screenings: one need</td>
<td>4,377</td>
<td>33.7%</td>
<td>4,027</td>
</tr>
<tr>
<td>Screenings: two needs</td>
<td>2,508</td>
<td>19.3%</td>
<td>2,364</td>
</tr>
<tr>
<td>Screenings: three needs</td>
<td>1,176</td>
<td>9.0%</td>
<td>1,110</td>
</tr>
<tr>
<td>Screenings: four needs</td>
<td>525</td>
<td>4.0%</td>
<td>460</td>
</tr>
<tr>
<td>Screenings: five needs</td>
<td>163</td>
<td>1.3%</td>
<td>89</td>
</tr>
</tbody>
</table>

- Screenings: Food security need: 2,978 (22.9%), 2,778 (21.8%), 5,756 (22.3%)
- Screenings: Housing need (combined): 1,586 (12.2%), 1,344 (10.5%), 2,930 (11.4%)
- Screenings: Housing security need: 1,008 (7.8%), 736 (5.8%), 1,744 (6.8%)
- Screenings: Housing quality need: 744 (5.7%), 752 (5.9%), 1,496 (5.8%)
- Screenings: Transportation need: 1,543 (11.9%), 1,314 (10.3%), 2,857 (11.1%)
- Screenings: Utilities need: 920 (7.1%), 835 (6.5%), 1,755 (6.8%)
- Screenings: Safety need: 85 (0.7%), 69 (0.5%), 154 (0.6%)

<table>
<thead>
<tr>
<th>Average number of identified HRSN</th>
<th>0.55</th>
<th>N/A</th>
<th>0.50</th>
<th>N/A</th>
<th>0.53</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevalence of higher-risk individuals, eligible for navigation (out of total screenings)</td>
<td>1,494</td>
<td>11.5%</td>
<td>805</td>
<td>6.3%</td>
<td>2,299</td>
<td>8.9%</td>
</tr>
</tbody>
</table>

**Table 3.** Prevalence of health-related social needs identified by the AHC model screening tool. (Year One: May 1, 2018-April 30, 2019; Year Two: May 1, 2019-Feb. 29, 2020; Project-to-date: May 1, 2018-Feb. 29, 2020). Higher risk is defined by having any number of health-related social needs and two or more emergency department visits in the last 12 months.
Prevalence of Health-Related Social Needs By Number: Of Screenings with Identified Needs

Figure 3. Prevalence of the number of health-related social needs based on screenings with identified needs (n=8,404), project to date (May 1, 2018-Feb. 29, 2020).

Prevalence of Health-Related Social Needs by Type: Of Screenings with Identified Needs

Figure 4. Prevalence of the types of health-related social needs based on screenings with identified needs (n=8,404), project to date (May 1, 2018-February 29, 2020).
**Result 9:** More than two-thirds of screenings identified zero unmet HRSNs (67.4%), meaning that less than a one-third of screenings accounted for all identified needs across the region.

**Result 10:** Of screenings with identified needs, a majority of households (58%) reported only one unmet HRSN.

**Result 11:** Food security is the top-reported unmet HRSN (68% of screenings with identified needs). Housing (security/quality, 35%) and transportation (34%) needs were reported at similar rates and were identified at approximately half the rate of food security.

Utilities are consistently the fourth most frequently reported unmet HRSN (21% of screenings with identified needs).

Safety-related needs consistently report at the bottom tier of needs (2% of screenings with identified needs). Safety needs are underreported, so this is only a cursory baseline of potential need in the region.

**Result 12:** Housing security and housing quality needs occur at approximately the same rate which may suggest a relationship between these issues (Table 3).

**Result 13:** Only 9% of total screenings were of high-risk individuals. However, of screenings with identified needs, 27% were classified as high-risk. This suggests that individuals with needs are more likely to visit emergency departments for medical treatment.

**Result 14:** Comparing project years, the trends in the number and types of identified HRSNs are similar. These trends persist despite various clinical partners, locations and differences in start-up screening periods. This suggests consistent unmet HRSNs across the region within the demographic and socioeconomic neighborhoods the AHC serves (Figures 5 and 6).

**Result 15:** The Denver Regional AHC results coincide with other Colorado screening trends. Rocky Mountain Health Plans manages the Accountable Healthy Communities model in the western slope of Colorado. As in the Denver region, Rocky Mountain Health Plans identified food security as the top reported need (43% of total screenings) followed by housing security/quality (28%), transportation (20%), utilities (14%) and safety (4%)\(^8\). These results demonstrate consistent unmet HRSNs both in urban and rural areas.

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\(^8\) Rocky Mountain Health Plans. (2020, February). *Accountable Health Communities Model Update.* [PDF].
Figure 5. Comparison of the number of health-related social needs identified per screening in year one (May 1, 2018-April 30, 2019) and year two (May 1, 2019-Feb. 29, 2020).
Figure 6. Comparison of the types of health-related social needs identified per screening in year one (May 1, 2018-April 30, 2019) and year two (May 1, 2019-Feb. 29, 2020).
Current State Assessment of Service Availability and Accessibility

This section introduces an assessment of the programs and services available to address HRSNs. It represents the knowledge and resources understood and used by the Denver Regional AHC clinical and community partners to address HRSNs. The assessment is not all-encompassing but represents a strong groundwork upon which the Denver Regional AHC work groups build in their work to identify, prioritize and close gaps in community-based services.

For each HRSN, the following section includes a summary of the prioritized gaps to address, an assessment of current programs and services, gaps and barriers to service, and key strategies and opportunities for improvement. The DRCOG AHC project team organized this assessment but the content originates from AHC clinical and community partners as detailed under each HRSN. This assessment informs the Denver Regional AHC’s work group efforts; more detail on the work groups’ quality improvements is included in the Quality Improvement Plan report.
Food Security

Summary

The food security work group elected to address the most common reported service barrier: accessibility of food resources. To enhance access, the food security work group opted for a colocation model, partnering primary care clinics with community organizations to provide food pantry services, benefit screenings and education at clinic sites through food resource fairs. Available food included fresh produce, meat and dairy, and shelf-stable products. Benefit screenings and education included information about the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants and Children program (WIC).

The food security work group is evaluating the success of the two food resource fairs toward its goals and how to direct future efforts in light of the coronavirus disease pandemic that emerged in late 2019.

Baseline Data and Key Metrics

22% of total screenings identified a food security need. 68.5% of screenings with identified needs reported a food security need, making food security the most prevalent need.
Assessment of Available Programs and Services

A list of primary resources AHC partners utilize to address food needs, organized in the Denver Regional AHC community resource inventory:

Public Programs:
- Child and Adult Care Food Program
- Commodity Supplemental Food Program
- Colorado Works/Temporary Assistance for Needy Families
- DoubleUp Food Bucks
- Free and reduced-cost school lunches
- Supplemental Nutrition Assistance Program (SNAP)
- The Emergency Food Assistance Program
- Women, Infants and Children program (WIC)

Food Pantries:
- Agape Life Fellowship Food Bank
- Arvada Community Food Bank
- Double Up Colorado
- First Presbyterian Church of Englewood Food Bank
- Food Bank of the Rockies
- His Provision Food Bank
- Jewish Family Service of Colorado
- Little Flower Center
- Metro Caring
- Open Arms Food Bank
- Restoration Outreach
- SECORCares
- The Action Center

Meal Delivery Programs:
- City and County of Broomfield Meals on Wheels
- Project Angel Heart
- Town of Littleton Cares (TLC) Meals on Wheels
- Volunteers of America
Community-based organizations providing services or referrals:
- Aging Well Resource Center
- Aurora Day Resource Center
- Broomfield Feeding Families and Fueling Hope
- DRCOG Area Agency on Aging
- Congregate dining centers (for example, Volunteers of America)
- Hunger Free Colorado
- Mile High United Way 2-1-1
- Seniors’ Resource Center

Identification and Prioritization of Gaps and Barriers to Service, and Key Strategies and Opportunities for Improvement

The following chart comprises three sections: 1) Gaps and barriers to service, contributing factors, key strategies and opportunities for improvement as reported by community-facing staff who screen and navigate individuals and households to address unmet needs; 2) the prioritized gap or barrier to service recommended by community-facing staff for the work group to address; and 3) the prioritized gap or barrier to service with key strategies and opportunities for improvement as determined by the work group. See the “Food Security: Gaps and Barriers to Service Data Sources” in the Qualitative Data Appendix for list of contributing partners.

Work groups strongly consider community-facing staff contributions and determine final prioritized gaps and improvement strategies based on feasibility of effect with available resources within the project timeline.
### Gaps and barriers to service

<table>
<thead>
<tr>
<th><strong>Gaps and barriers to service</strong></th>
<th><strong>Factors contributing to service gaps</strong></th>
<th><strong>Key strategies and opportunities for improvement (short- and long-term)</strong></th>
</tr>
</thead>
</table>
| Lack of knowledge about food resources | • Not knowing where to go to get the information | • Spread more information about Hunger Free Colorado and other resources (for example, We Don’t Waste)  
• Farm stands  
• Colocation: Food pantries on-site at clinics  
• Provide incentive to reduce no-shows  
• Provide bags for carrying food |
| Challenges getting to food resources | • Lack of transportation (including public and private options) | • Mobile food pantries/food trucks  
• Possibility of food delivery in extenuating circumstances (if available, publicize existing opportunities for food delivery) |
| Dietary, cultural or taste needs and preferences (for example, older adults) | • Limitations on supply | • Explore ways to expand existing resources (for example, Project Angel Heart) |
| Not knowing how to prepare foods | • Challenging/differing food supplies, lack of experience with types of foods available | • Guides/recipes for foods provided |
| Expectations for quality of food and assumptions that it is required for people to take all food offerings | • Inadequate communications to manage expectations and clear up misunderstandings | • Education for people seeking services and for staff navigating people to services |
| Hours of operation of food pantries and resources | • Limited supply and capacity of sites | • None reported at this time |
| Limited understanding of nonemergency medical transportation and (NEMT) Medicaid transportation | • Cyclical change in providers (due to contracting) makes it difficult for people to track their available service providers, and for staff to navigate people to available resources | • Education on transportation services for providers and for people seeking services |
### Prioritized gap or barrier to service recommended by community-facing staff for the work group to address:

**Transportation issues related to the time and energy required to go to different locations for services**

<table>
<thead>
<tr>
<th>Prioritized gap or barrier to service determined by the work group</th>
<th>Factors contributing to service gaps</th>
<th>Key opportunities and strategies for improvement determined by the work group</th>
</tr>
</thead>
</table>
| The accessibility of food resources/services in the community | • Challenge keeping an up-to-date community resource list. Resource information changes frequently.  
• Various hours of operations (for example, food pantries) | • Collaborate with agencies that already provide services to people with food security needs in order to leverage existing services and increase accessibility  
• Colocation of services |

### Environmental scan

In spring of 2020, the food security work group initiated an assessment of other local, state and U.S. programs and promising practices related to service availability and accessibility to inform its community-level quality improvement efforts. The DRCOG AHC project team assists in outreach, research and consolidation of content to complete the scan. See separate addendum submitted to the Centers for Medicare and Medicaid Services for additional information.
Housing Security and Quality

Summary

The housing work group prioritized improving support and services for renter rights and landlord obligations associated with housing quality and maintenance, and restrictions on eviction. Contributing factors include limited resources and a lack of awareness of those resources. The work group is currently strategizing opportunities to increase awareness of the improved habitability statute that supports health and safety of renters, passed as part of Colorado’s 2019 Residential Tenants Health and Safety Act, and related resources and services for households.

Baseline Data and Key Metrics

11.4% of total screenings identified a housing need; 6.8% of those are security-related and 5.8% are quality-related.

35% of screenings with identified needs reported a housing security/quality need, making housing the second most prevalent need.
Assessment of Available Programs and Services

A list of primary resources AHC partners use to address housing-related needs, organized in the Denver Regional AHC community resource inventory:

**Housing Security-related Resources**

- Local housing authorities
- Community-based organizations with housing counseling, rental assistance and other services:
  - Aging Well Resource Center
  - Almost Home
  - Atlantis Community
  - Aurora Day Resource Center
  - Brothers Redevelopment
  - Center for People with Disabilities
  - Cherry Hills Community Church
  - City of Aurora Community Development Division
  - Colorado Housing Search
  - Denver County Temporary Rental and Utility Assistance
  - DRCOG Area Agency on Aging
  - Help and Hope Center
  - Jewish Family Service of Colorado
  - Mile High United Way 2-1-1
  - South Metro Housing Options
  - Lawrence Street Community Center
  - New Genesis
  - Red Cross Mile High Chapter
  - Sacred Heart House
  - Salvation Army
  - Samaritan House
  - Senior Support Services
  - The Gathering Place
  - Urban Peak
  - Housing Options

**Housing Quality-related Resources**

- Brothers Redevelopment
- Colorado Department of Public Health and Environment
- City of Denver Healthy Families Healthy Homes
- Denver Urban Renewal Authority
- Douglas County Department of Community Development
Third-Year Gap Analysis

- Energy Resource Center of Colorado
- Home Builders Foundation
- InPower Home Solutions
- Rebuilding Together Metro Denver
- Senior Hub
- Weatherization programs to include:
  - Arapahoe County Human Services
  - Boulder County Housing Authority Longs Peak Energy Conservation
  - Energy Outreach Colorado
  - Energy Resource Center
  - Low Income Energy Assistance Program

Identification and Prioritization of Gaps and Barriers to Service, and Key Strategies and Opportunities for Improvement

The following chart comprises four sections: 1) gaps and barriers to service, contributing factors, key strategies and opportunities for improvement as reported by community-facing staff who screen and navigate individuals and households to address unmet needs1; 2) whether the reported gap or barrier to service is related to rental or homeownership; 3) the prioritized gap or barrier to service recommended by community-facing staff for the work group to address2; and 4) the prioritized gap or barrier to service with key strategies and opportunities for improvement as determined by the work group3. See the “Housing Security and Quality: Gaps and Barriers to Service Data Sources” in the Qualitative Data Appendix for list of contributing partners.

Work groups strongly consider community-facing staff contributions and determine final prioritized gaps and improvement strategies based on feasibility of effects with available resources within the project timeline.
## Gaps and barriers to service

<table>
<thead>
<tr>
<th>Gaps and barriers to service</th>
<th>Rental or homeownership-related issue?</th>
<th>Factors contributing to service gaps</th>
<th>Key opportunities and strategies for improvement (short- and long-term)</th>
</tr>
</thead>
</table>
| Month-to-month renting       | √ Rental properties                    | • No recourse for families in month-to-month leases  
• By raising issues, families on month-to-month leases could be put at-risk of losing their home.  
• Requirements to clear any repairs with the landlord  
• Limited renters’ rights | • Increase availability and access to legal resources for families in these situations (related to housing quality) |
| Pest removal                 | √ Homeownership                         | • Limited funding for these services | • More funding for these services  
• More affordable service providers for this work |
| The landlord is a family member who owns the property, limiting access to available resources to address environmental concerns due to family control and dynamics | √ Rental properties  
√ Homeownership | • Homeowners: In general, there are few resources to help cover the cost of property repairs or bug infestations  
• Renters: Landlord may not have the financial resources to address environmental issues  
• Renters: Difficult family dynamics when the landlord is unwilling to allow the family member (who is renting) to make repairs to the property  
• Renters: There are often informal arrangements among family members with no formal lease | • None reported at this time |
| Limited services for eviction situations | √ Rental properties | • Must wait to get help until they receive an eviction | • More guidance and assistance to |
| Lack of affordable housing | √ Rental properties  
<p>|                           | √ Homeownership       | letter which delays ability to get needs met | prepare and handle these situations |
|                           |                       | • Renters: People can access services (safety net rental assistance through local departments of human services) but can’t always access resources in a timely manner due to application processes |
|                           |                       | • Renters: Local departments of human services have many eligibility requirements and each county is different which can make it difficult for navigators to track differing requirements and assist families |
|                           |                       | • Renters: When accessing rental assistance, households must demonstrate the situation is an emergency and that the household can cover rent in the future (proof of income) |
|                           |                       | • Renters: Refugees are especially impacted due to communication barriers; poor housing quality when arriving in the U.S. (limited stock for resettlement agencies), then they are “stuck” |
|                           |                       | • Homeowners/those interested in purchasing a home: challenged by costs |
| Limited advocacy for renters regarding environmental concerns | √ Rental properties | • Few resources for people who are undocumented due to legal issues |
|                           |                       | • If parents are undocumented then they don’t qualify for affordable |
|                           |                       | • Increase availability and access to legal assistance, especially for environmental issues |</p>
<table>
<thead>
<tr>
<th>Repeated use of “emergency funds”</th>
<th>√ Rental properties</th>
<th>√ Homeownership</th>
<th>Renters/Homeowners: Living on a budget every month with no longer-term resources to stabilize their situation</th>
<th>None reported at this time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of awareness and availability of maintenance-related resources</td>
<td>√ Rental properties</td>
<td>√ Homeownership</td>
<td>For Renters/Homeowners:</td>
<td>Education about available resources for renters, landlords and homeowners</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Not knowing where to go for assistance</td>
<td>• Increased funding options for home maintenance resources</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Overall, limited funding for assistance especially for water bills</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Counties have different levels of funding and services.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Can’t afford to move or fix problems</td>
<td></td>
</tr>
</tbody>
</table>

Prioritized gap or barrier to service recommended by community-facing staff for the work group to address:

Lack of affordable, quality/safe housing for renters and homeowners.
While the greatest gap is lack of affordable, quality housing, the gap recommended to the work group to address is limited advocacy and legal recourse for renters due to the project timeline.

Key opportunities and strategies for improvement:
- Collective advocacy for local/state policy change efforts
- Landlord education and training regarding:
  - Available resources for home modifications/environmental issues
  - How to prevent problems before they happen (in conjunction with training for tenants)
  - Benefits of modifications/improvements; create “buy-in” for landlords especially when resources are at no cost.

<table>
<thead>
<tr>
<th>Prioritized gap or barrier to service determined by the work group</th>
<th>Rental or homeownership-related issue?</th>
<th>Factors contributing to service gaps</th>
<th>Key opportunities and strategies for improvement determined by the work group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase knowledge about support and services for renter rights and landlord obligations associated with housing quality and maintenance, and restrictions on eviction</td>
<td>✓ Rental properties</td>
<td>• Limited resources • Lack of awareness of available resources</td>
<td>Increase awareness of the improved habitability statute that supports health and safety of renters, passed as part of Colorado’s 2019 Residential Tenants Health and Safety Act, and related resources and services.</td>
</tr>
</tbody>
</table>

**Environmental scan**

In spring of 2020, the housing security and quality work group initiated an assessment of other local, state and U.S. programs and promising practices related to service availability and accessibility to inform its community-level quality improvement efforts. The DRCOG AHC project team assists in outreach, research and consolidation of content to complete the scan. See separate addendum submitted to the Centers for Medicare and Medicaid Services for additional information.
Third-Year Gap Analysis

Utilities

Summary
The top three service gaps reported by community-facing staff were closely ranked and include lack of knowledge of available resources, difficulties accessing resources due to complicated application processes and identifying organizations with current capacity. The utilities work group opted to address these gaps through a training program to increase awareness of utility and weatherization programs, eligibility and application processes and is currently evaluating next steps for project development.

Baseline Data and Key Metrics
6.8% of total screenings identified a utility need. 21% of screenings with identified needs reported a utility need, making utility assistance the fourth most prevalent need.
Assessment of Available Programs and Services

A list of primary resources AHC partners use to address utility needs, organized in the Denver Regional AHC community resource inventory:

Community-based programs:
- Almost Home
- Broomfield Feeding Families and Fueling Hope
- Catholic Charities and Community Services
- Community Ministry of Southwest Denver
- DRCOG Area Agency on Aging
- Energy Outreach Colorado
- Help and Hope Center
- Integrated Family Community Services
- Senior Assistance Center

Public programs
- Low-Income Energy Assistance Program (LEAP)
- Denver County Temporary Rental and Utility Assistance Program
- Salvation Army
- Xcel Energy

Identification and Prioritization of Gaps and Barriers to Service, and Key Strategies and Opportunities for Improvement

The following chart comprises three sections: 1) gaps and barriers to service, contributing factors, key strategies and opportunities for improvement as reported by community-facing staff who screen and navigate individuals and households to address unmet needs; 2) the prioritized gap or barrier to service recommended by community-facing staff for the work group to address; and 3) the prioritized gap or barrier to service with key strategies and opportunities for improvement as determined by the work group. See the “Utilities: Gaps and Barriers to Service Data Sources” in the Qualitative Data Appendix for list of contributing partners.

Work groups strongly consider community-facing staff contributions and determine final prioritized gaps and improvement strategies based on feasibility of impact with available resources within the project timeline.
# Third-Year Gap Analysis

<table>
<thead>
<tr>
<th>Gaps and barriers to service</th>
<th>Factors contributing to service gaps</th>
<th>Key strategies and opportunities for improvement (short- and long-term)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Charge Rule Change⁹</td>
<td>People are afraid to apply for public assistance even if their household may qualify because they do not want to lose their opportunity to receive permanent status in the United States</td>
<td>Education and access to information regarding public charge for families</td>
</tr>
</tbody>
</table>
| Different requirements for applying to Energy Outreach Colorado assistance based on the time of year | During the LEAP season, a household must first apply for LEAP before applying to Energy Outreach Colorado  
  Annual LEAP season: October-April | Simplify application process |
| Xcel Energy¹⁰:  
  Limits on frequency of assistance | Household may only apply for Energy Outreach Colorado assistance once per year and up to a value of $1,000  
  Annual Energy Outreach Colorado calendar year: October-September | Instead of limiting households to requesting assistance up to once per year, limit the maximum amount of funding a household can receive per year (for example, develop a formula to identify the maximum amount of money any one household can receive per year based on number of occupants and size of the home)  
  Alter existing allocations of assistance so that a household can apply for Energy Outreach Colorado assistance as many times in a year as needed until that household reaches its maximum funding limit for the year |
| Identifying organizations that receive Energy Outreach Colorado | No central spot for resources; time consuming to do on your own | Centralization of resources > updated information > |

⁹ In immigration law, public charge is considered grounds for inadmissibility. Under its terms, a person considered at-risk of becoming dependent on government support may be deemed a “public charge” and denied a visa, green card or admission to the United States. Due to federal court injunctions, the Public Charge Rule did not come into effect until Feb. 20, 2020. Immigrant Legal Resource Center. Public Charge. (2020, March 30). https://www.ilrc.org/public-charge

¹⁰ Xcel Energy is the region’s largest service provider; there are other energy companies that serve the region.
<table>
<thead>
<tr>
<th>Funding and have current funding available</th>
<th>Must contact each organization individually to identify whether that organization currently has funding available. Then, the individual must schedule an appointment to meet with the organization in-person to apply for assistance (depending on organization).&lt;br&gt;• Lack of communication, coordination in clinical organization (decentralized)</th>
<th>designated timelines for updates&lt;br&gt;• Use the Energy Outreach Colorado hotline and website as a hub for locating organizations that currently have funding and for scheduling an appointment to apply for funding in-person (when required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issues when attempting to demonstrate medical necessity to require electricity to remain on</td>
<td>Apply directly with energy company to receive medical necessity certificate:&lt;br&gt;• Must provide paperwork to energy company demonstrating medical necessity within two weeks&lt;br&gt;• Household may receive a “hold” on their account during the two weeks, so their energy is not shut off while gathering paperwork</td>
<td>Allow up to one month for the household to provide the paperwork verifying medical necessity&lt;br&gt;• Expand the guidelines for what qualifies as “medical necessity”</td>
</tr>
<tr>
<td>There are limited to no resources available to help households with water bills</td>
<td>Considered nonemergent (unlike electricity)&lt;br&gt;• Sometimes quarterly bills come as a surprise (for example, if there is a leak)&lt;br&gt;• Only two organizations known that provide this assistance in the metro area</td>
<td>Set up a state program similar to Energy Outreach Colorado to help people access assistance paying for water bills</td>
</tr>
<tr>
<td>Paperwork required to apply for Energy Outreach Colorado and LEAP program assistance (Homeless to Home, LEAP, bill payment assistance)</td>
<td>Program qualifications are unclear to patients/clients and qualified professionals, which can result in multiple applications being filled out&lt;br&gt;• Lack of communication, coordination in clinical organization (decentralized)</td>
<td>Applications for all Energy Outreach Colorado and LEAP programs be streamlined into one application, similar to the application used to apply for Medicaid/SNAP/cash assistance</td>
</tr>
<tr>
<td>No training/education on available resources or where to access them</td>
<td>Intrinsically complex, constantly changing</td>
<td>Training provided by Energy Outreach Colorado for providers</td>
</tr>
</tbody>
</table>
"You don’t know what you don’t know"

- Organizations manage their own resource lists, and sometimes multiple lists within one organization (siloeed and duplicate lists)
- Mile High United Way 2-1-1 has many resources, but they are not always geographically close to the family or providers aren’t familiar with the resource and don’t want to refer to an unknown/out-of-date resource
- A lot of people do not even know that if you receive LEAP assistance, you receive a lower Xcel kilowatt hour rate
- With more knowledge about available resources, use may increase
- Bolster existing organizations to improve reliability of resource lists
- Designate a point person to receive referrals at organizations (note: requires a back-up person to cover staff vacations or staff turnover, so referrals don’t lapse); or
- Create a standardized referral process with a specific contact number for referrals (i.e. not a specific person but main intake line).
- Treat internet access as a utility – no internet is a huge barrier for accessing all resources

Prioritized gap or barrier to service recommended by community-facing staff for the work group to address:

Closely ranked:
- Difficulty identifying organizations that receive funding and have current funding available
- Difficult application processes: each organization has different rules/guidelines
- Lack of education, knowledge and information on available utility resources

<table>
<thead>
<tr>
<th>Prioritized gap or barrier determined by the work group</th>
<th>Factors contributing to service gaps</th>
<th>Key opportunities and strategies for improvement determined by the work group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address the lack of training and education on available utility resources for patients/clients and community-facing staff</td>
<td>No central spot for resources; time consuming to do on your own Organizations manage their own resource lists, and sometimes multiple lists within one organization Intrinsically complex, constantly changing Lack of communication, coordination</td>
<td>Develop a training program to increase awareness of utility and weatherization programs, eligibility and application processes.</td>
</tr>
</tbody>
</table>
Environmental scan

In spring of 2020, the utilities work group initiated an assessment of other local, state and U.S. programs and promising practices related to service availability and accessibility to inform its community-level quality improvement efforts. The DRCOG AHC project team assists in outreach, research and consolidation of content to complete the scan. See separate addendum submitted to the Centers for Medicare and Medicaid Services for additional information.
Safety

Summary
The safety work group prioritized the most common reported service barrier: lack of knowledge about how to approach and respond to safety-related situations. Lack of training and organizational policy for staff to follow when addressing safety-related situations were the primary contributing factors. The safety work group is exploring survey methods to better identify specific training topics to inform a potential new training curriculum for clinical and community organizations.

Baseline Data and Key Metrics
0.6% of total screenings identified a safety-related need. 2% of screenings with identified needs reported a safety need, making safety the least reported need. Due to the nature of the need, the Denver Regional AHC project team strongly believes the issue is underreported.

Assessment of Available Programs and Services
A list of primary resources AHC partners use to address safety-related needs, organized in the Denver Regional AHC community resource inventory:
**Child and Adult Protective Services:** Every county human services office within the region operates a child protective and adult protective services program for children and at-risk adults experiencing abuse or neglect.

**Welfare Checks:** Every county sheriff’s office provides welfare checks for at-risk adults or individuals in imminent risk for mistreatment.

**Hubs providing referrals to local organizations, programs and services:**
- AARP Foundation ElderWatch
- DRCOG Area Agency on Aging
- Gateway Domestic Violence Services
- National Domestic Violence Hotline
- National Human Trafficking Hotline
- Rape, Abuse and Incest National Network (RAINN) Hotline
- Servicios de la Raza
- Strong Hearts Helpline for Native Americans
- Violence Free Colorado
- The Blue Bench Sexual Assault Hotline
- The Crisis Center Hotline
- The Trevor Project Hotline

**Community-based programs providing direct services:**
- Rose Andom Center
- SafeHouse Denver, Inc.

**Identification and Prioritization of Gaps and Barriers to Service, and Key Strategies and Opportunities for Improvement**

The following chart comprises three sections: 1) gaps and barriers to service, contributing factors, key strategies and opportunities for improvement as reported by community-facing staff who screen and navigate individuals and households to address unmet needs\(^1\); 2) the prioritized gap or barrier to service recommended by community-facing staff for the work group to address\(^2\); and 3) the prioritized gap or barrier to service with key strategies and opportunities for improvement as determined by the work group\(^3\). See the “Safety: Gaps and Barriers to Service Data Sources” in the Qualitative Data Appendix for list of contributing partners.

Work groups strongly consider community-facing staff contributions and determine final prioritized gaps and improvement strategies based on feasibility of effects with available resources within the project timeline.
### Gaps and barriers to service

<table>
<thead>
<tr>
<th>Gaps and barriers to service</th>
<th>Factors contributing to service gaps</th>
<th>Key strategies and opportunities for improvement (short- and long-term)</th>
</tr>
</thead>
</table>
| Staff do not know what to do when asking about safety-related concerns, responding to needs, referring to resources and following up with people | Lack of clinic policies and workflow processes on who can address and track issues | Education/training on how to handle safety-related situations  
Develop work groups at clinics/organizations to discuss policies, and plan for training, workflow |
| Stigma (taboo topic) | Not often talked about  
Lack of provider/staff comfort  
Lack of a person’s comfort  
Discomfort talking about it due to generational experiences and expectations | Training and education for all involved  
Information and resources to break down barriers before the need/discussion arises |
| Bullying among youth (home or school environment) | Lack of resources | Designate social worker to use list of resources/education  
Safe2Tell; anonymous reporting |

### Prioritized gap or barrier to service recommended by community-facing staff for the work group to address:

**Closely ranked:**
- Stigma, people not feeling safe to access available services  
- Lack of clinic policies on who can address/track these issues  
- Limited resources and a lack of knowledge of these resources

**Key opportunities and strategies for improvement:**
- Training within clinical settings to increase confidence about addressing safety-related situations, how to ask questions, respond and identify stages of readiness in people seeking support  
- Role playing and motivational interviewing  
- Consider where screeners come in (workflow)

### Prioritized gap or barrier to service determined by the work group

<table>
<thead>
<tr>
<th>Gaps and barriers to service</th>
<th>Factors contributing to service gaps</th>
<th>Key opportunities and strategies for improvement determined by the work group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of knowledge on how to approach and respond to safety-related situations</td>
<td>Lack of training and organizational policy for staff to follow when asking about and responding to safety-related situations</td>
<td>Increase access to services, improve education and training to promote screening and referral for domestic violence-related needs.</td>
</tr>
</tbody>
</table>
Environmental scan

In spring of 2020, the safety work group initiated an assessment of other local, state and U.S. programs and promising practices related to service availability and accessibility to inform its community-level quality improvement efforts. The DRCOG AHC project team assists in outreach, research and consolidation of content to complete the scan. See separate addendum submitted to the Centers for Medicare and Medicaid Services for additional information.
Transportation

Summary

To reduce duplication of effort and enhance impact, the AHC advisory board did not convene a transportation work group and instead voted to allow the DRCOG AHC project team to support existing transportation improvement efforts. The DRCOG AHC project team will provide the input received from community-facing staff to the Denver metro area’s Coordinated Public Transit Human Services Transportation Plan. The coordinated transit plan incorporates regional stakeholder engagement to better understand the needs of older adults, individuals with low-incomes and disabilities, and guide future transportation improvements. The input received from AHC community-facing staff will be part of a larger effort to advance transportation services across the region.

Baseline Data and Key Metrics

11.1% of total screenings identified a transportation need. 34% of screenings with identified needs reported a transportation need, making transportation the third most prevalent need, closely behind housing (35%).
Assessment of Available Programs and Services

A list of primary resources AHC partners use to address transportation needs, organized in the Denver Regional AHC community resource inventory:

**Community-based programs:** In general, rides must be scheduled one week in advance. Due to limited capacity, most service providers prioritize medical and dental appointments with some availability for grocery store trips. Limited trips are available for daily living activities such as hair appointments or religious services.

- American Cancer Society
- City and County of Broomfield – Easy Ride
- City of Littleton - Omnibus
- Denver Regional Mobility and Access Council
- Douglas County – First Call
- DRCOG Area Agency on Aging
- Hands of the Carpenter
- Littleton Shopping Cart
- Neighbor Network
- Seniors’ Resource Center
- Via

**Public programs: Regional Transportation District (RTD):** Operates bus and rail services throughout the metro area with additional services and discounts for youth, individuals with disabilities and older adults.

- Access-a-Cab
- Access-a-Ride
- fixed route
- FlexRide
- LiVE program
- Senior Ride

**Access2care:** For Denver Health patients only.

**Intelli-Ride:** Manages non-emergency medical and nonmedical transportation for Health First Colorado (Medicaid) members within the state.

**Ride-hailing services:** Lyft, Uber, HopSkipDrive
Identification and Prioritization of Gaps and Barriers to Service, and Key Strategies and Opportunities for Improvement

The following chart comprises three sections: 1) gaps and barriers to service, contributing factors, key strategies and opportunities for improvement as reported by community-facing staff who screen and navigate individuals and households to address unmet needs; 2) the prioritized gap or barrier to service recommended by community-facing staff for the work group to address; and 3) the prioritized gap or barrier to service with key strategies and opportunities for improvement as determined by DRCOG’s AHC project team. See the “Transportation: Gaps and Barriers to Service Data Sources” in the Qualitative Data Appendix for list of contributing partners.

<table>
<thead>
<tr>
<th>Gaps and barriers to service</th>
<th>Factors contributing to service gaps</th>
<th>Key strategies and opportunities for improvement (short- and long-term)</th>
</tr>
</thead>
</table>
| Specific requirements to schedule transportation | - Must be a week in advance  
- Multiple days and appointments are not planned that far in advance to comply with scheduling requirements | - Allow for more flexible scheduling |
| Services not reliable | - People schedule the transportation and then do not receive the ride | - Improve reliability |
| Limited provider options | - Limits where people are able to go  
- Appointments have to be within a certain distance of pick-up location  
- Only provide transportation during certain hours  
- Will only provide transportation for medical appointments | - Expand to more provider choices, locations, purpose for rides (for example, spiritual practice) and hours |
| Many scheduling/ notification systems are automated | - Technology to use is very tricky for older adults to navigate | - None reported at this time |
| People feeling uncomfortable with public transportation | - Safety  
- Cleanliness | - None reported at this time |
<p>| Limited resources available to individuals who do not have Medicaid, are not older | - RTD offers various discounts including the Youth Discount and the LiVE Program, but individuals | - Ability to apply for LiVE program when applying in- |</p>
<table>
<thead>
<tr>
<th>Adults or do not have a disability</th>
<th>are only able to apply for the LiVE program through a Colorado Program Eligibility and Application Kit account</th>
<th>Person or over the phone for any other public benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>People are unfamiliar with the various services that RTD provides</td>
<td>None reported at this time</td>
<td>Education and training for providers and people seeking services</td>
</tr>
<tr>
<td>Eligibility for Medicaid members to use transportation services</td>
<td>Every Medicaid member does not necessarily qualify for non-emergent medical transportation (NEMT)</td>
<td>Anyone who qualifies for Health First Colorado (Medicaid) automatically qualifies for basic transportation benefits</td>
</tr>
<tr>
<td>Logistical challenges for those who currently use nonemergent medical transportation (NEMT)</td>
<td>Travel may involve multiple transfers RTD tickets will be provided to the member who has the appointment and one escort if needed, but the individual must demonstrate need for an escort</td>
<td>Education/coaching on examples of how to demonstrate the need for the additional set of tickets; coordinating appointments as much as possible</td>
</tr>
<tr>
<td>Challenges in mileage reimbursement for Medicaid members</td>
<td>Process is cumbersome/multiple steps involved</td>
<td>Make it one step instead – member is no longer required to set up the mileage reimbursement request before the appointment but instead can request mileage reimbursement using the Medicaid Mileage Reimbursement Request Form when the member attends the appointment</td>
</tr>
</tbody>
</table>
### Challenges using passenger vehicles for Medicaid members

- Must demonstrate the need for traveling with an escort
- Must prove medical/mental health necessity
- Paperwork must be signed by medical staff
- Process is cumbersome especially when completing the Medicaid Level of Service Form

- For families, if one child in the household has a need, then the other children in the household qualify for rides using the passenger vehicle based on the sibling’s need
- When submitting the Level of Service Form for the child with the need, the other siblings’ names, dates of birth, and identification are added to that Level of Service Form so that IntelliRide (Colorado Medicaid transportation provider at time of focus group) can approve all the children for rides
- If a parent/guardian is approved for rides by passenger vehicle through IntelliRide, the other members automatically qualify for rides by passenger vehicle

### Passenger vehicles aren’t available for strictly social-related needs

- Social need situations do not qualify an individual to receive transportation by passenger vehicle

  Example: An individual is experiencing homelessness and uses a mailing address to receive mail. The mailing address is not near where the individual often stays, so the person needs transportation to retrieve their mail

- Specific social situations (for example, homelessness) qualify an individual to receive transportation by passenger vehicle temporarily for three months at a time

### Misunderstanding/lack of awareness about nonmedical transportation (NMT)

- Information is lacking on what nonmedical transportation (NMT) is and who is eligible to receive it

- Education and training about this benefit for providers and people seeking services
Prioritized gap or barrier to service recommended by community-facing staff for the work group to address:

Closely ranked:
- Reliability of transportation services
- Lack of resources for people who do not have Medicaid, a disability, aren’t older adults or for people in special social situations (for example, homelessness)
- Transportation for nonmedical appointments

<table>
<thead>
<tr>
<th>Prioritized gap or barrier to service determined by DRCOG AHC project team</th>
<th>Factors contributing to service gaps</th>
<th>Key opportunities and strategies for improvement determined by DRCOG AHC project team</th>
</tr>
</thead>
<tbody>
<tr>
<td>The need for increased advocacy for older adults, people with disabilities and people with low incomes to inform regional transportation improvements efforts</td>
<td>Older adults, people with disabilities and people with low incomes have different experiences and challenges accessing transportation services</td>
<td>Contribute input from Denver Regional AHC community-facing staff to inform the Coordinated Public Transit Human Services Transportation Plan</td>
</tr>
</tbody>
</table>

Environmental scan

In late spring/summer of 2020, the Denver Regional AHC project team will complete an assessment of other local, state and U.S. programs and promising practices related to service availability and accessibility to inform its community-level quality improvement efforts. The DRCOG AHC project team will consult with the AHC advisory board and will complete the outreach, research and consolidation of content to complete the scan. See separate addendum submitted to the Centers for Medicare and Medicaid Services for additional information.
Technical and Quantitative Data Appendix

Community Profile: Denver Regional AHC Service Area Map

Map 1. Denver Regional Accountable Health Community Service Area: Highest Concentrations of Screened Households: Constructed using a kernel density tool which determines the density of screenings per square mile. The four shades of color on the map show the various densities of screenings based on beneficiary addresses. Shades are delineated by quartiles, meaning that the lightest color represents 25% of screening density; the next shade represents 25% more of screening density and so forth up to 100%. Density screenings are used instead of specific beneficiary addresses to protect beneficiary identity and privacy. Addresses that listed P.O. boxes, homeless statuses or an invalid street name or ZIP code were omitted.

Current State Assessment of Population and Community Needs

Identification of at-risk census tracts

Using 2018 American Community Survey (ACS) 5-Year tract level estimates, Denver Regional AHC project team calculated 11 measures for each census tract in the AHC service area.

<table>
<thead>
<tr>
<th>ACS measure</th>
<th>ACS description</th>
<th>ACS ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent nonwhite/non-Hispanic</td>
<td>Percent of persons in the census tract that identify as nonwhite/non-Hispanic</td>
<td>B03002</td>
</tr>
<tr>
<td>Percent below poverty line</td>
<td>Percent of households in the census tract with income below the federal poverty line for the last 12 months</td>
<td>B17017</td>
</tr>
<tr>
<td>Percent older adults</td>
<td>Percent of persons 60 and over</td>
<td>B01001</td>
</tr>
<tr>
<td>Percent under 18</td>
<td>Percent of persons under 18 years old</td>
<td>B01001</td>
</tr>
<tr>
<td>Percent minority</td>
<td>Percent of persons who identify as a race other than white only</td>
<td>B02001</td>
</tr>
<tr>
<td>Percent low education</td>
<td>Percent of persons 25 and older with less than high school education</td>
<td>B06009</td>
</tr>
<tr>
<td>Percent without health insurance</td>
<td>Percent of persons without health insurance coverage</td>
<td>B27001</td>
</tr>
<tr>
<td>Percent with disability</td>
<td>Percent of persons with a disability</td>
<td>B18101</td>
</tr>
<tr>
<td>Percent on assistance</td>
<td>Percent of households with cash public assistance or Food Stamps/Supplemental Nutrition Assistance Program</td>
<td>B19058</td>
</tr>
<tr>
<td>Percent born outside of the United States</td>
<td>Percent of persons born outside of the United States, both naturalized U.S. citizens and not a U.S. citizen</td>
<td>B05002</td>
</tr>
<tr>
<td>Median portion of income to rent</td>
<td>Median gross rent as percentage of household income in the past 12 months</td>
<td>B25071</td>
</tr>
</tbody>
</table>
After constructing the above measures, census tracts in the top quartile for each measure were identified. If a census tract was in the top quartile for six or more of the above measures, it was identified as at-risk.

**Identification of high AHC screening density census tracts**

All addresses provided during screenings were geocoded to allow assignment to a census tract. Data for individuals that identified as homeless, provided a post office box or provided addresses that couldn’t be assigned to a known location were excluded.

Density of AHC screenings were calculated as AHC screenings per 1,000 population in each census tract. High screening areas were defined to include all census tracts with densities of screenings in the top quartile.

**At-risk census tracts vs. high-screened AHC census tracts**

The American Community Survey accounts for “foreign born” individuals. The Denver Regional AHC chooses person-centered language and opts for “individuals born outside the U.S.” in this report.
Qualitative Data Appendix

Current State Assessment of Service Availability and Accessibility

Disclaimer: Content in the Summary of Gaps and Barriers to Service is reported from the data sources listed during the specified date. Content is not verified or altered for accuracy. It is included as a summary of the experiences of the contributors, and furthermore used to guide the direction of priority-setting for the work group.

Food Security: Gaps and Barriers to Service Data Sources

1Discussion with six staff (navigators, care managers) representing four clinical partner sites (primary care, home health): Denver Health Westside clinic, Doctors Care, Dominican Home Health Agency, STRIDE Community Health Center, September 2019. Additional input from two Denver Health emergency department navigators, February 2020.

2Follow-up discussion with 10 staff (dieticians, care managers, navigators) representing five clinical sites (primary care, behavioral health, home health): Denver Health Westside clinic, Doctors Care, Dominican Home Health Agency, Jefferson Center for Mental Health, Tri-County Health Department, Jan. 28, 2020.

3Food Security work group discussion, June 3, 2019.

Housing Security and Quality: Gaps and Barriers to Service Data Sources

1Discussion with six staff (navigators, care managers) representing four clinical partner sites (primary care, home health): Denver Health Sam Sandos Westside Family Health Center, Doctors Care, Dominican Home Health Agency, STRIDE Community Health Center, September 2019.

2Follow-up discussions with 10 staff (dieticians, care managers, navigators) representing five clinical sites (primary care, behavioral health, home health): Denver Health Sam Sandos Westside Family Health Center, Doctors Care, Dominican Home Health Agency, Jefferson Center for Mental Health, Tri-County Health Department, Jan. 28, 2020; and with 12 staff (dieticians, care managers, navigators) representing six clinical partner sites (primary care, home health): Denver Health Sam Sandos Westside Family Health Center, Denver Health Emergency Department, Doctors Care, Dominican Home Health Agency, STRIDE Community Health Center, Tri-County Health Department, March 9, 2020.

3Housing work group discussion, March 30, 2020.
Utilities: Gaps and Barriers to Service Data Sources

1Discussion with six staff (navigators, care managers) representing four clinical partner sites (primary care, home health): Denver Health Sam Sandos Westside Family Health Center, Doctors Care, Dominican Home Health Agency, STRIDE Community Health Center, September 2019. Additional input from two Denver Health emergency department navigators, February 2020.

2Follow-up discussions with 10 staff (dieticians, care managers, navigators) representing five clinical sites (primary care, behavioral health, home health): Denver Health Sam Sandos Westside Family Health Center, Doctors Care, Dominican Home Health Agency, Jefferson Center for Mental Health, Tri-County Health Department, Jan. 28, 2020; and with 12 staff (dieticians, care managers, navigators) representing six clinical partner sites (primary care, home health): Denver Health Westside clinic, Denver Health Emergency Department, Doctors Care, Dominican Home Health Agency, STRIDE Community Health Center, Tri-County Health Department, March 9, 2020.

3Utilities work group discussion, In progress.

Safety: Gaps and Barriers to Service Data Sources

1Discussion with six staff (navigators, care managers) representing four clinical partner sites (primary care, home health): Denver Health Sam Sandos Westside Family Health Center, Doctors Care, Dominican Home Health Agency, STRIDE Community Health Center, September 2019.

2Follow-up discussion with 10 staff (dieticians, care managers, navigators) representing five clinical sites (primary care, behavioral health, home health): Denver Health Sam Sandos Westside Family Health Center, Doctors Care, Dominican Home Health Agency, Jefferson Center for Mental Health, Tri-County Health Department, Jan. 28, 2020.

3Safety work group discussion, July 23, 2019

Transportation: Gaps and Barriers to Service Data Sources

1Discussion with six staff (navigators, care managers) representing four clinical partner sites (primary care, home health): Denver Health Sam Sandos Westside Family Health Center, Doctors Care, Dominican Home Health Agency, STRIDE Community Health Center, September 2019. Additional input from two Denver Health emergency department navigators, February 2020.

2Follow-up discussion with 10 staff (dieticians, care managers, navigators) representing five clinical sites (primary care, behavioral health, home health): Denver Health Sam Sandos Westside Family Health Center, Doctors Care, Dominican Home Health Agency, Jefferson Center for Mental Health, Tri-County Health Department, Jan. 28, 2020.
3DRCOG AHC project team, March 2020, supported by the Denver Regional AHC Advisory Board approval in October 2019 for the project team to advocate for transportation improvements outside of work group activities.

Environmental Scans

See separate addendum coinciding with the publication of this report to view environmental scans for each health-related social need work group.

Photo Contributions

The photos depicted on the front and back cover of this report are from the AHC Food Security work group’s food resource fair. Media releases with permission to share photographs were obtained from participants.