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DENVER REGIONAL COUNCIL OF GOVERNMENTS

Denver Regional Accountable Health Community (AHC)

Gap Analysis – Year 2

Contents

Abstract

The Denver Regional Accountable Health Community's second gap analysis identifies the gaps in delivering community-based services to address health-related social needs to Medicare and Medicaid beneficiaries in a predefined geographic target area. Within the predefined area are focus areas identified to contain people expected to have potentially higher health risks due to socioeconomic indicators. The characteristics of the population screened and provided navigation to community-based services correlated with the overall population characteristics of the target and focus areas, which indicates that the people expected to benefit most from services based on socioeconomic indicators were reached. While the capacity of community-based services to respond to high demand is limited, the most prevalent gap identified was the connection to — or accessibility of — community-based services from clinical settings. Accountable Health Communities project staff have prioritized overcoming challenges of access as means to address health-related social needs in the region through the integration of community health providers and clinical health providers.

Denver Regional Accountable Health Community Partners

Organization
Aurora Mental Health Center
Brothers Redevelopment
Centura Health
Denver Health
Energy Outreach Colorado
Jefferson Center for Mental Health
Jewish Family Service
STRIDE Community Health Center (formerly Metro Community Provider Network)
Project Angel Heart
Seniors' Resource Center
The Town of Littleton Cares (TLC) Meals on Wheels
Volunteers of America Colorado Branch
Violence Free Colorado (formerly Colorado Coalition Against Domestic Violence)

Introduction

In May 2017, the Center for Medicare and Medicaid Innovation awarded funding to the Denver Regional Council of Governments (DRCOG) and its established consortium of clinical and community health partners to determine the impact of addressing five health-related social needs (HRSNs) on health care costs and quality outcomes. During the five years of funding, the consortium will screen community-dwelling Medicare and Medicaid beneficiaries to evaluate the need for community assistance to address housing security and quality, food security, utility assistance, transportation or interpersonal violence.

As the second year of funding and the first year of operations come to a close, the Denver Regional Accountable Health Community (AHC) completed its second annual gap analysis. The analysis provides the AHC and its stakeholders with information and direction on how to close identified gaps to improve the delivery of community-based services in the region. The gap analysis is based on data generated by the U.S. Census Bureau and AHC consortium as well as qualitative information from bridge organization staff, the AHC advisory board and clinical navigators. The report serves as a guide for the AHC advisory board in prioritizing and working to close the identified gaps in community services during the year to come.

This report presents background on DRCOG as the bridge organization, an outline of methods and approach, successes and limitations of AHC implementation to-date, data describing the community served, a description of existing social services and community-based services, gaps in provision of community-based services and strategies to address identified gaps.

Background and Purpose

Background

DRCOG is a quasi-governmental association of 58 local governments serving a region that is home to 3.2 million people, more than half of the state's population. Through DRCOG, local governments establish guidelines, set policy and allocate funding. Among other roles, DRCOG operates as the federally designated Area Agency on Aging (AAA), and is responsible for assessing, planning, offering and coordinating services for older adults across an eight-county region. The AAA allocates federal and state funding for programs mandated by the Older Americans Act and the Older Coloradans Act, funding 45 services offered through 27 organizations. Essential services for older adults include nutrition, rides to medical and nonmedical appointments, personal care, minor home repairs and maintenance, and legal assistance.

DRCOG and the AAA's activities are guided by a board of directors comprising local elected officials, an executive team and an operational team of service delivery and data analysis experts. In-house technology professionals prepare spatial and tabular data in support of regional planning and modeling as well as the AHC.

As an AAA, DRCOG provides direct services to older adults (60-plus) and individuals with disabilities (18 and older), including community-based case management, transition services, options counseling, ombudsman services, Medicare counseling and an information and assistance phone line. The AAA also operates a network of community service providers that address more than 35 social needs such as transportation, food security and legal services for older adults.

In addition to the background and knowledge of social needs of the bridge organization, the AHC's strength is enhanced by each consortium partner's expertise and participation. The AHC advisory board has convened, with robust participation, once a month since funding was awarded in 2017 to review the program's operations, identify strengths and discuss ways to overcome challenges. The clinical navigators have met monthly since operations commenced in May 2018 to share best practices, plan and implement rapid-cycle improvement strategies. AHC project staff are especially pleased with the clinical and community integration of the navigator meetings. Community partners regularly offer to host navigator meetings, which promotes greater understanding among partners of the breadth and sophistication of community-based organizations in the AHC and their role in addressing HRSNs.

The Denver Regional Accountable Health Community is a consortium of contracted clinical and community-based partners and other stakeholders that have formed a partnership to determine the effects of identifying and addressing the HRSNs of community-dwelling Medicare and Medicaid beneficiaries in the Denver metro area. The consortium is entering its third year of funding and is working on three core areas: first, to create and streamline clinical workflows to efficiently identify individuals with social needs and refer them to community-based organizations for assistance; second, to successfully enroll people in and initiate services to address their needs; third, to create and integrate a formal coalition of organizations to work together to improve the health of the community and its residents. The consortium's self-defined mission and vision statements 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.

Purpose

The analysis will be used by the AHC advisory board to address the gaps identified and by the consortium to work together to close those gaps. Further, the consortium will use the analysis as a benchmark for measuring the success of its work in the months and years to come. While preparing the gap analysis is required for AHC funding, the Denver Regional Accountable Health Community also considers it an opportunity to work collaboratively across multiple sectors of health care to increase the delivery of essential community-based services. As will be made clear in the analysis that follows, there are significant and avoidable gaps in the delivery of vital community services and such gaps directly affect the cost of healthcare and health outcomes in the region.

Method and Approach

To determine the gaps in community-based services, Accountable Health Communities project staff took a three-pronged approach to developing this document. First, they defined the population by geography and demographic characteristics in the predefined geographic target area (see "Current State Assessment: Population/Community Characteristics" below).

Second, project staff describe the availability and accessibility of existing social service and community-based programs available to that population (see "Current State Assessment: Service Availability and Accessibility" below).

Third, project staff identify the access gaps in the provision of community-based services by analyzing the data collected by community partners and through a representative vignette to explore the time, financial, and logistical difficulties individuals face when accessing and receiving community-based services. In this section, a descriptive analysis explores access and service difficulties not readily discernible from available quantitative data sets. The information in the third section is informed by operational experience, reports from clinical navigators and AHC advisory board members.

This analysis is confined to a predetermined geographic target area, a physical boundary defined by the community-dwelling Medicare and Medicaid beneficiaries served by the AHC's clinical partners. As required by the AHC Funding Opportunity Announcement in April of 2016, DRCOG, as the bridge organization, drew a boundary around the Denver region that encompasses 51% of the Medicare and Medicaid beneficiaries who were treated by the consortium's clinical partners in the 12 months prior to April 2016. As a result of analysis in the project start-up period (May 2017 to April 2018) three geographic focus areas emerged within the 51% boundary that contained areas of greater need.

The AHC focus areas are:
(i) west Denver between 6th Avenue, Jewell Avenue, Interstate 25 and Federal Boulevard
(ii) west Aurora between Quebec Street and Tower Road along East Colfax Avenue and
(iii) north Federal Boulevard corridor between I-25 and 120th Avenue.

As the bridge organization, DRCOG defined the focus areas as a set of contiguous census tracts. Therefore, tracts with fewer low-income populations surrounded by tracts with a high share of low-income populations were included in the focus areas. AHC project staff determined that the overall composition of a neighborhood was more important than income. Specifically, a tract with higher relative income surrounded by tracts with a significant share of low-income populations is likely affected by the context of poverty that surrounds it.

Findings

This analysis determined a gap between the need for and the delivery of community-based services in the Denver region. The gap, identified by the AHC through preliminary quantitative and qualitative data, indicates that while there is limited availability of certain community resources, the accessibility of resources is a significant challenge spanning all HRSNs, limiting the ability of people to connect to the resources that could address their needs.

At the outset of operations in May 2018, project staff believed that gaps in community service would be identified in geographic locations in the region where community-based organization services were not available due to limited monetary or staffing resources. Project staff expected that examples might include rural communities that required more staff time and travel to deliver services than is economically feasible, or resource-seeking individuals who speak languages other than those spoken by community-based organization staff. However, based on both qualitative and quantitative data, project staff found their previous assumption did not hold. Instead, project staff determined that the major gaps in service to address the HRSNs among Medicare and Medicaid beneficiaries in the Denver region target area are not merely based on the availability of community-based organization services, but rather, the accessibility of such services. Community-based organizations provide services, but barriers prevent individuals and families from successfully receiving services. Such barriers include operational difficulties (such as lack of reliable phone communication allowing for contact with service providers), the significant time required to identify, locate and access community-based organizations and the substantial experience needed to successfully interact with clinical and community-based providers.

Success and Limitations

In its first year of operations, the Denver Regional AHC achieved many successes and identified the most critical areas for future improvement.

This analysis highlights the following successes:

- **Coverage in the west Denver focus area**, a neighborhood previously identified as a focus area due to high social risk indicators, represented 37.5% of the population screened by the AHC clinical partners.
- **Serving vulnerable populations.** The population that AHC clinical partners screened corresponds to low-income residents, minorities and individuals with lower educational attainment. The analysis shows that needs among such populations relate to food security and transportation, even when they live in areas with a relatively dense network of community-based services. The populations receiving navigation services from AHC partners appear to be even more vulnerable: 23.5% report an annual income under $10,000 and 65.4% report an annual income under $35,000. Moreover, the AHC is reaching individuals in the community who are most vulnerable based on social and health risk indicators.
- **Serving people younger than 18.** AHC partners screened 5,921 individuals under age 18. Understanding that the health detriments from unmet social needs are iterative and compounding, AHC project staff understand it's paramount to change the social trajectories of children to promote greater wellness in youth into adulthood and older adulthood. With a significant amount of its screenings being completed with a pediatric population, the AHC is detecting social needs, addressing them and promoting the health of the region's youth.

This analysis identifies potential limitations and avenues for improvement:

- **Heterogeneous geographic coverage.** While certain neighborhoods in the target and focus areas have been successfully covered by the AHC, the AHC service rates in other vulnerable neighborhoods are lower (see figures 11, 12, 13 and 15). The AHC will monitor those geographical gaps and propose in its quality improvement plan solutions to remove administrative and operational hurdles that limit screening coverage in less-served neighborhoods.
- **Heterogeneous data quality.** Although the AHC collects rich data on the clinical side of operations and tracks every screening and navigation case, data from the community service side is less robust. Clinical providers do not necessarily refer beneficiaries to community-based organizations contracted to share data with the AHC if another community-based organization is better suited to meet the individual's needs. This limits the AHC's ability to identify whether a beneficiary successfully connected with a community-based service beyond the information provided in navigation case data collected by clinical providers. However, the bridge organization

is fully committed to close data gaps and will prioritize expanding its outreach and contracts with community-based organizations as a part of its upcoming quality improvement activities.

- **Operational data consistency.** This analysis highlights that administrative and operational challenges including start-up, clinical staff changes, and lapses in communication among clinical providers, community providers and beneficiaries limit the AHC project staff's ability to fully grasp the effects of the AHC consortium's efforts on the populations it serves. Project staff expect the AHC's planned quality improvement activities will help overcome these initial challenges.
- **Legal barriers to data collection.** Collecting data on beneficiaries referred to community-based organization services in cases of interpersonal violence is prohibited by Colorado state statute. Therefore, the AHC does not analyze the collected data related to interpersonal violence in the ensuing analysis. As a result, this analysis only presents findings related to four HRSNs.
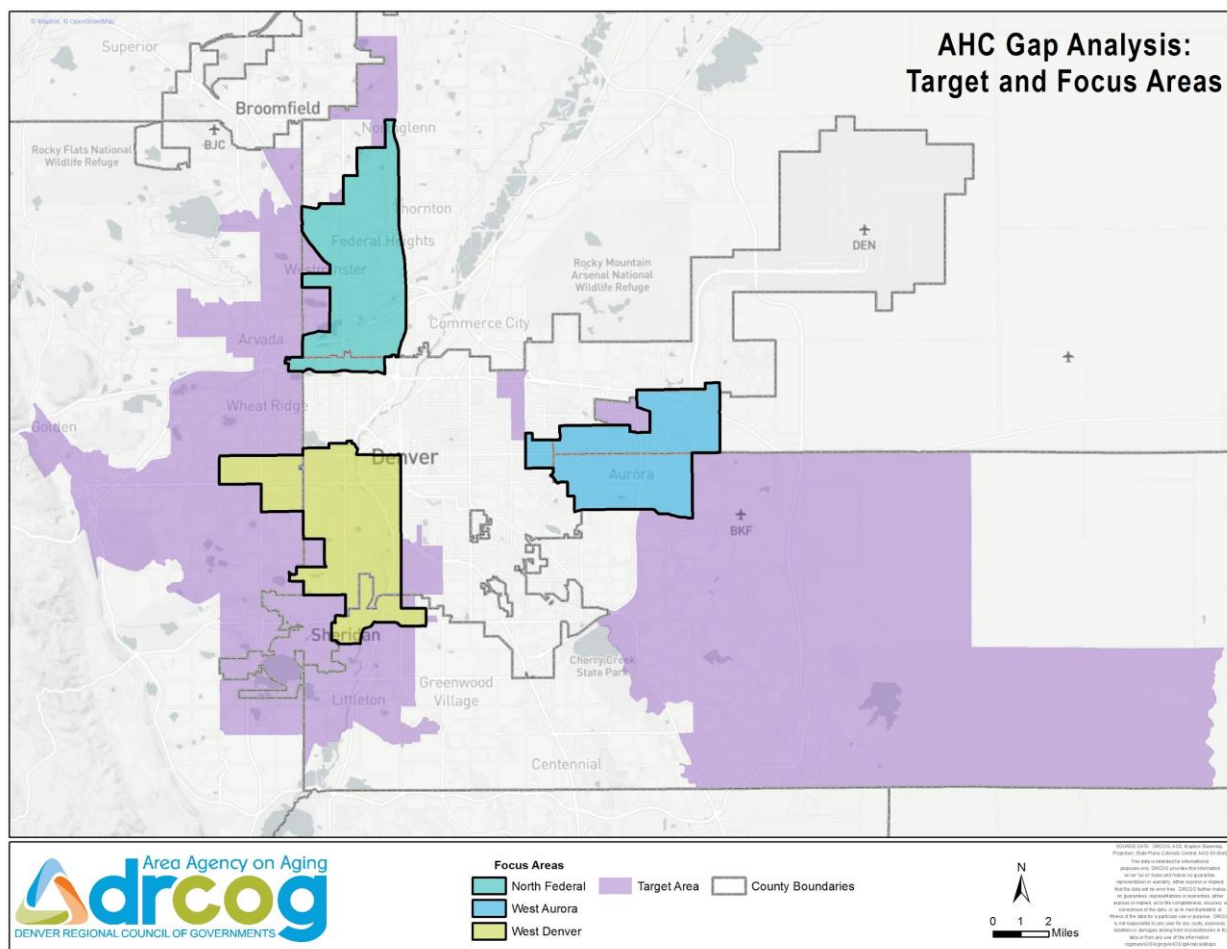
Figure 1: *AHC target area and focus areas. Focus areas are identified using census tract-level counts of the population under the federal poverty level. Source: U.S. Census Bureau (American Community Survey, 2017).*

Percent of Population Below Poverty Level

% of Population	Focus Areas	
0.0 - 3.0	North Federal	County Boundaries
3.1 - 6.0	West Aurora	Interstates
6.1 - 9.9	West Denver	Highways
10.0 - 16.9	Target Area	
17.0 - 80.6		

Figure 2: *Percent of the population below federal poverty level within the AHC target and focus areas.*
Source: U.S. Census Bureau (American Community Survey, 2017).

I. Current State Assessment: Population/Community Characteristics

This section covers the characteristics of the AHC target area and focus areas and documents that the target area covers the most vulnerable populations, including those that are low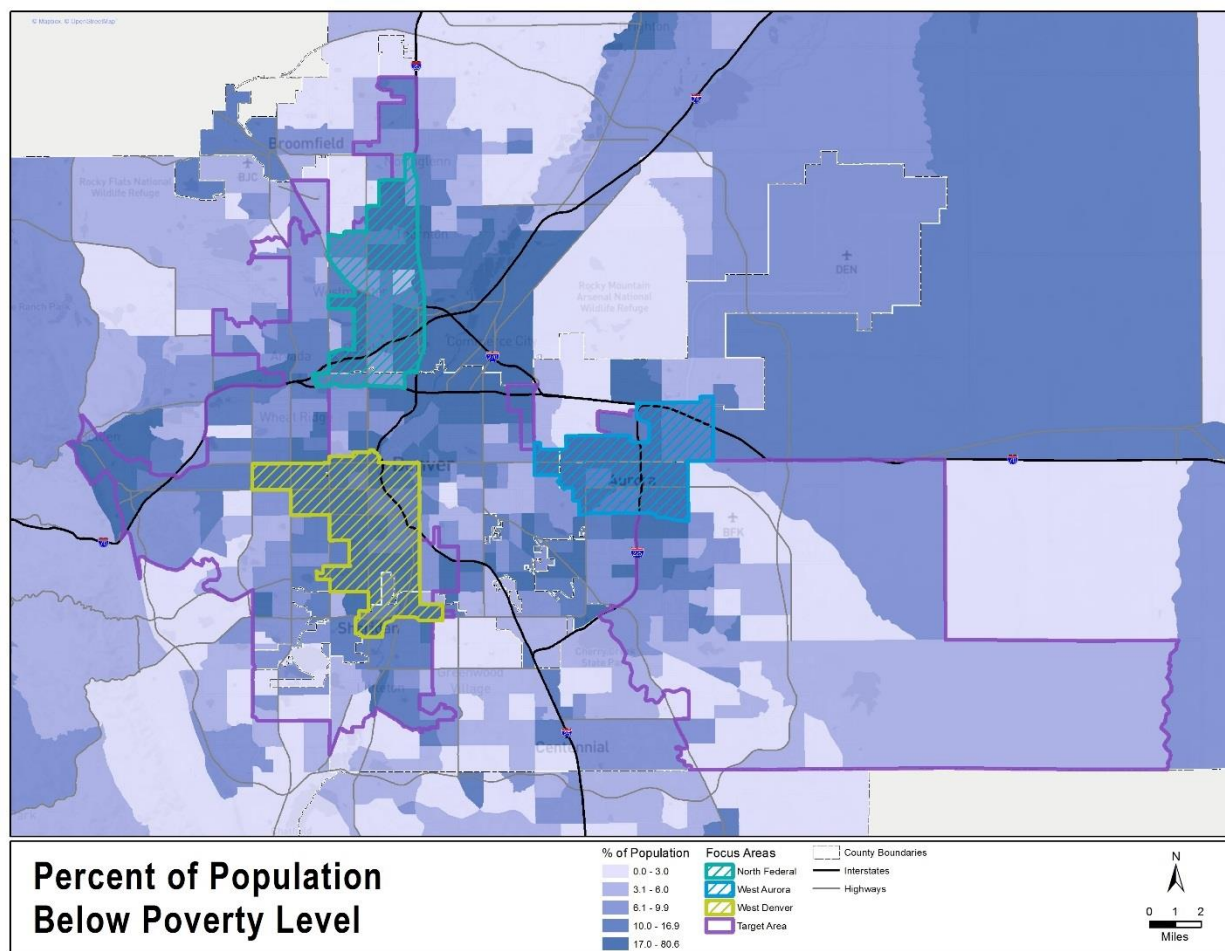-income, 65 and older and rent burdened. It also emphasizes the diversity of the population the AHC project reached, including minorities and residents of neighborhoods under gentrification pressure. This section identifies as a potential limitation the lower service rates of the AHC project among African-American populations.

A. Coverage of Vulnerable Populations

DRCOG identifies three types of vulnerabilities that are likely to trigger needs for food, transportation, utilities and housing:

- low-income populations
- population 65 and older
- rent-burdened population

The AHC target area represents 37% of the households living in the six counties of Adams, Arapahoe, Broomfield, Denver, Douglas and Jefferson. Project staff intend for it to target lower-income populations that are more likely to be enrolled in Medicaid (see Table 1).

Within the target area, three focus areas include communities where data indicates the most vulnerable populations reside. These focus areas contain 122,925 households and 377,000 individuals. The focus areas account for 30% of households and 32% of individuals in the overall AHC target area.
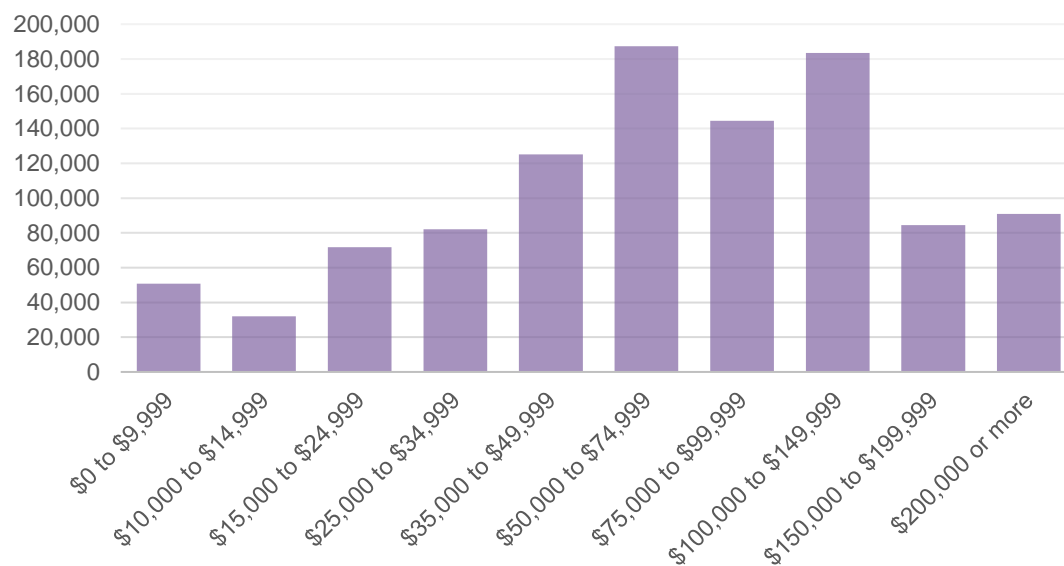
	Six Counties	AHC target area	North Federal	West Aurora	West Denver
Number of households	1,052,575	434,025	39,350	36,340	56,502
Population	2,742,181	1,152,912	112,552	107,053	157,363
Household size	2.57	2.62	2.83	2.92	2.76
Families (%)	63.06	62.29	64.54	60.12	56.43
Grandparents living with grandchildren (%)	3.30	3.93	5.61	6.41	5.55
Living Alone (%)	14.45	14.43	12.72	14.32	15.97
Households with income less than $20,000 (%)	11.02	13.43	14.82	21.30	24.23
Unemployed (%)	4.56	5.11	5.78	8.11	5.39
In labor force (%)	71.62	70.34	69.63	69.22	66.75
With cash public assistance or food stamps/SNAP (%)	7.84	10.35	14.80	21.32	18.87
Foreign born (%)	12.47	14.67	19.96	30.09	24.14
Uninsured (%)	9.43	12.14	17.92	22.39	20.43
Medicaid (%)	14.31	18.51	25.09	33.95	31.97
With a disability (%)	9.31	10.35	12.83	10.47	10.09
Hispanic or Latino (%)	23.24	29.89	51.95	47.13	57.07
African American (%)	5.71	6.42	1.32	18.58	3.81
Rent over 30% (%)	47.97	51.52	55.49	57.91	51.71

Table 1: *Socioeconomic indicators in the AHC target area and focus areas. Source: U.S. Census Bureau (American Community Survey, 2017).*

Income

Analyzing income distribution in west Denver and west Aurora reveals higher density of households with annual income less than $35,000 than the rest of the AHC target area (Figure 3). In these focus areas, 16% to 20% of households earn less than $15,000 per year. Poverty, albeit less pronounced, is still an issue along the north Federal corridor, where 21% of households earn less than $25,000 a year. Moreover, within the larger AHC target area, 48% of households that earn less than $15,000 per year are located in one of the three focus areas.

SIX COUNTIES

AHC TARGET AREA

NORTH FEDERAL

WEST AURORA

WEST DENVER
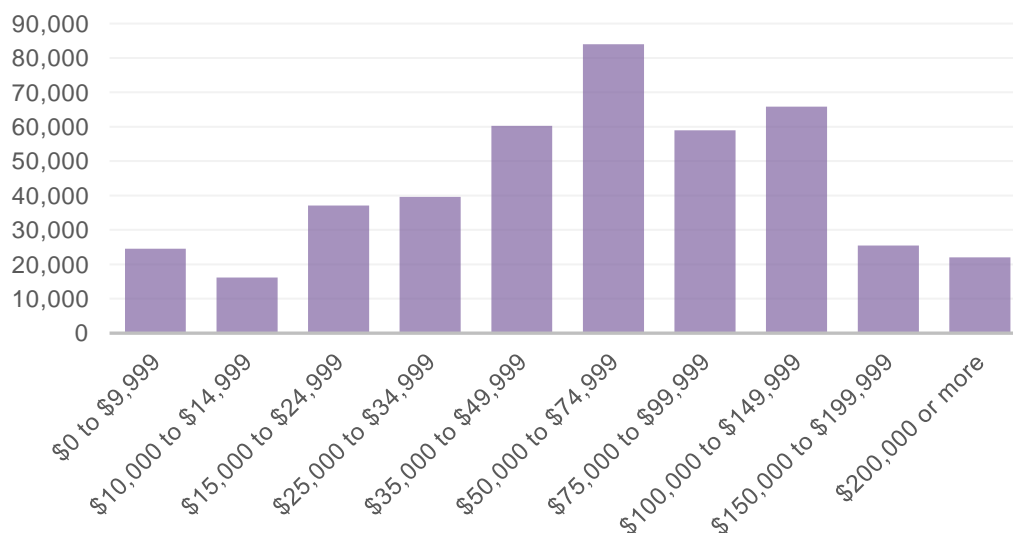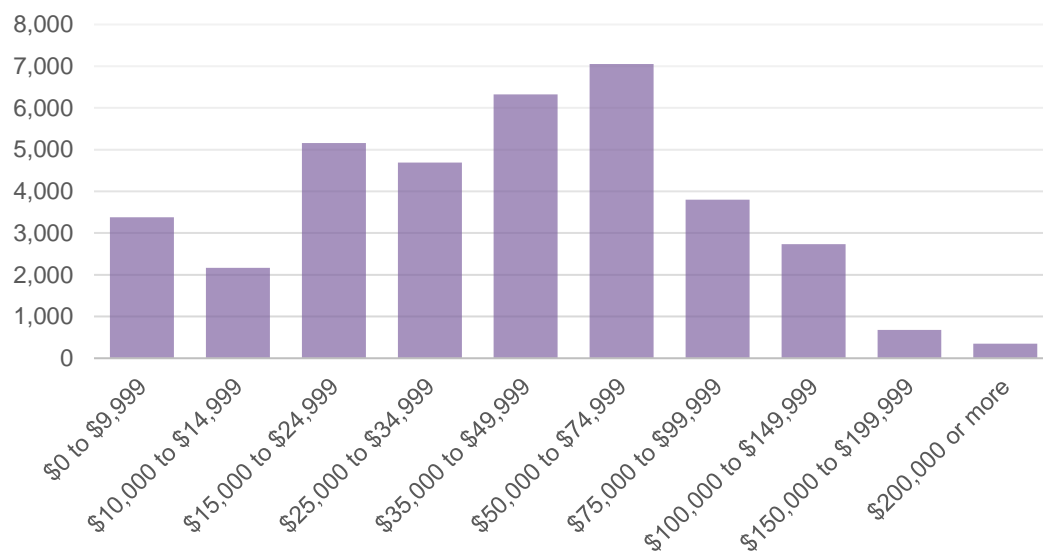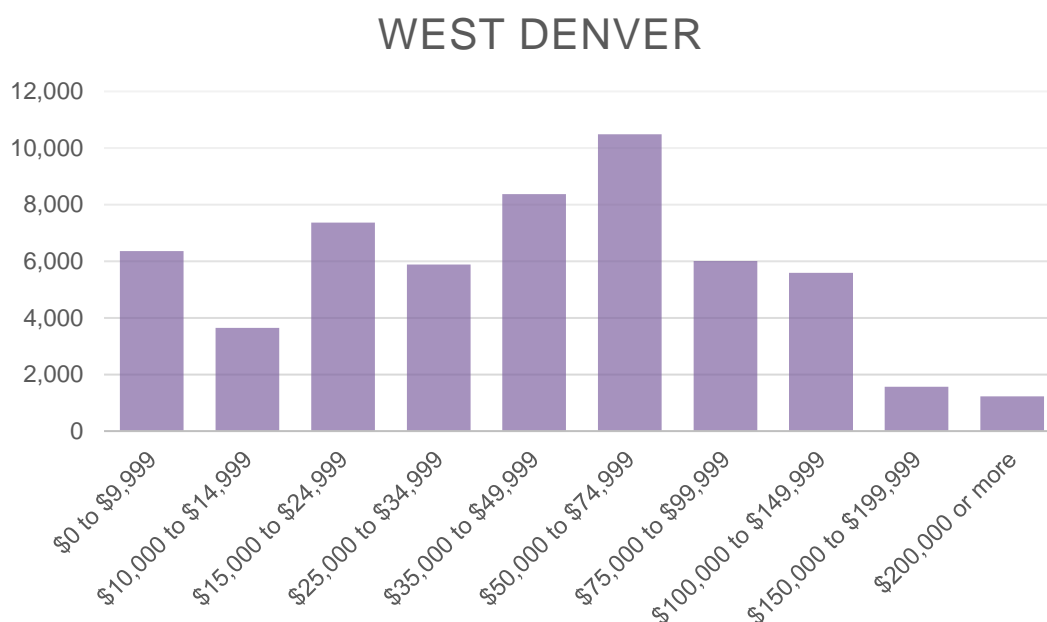
Figure 3: *Income distribution in all six counties, the AHC target area and focus areas. Source: U.S. Census Bureau (American Community Survey, 2017).*

Demographics

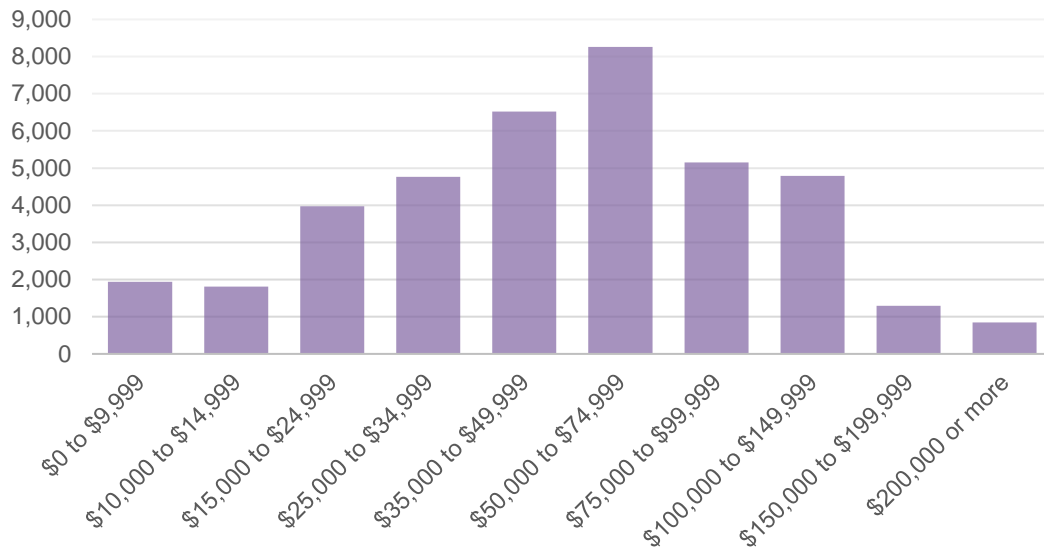Demographic trends in the AHC target area are characterized by a decreasing share of population under 20 years old and a large population between 25 and 34 years of age. The AHC target area is characterized by a substantial number of women aged 80 years or older.

However, Figure 4 and Figure 5 show that the focus areas have a larger percentage of population aged 25 to 34 but are less representative of the population 65 and older residing in the larger AHC target area. A potential gap in service delivery is due to most of the census tracts with a greater percentage of residents aged 65 and older located in periphery of the target area, where AHC consortium service rates are lower (see Section III).
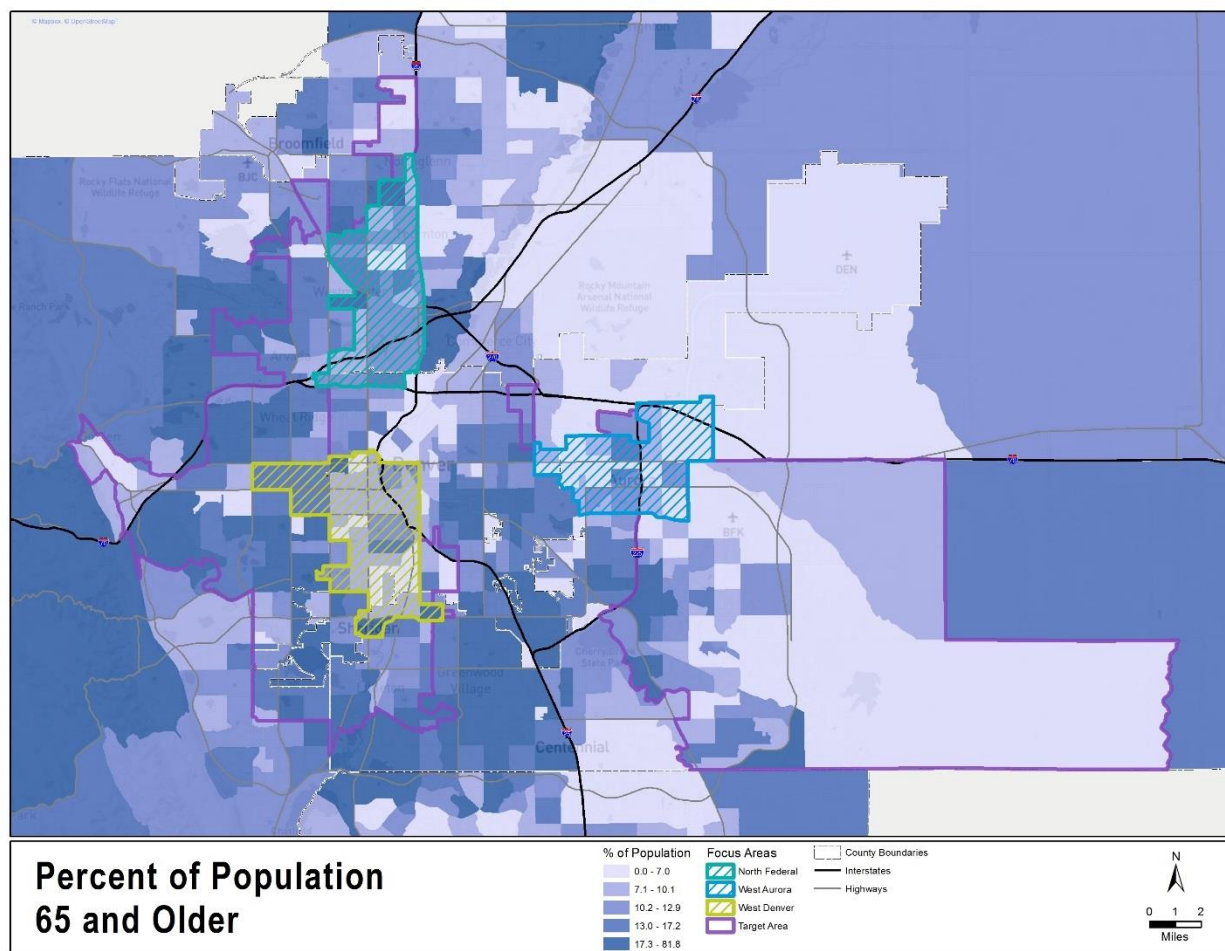
Figure 4: Share of populations aged 65 and older. Source: U.S. Census Bureau (American Community Survey, 2017).

Six Counties' Population by Age and Gender
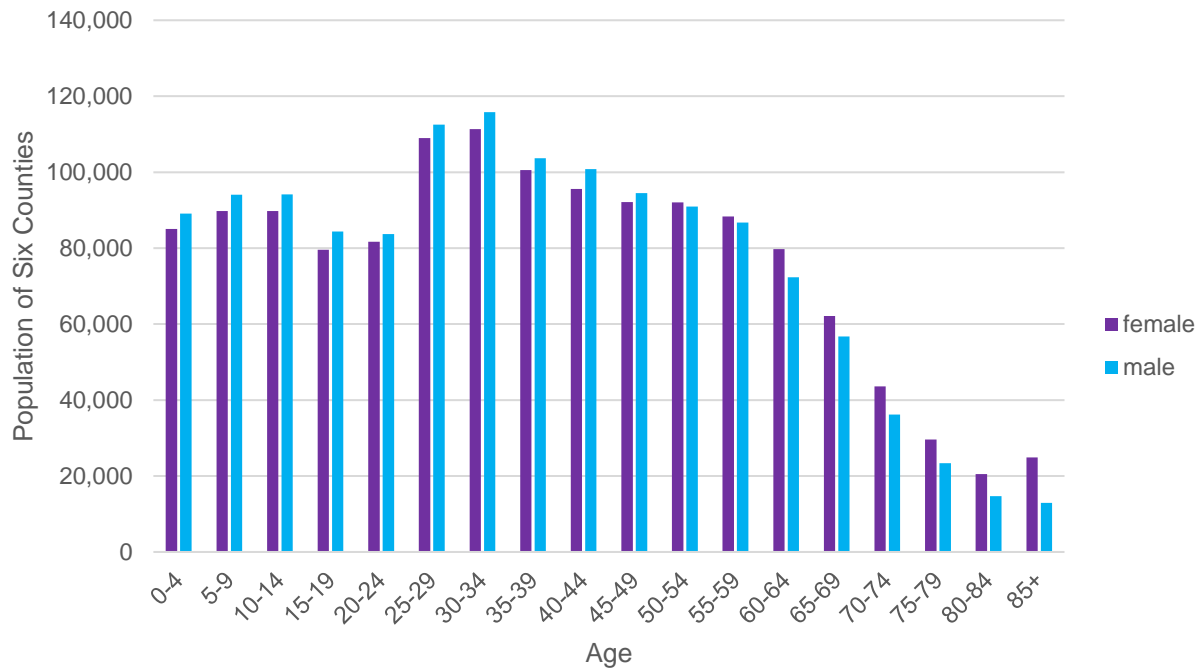
AHC Target Area Population by Age and Gender
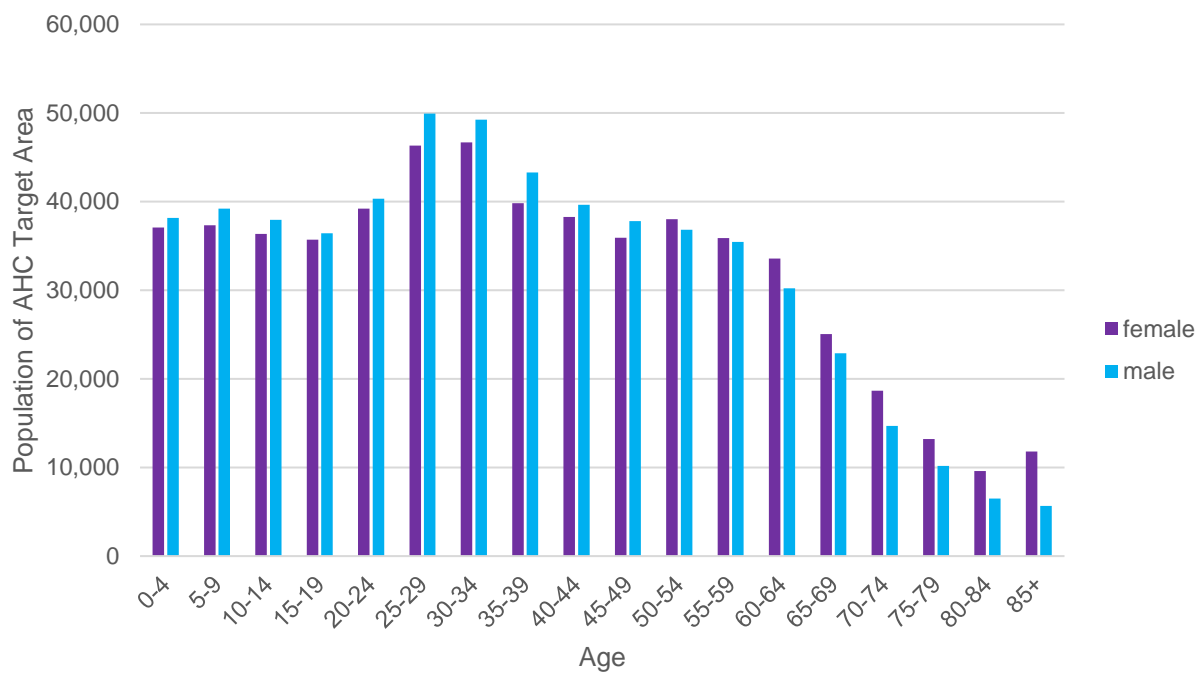
North Federal Population by Age and Gender
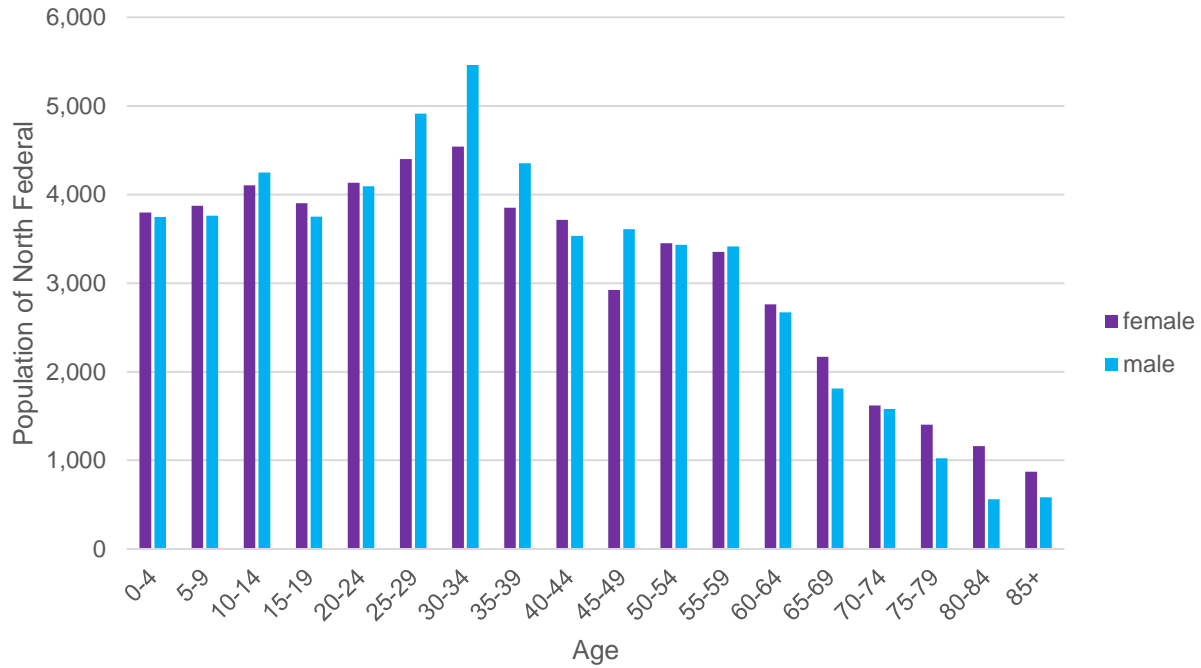
West Aurora Population by Age and Gender

West Denver Population by Age and Gender
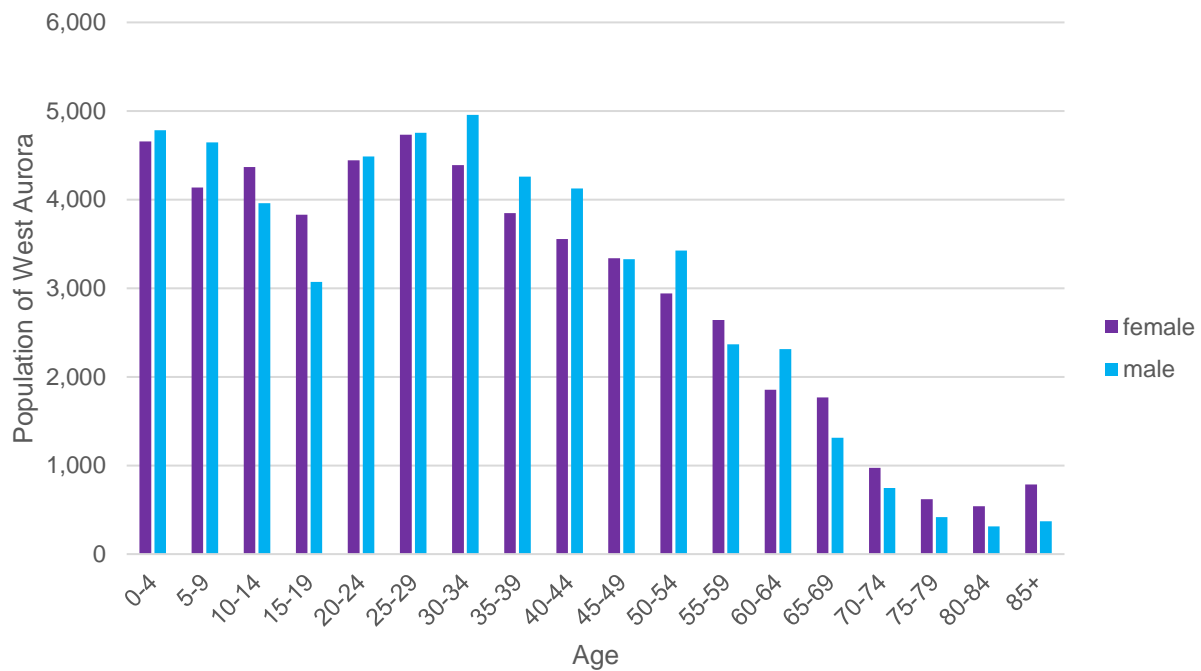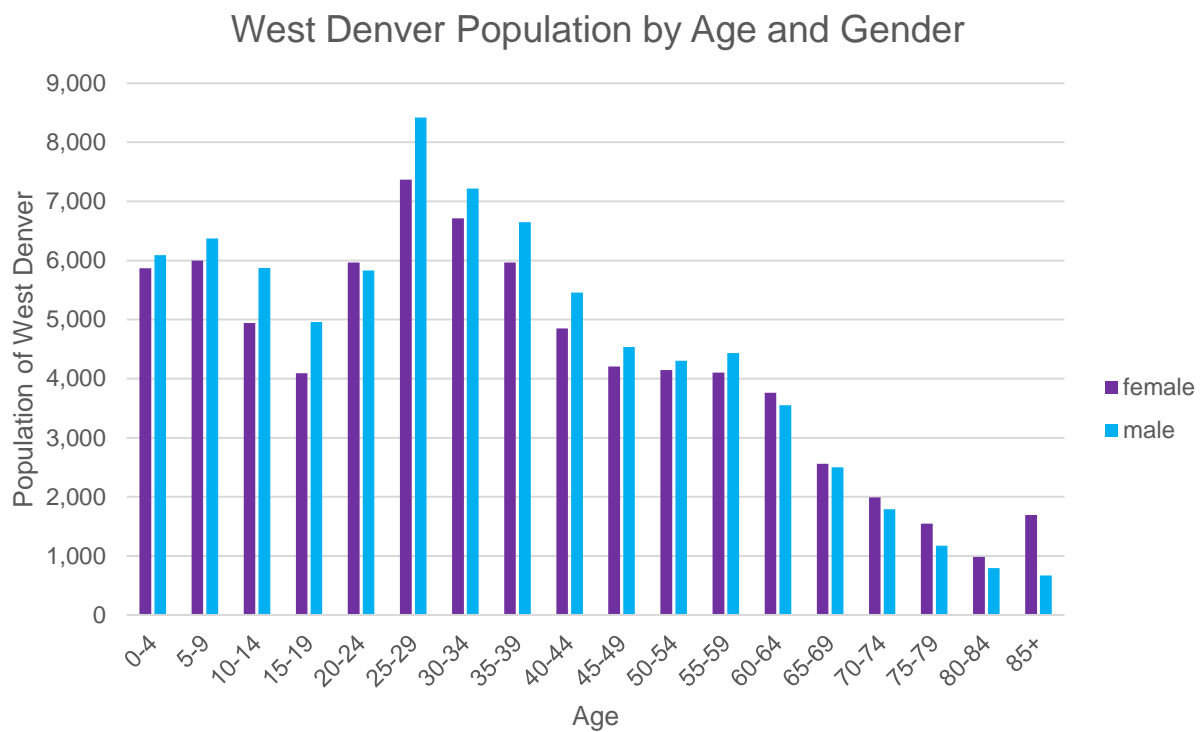
Figure 5: *Age distribution in the focus areas and in the AHC target area. Source: U.S. Census Bureau (American Community Survey, 2017).*

In the three focus areas (west Denver, north Federal and west Aurora), a majority (50-57%) of households report paying at least 30% of their income toward rent. These households are characterized as rent burdened. A more granular analysis in Figure 6 demonstrates concentrations of rent-burdened households in each focus area. Additionally, many households pay more than 50% of their income toward rent.

**Percent of Households
Rent Burdened**
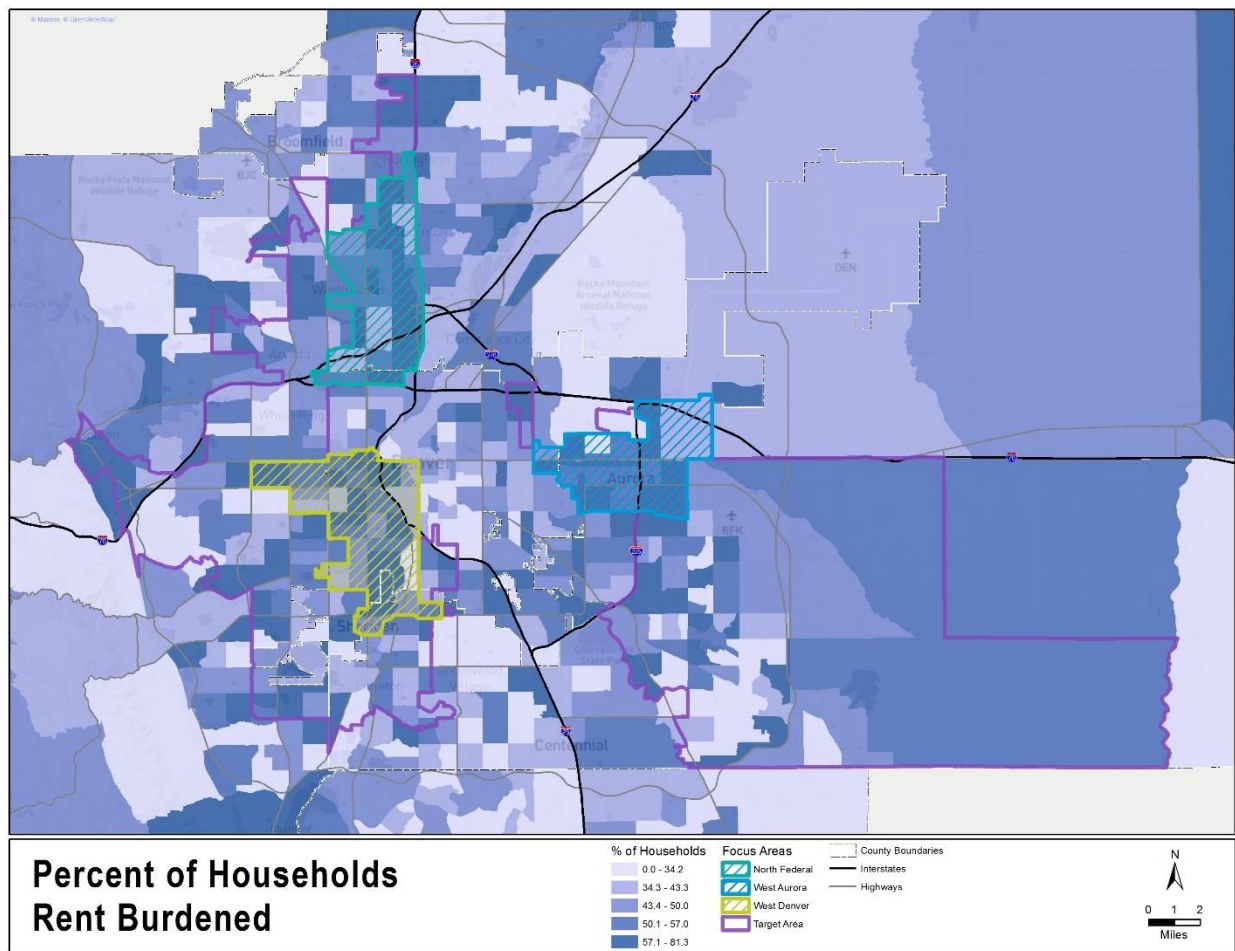
Figure 6: Share of households for which rent is more than 30% of their income (severely rent burdened). Source: U.S. Census Bureau (American Community Survey, 2017)

B. Neighborhood Diversity

The target area includes neighborhoods in the high-density urban core potentially facing gentrification pressures; neighborhoods with a large Hispanic population; and areas with a higher share of multigenerational households than the region as a whole.

Potential Gentrification

Investments in the Denver metropolitan area are transforming some low-income neighborhoods into higher density, higher income neighborhoods. Although it's not clear how gentrification will affect the core needs of the population within the AHC target area, project staff consider it necessary to identify the potential risk of displacement of low-income populations and the anticipated housing instability they would experience as a result.

Table 2 shows variables that are considered reliable indicators of neighborhood change: percentage of renters, median income, population with a bachelor's degree or higher, and median rent. Between 2010 and 2017, west Denver experienced a rapid increase in the percentage of households that rent homes and the percentage of individuals with higher education. This corresponds with significant investments in transit-oriented developments in the northeast quarter of west Denver**.** The north Federal focus area was the only geography analyzed that showed an increase in the percentage of Hispanic or Latino population.

	Population with a bachelor's degree or higher (%)		Median income ($)		Renters (%)		Hispanic or Latino (%)		Median rent ($)	
	2010	2017	2010	2017	2010	2017	2010	2017	2010	2017
AHC	17.85	21.47	50744	63871	37.59	40.39	30.66	30.01	895.46	1233.36
North Federal	8.77	11.94	43159	51969	36.68	39.62	43.37	51.95	888.84	1140.33
West Aurora	9.79	11.18	36351	40975	48.52	63.27	47.5	47.13	781.42	1024.43
West Denver	10.96	15.89	36704	44379	50.22	56.37	58.75	57.07	759.95	980.28

Table 2: *Changes in socioeconomic indicators between 2009 and 2017. Source: U.S. Census Bureau (American Community Survey, 2017).*

Besides socioeconomic changes, residential and nonresidential development or redevelopment investments in communities can help predict neighborhood change (see Figure 7)**.** Building permit data that details the dollar amount of construction projects is an indicator of future neighborhood changes. Such projects bring new households to the area and may also suggest rising property values and additional investments in real estate, land and buildings. An analysis of recent building permits reveals significant investments in the northern and eastern areas of the west Denver focus area.

Building Permit Values

Permit Value (USD)
- ○ 25,000,001 - 50,000,000
- ○ 50,000,001 - 100,000,000
- ● 100,000,001 - 309,749,518

Focus Areas
- North Federal
- West Aurora
- West Denver
- Target Area

County Boundaries
Interstates
RTD Rail Lines
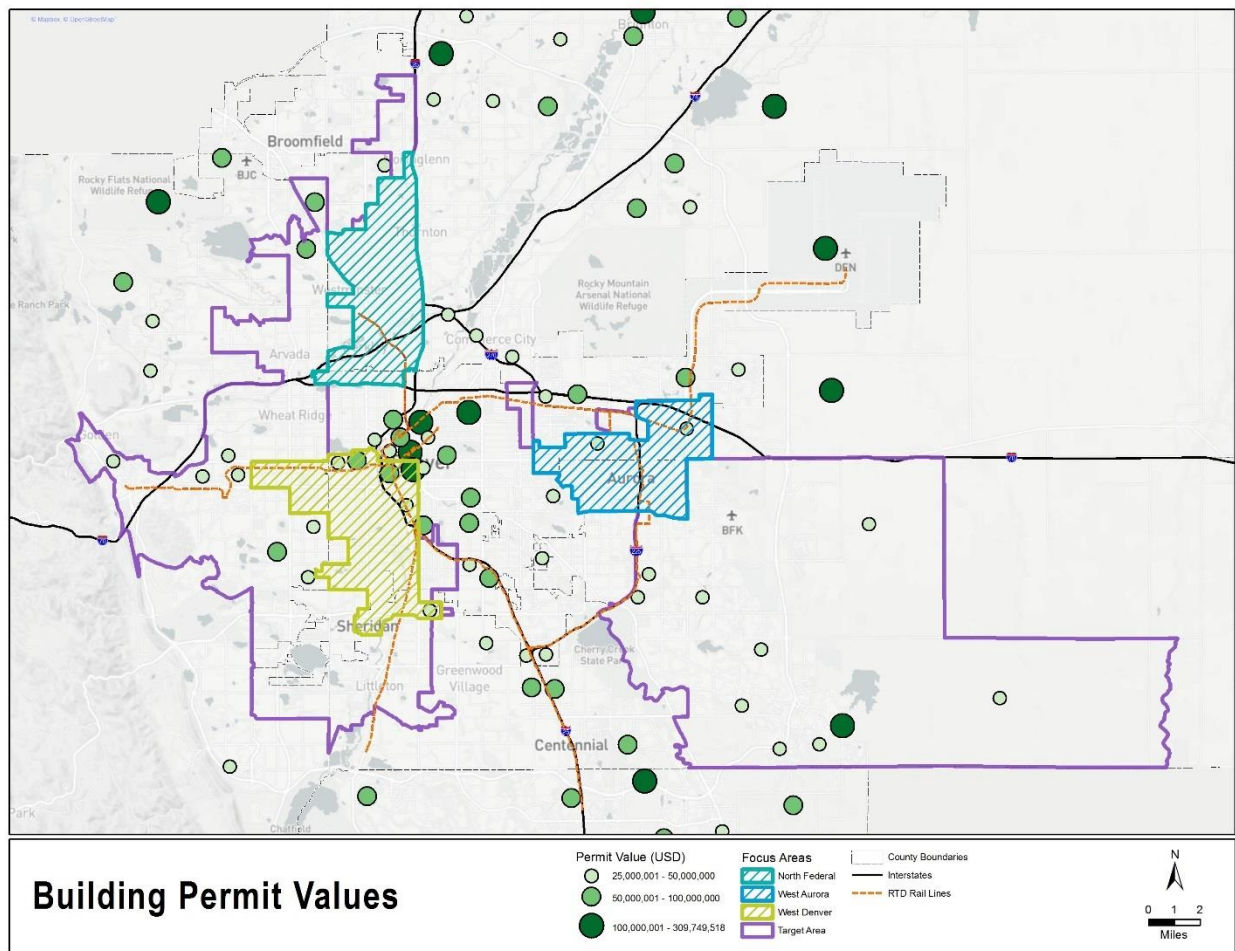
Figure 7: Value of residential and nonresidential permits. Source: Construction Monitor (2018)

Multigenerational Households

The core of the west Denver focus area contains a higher share of multigenerational families. Project staff is considering this variable when evaluating new partnerships and services.

Percent of Households with Grandparents Living with Grandchildren

% of Households
- 0.0 - 0.7
- 0.8 - 1.9
- 2.0 - 3.3
- 3.4 - 5.4
- 5.5 - 17.7

Focus Areas
- North Federal
- West Aurora
- West Denver
- Target Area

County Boundaries
Interstates
Highways
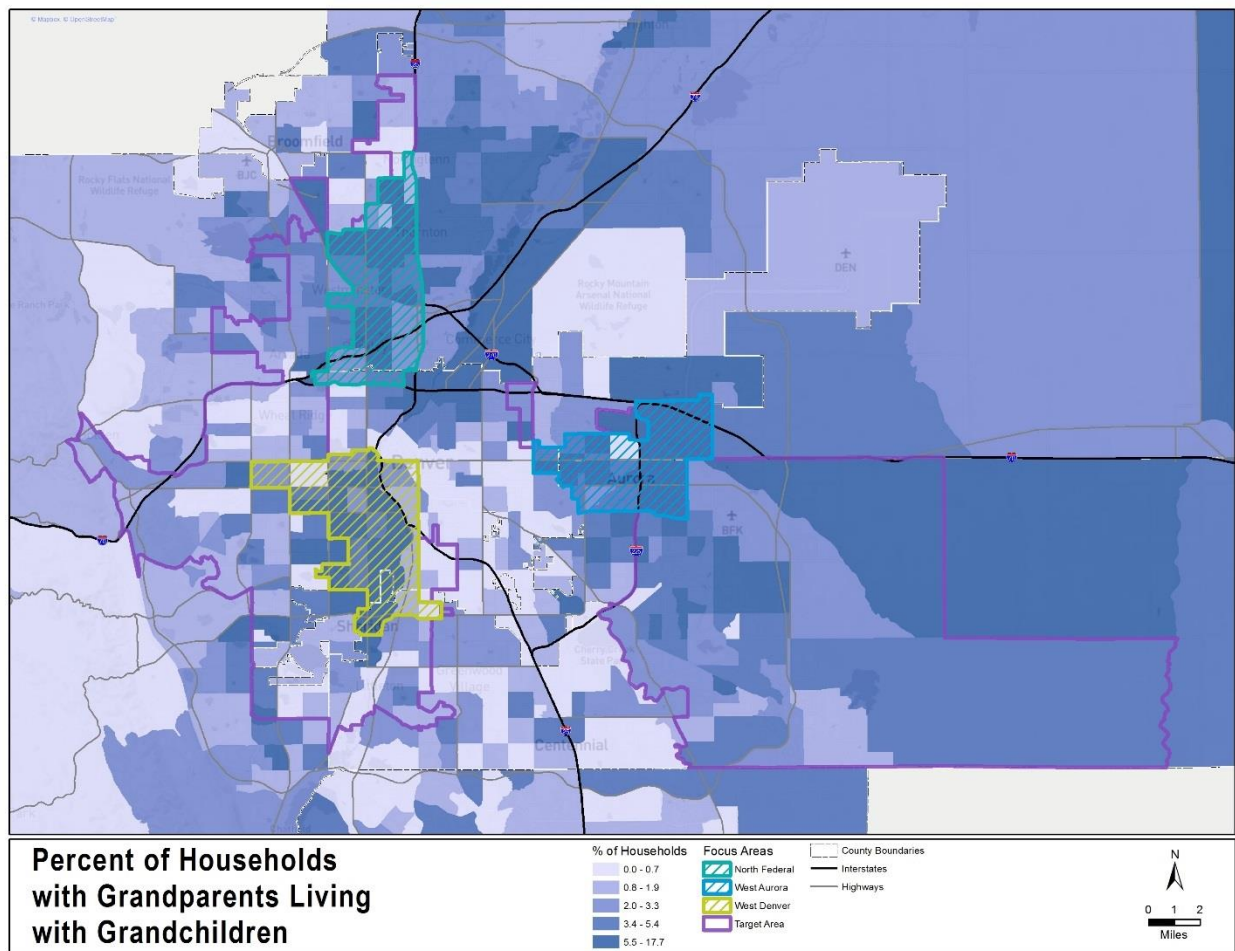
Figure 8: *Share of households with grandparents living with grandchildren. Source: U.S. Census Bureau (American Community Survey, 2017).*

Minorities

The three focus areas have a higher proportion of Hispanic residents than the rest of the AHC target area and the Denver metropolitan area (Figure 9). Although the AHC target area has a slightly lower share of African-American populations (5.7%) relative to the Denver metropolitan area (6.4%), the west Aurora focus area has a higher concentration of African-American populations (18.6%).
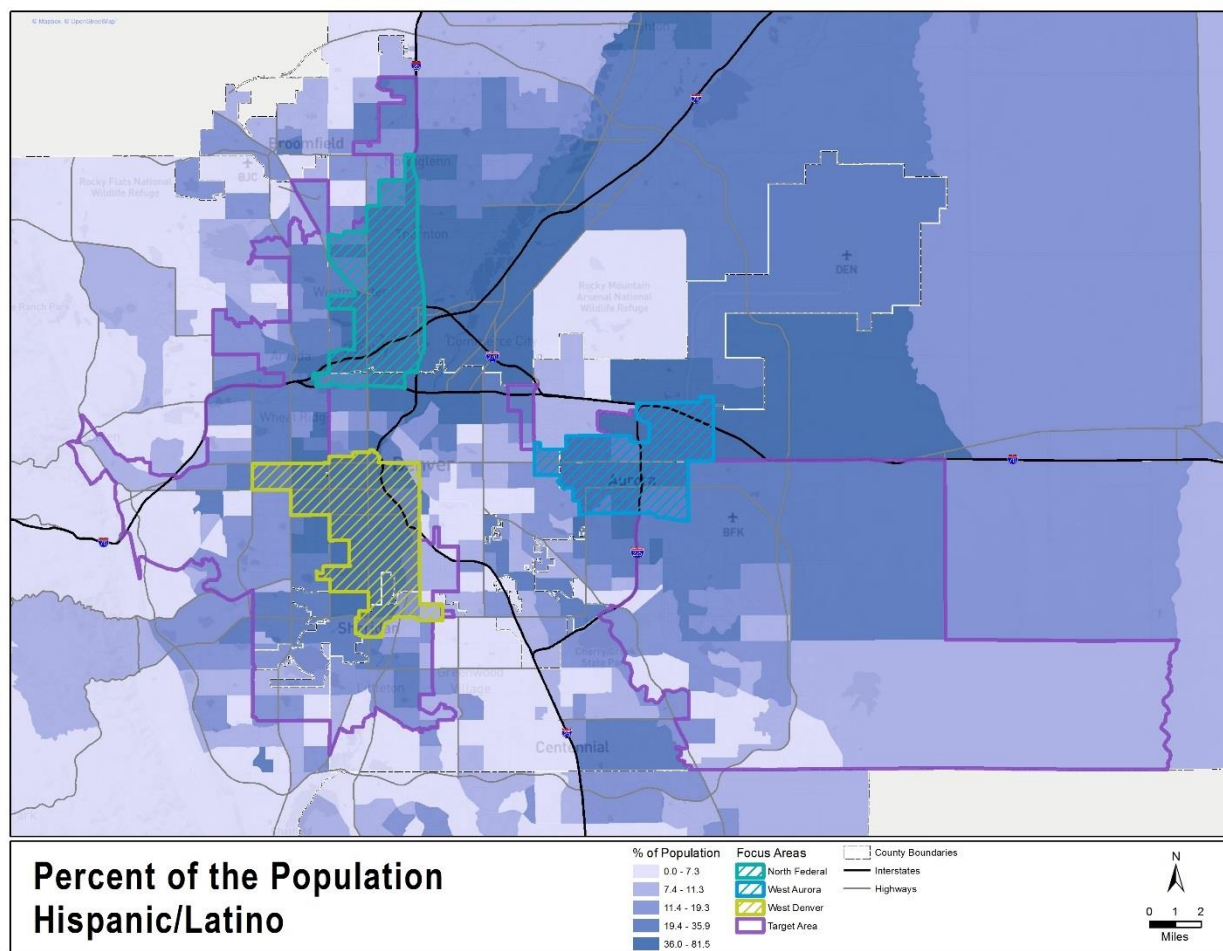
Figure 9: *Share of Hispanic or Latino residents. Source: U.S. Census Bureau (American Community Survey, 2017).*

Figure 10: *Share of African American residents. Source: U.S. Census Bureau (American Community Survey, 2017).*

II. Current State Assessment: Service Availability and Accessibility

Overview

A variety of community-based and human services programs are available in the AHC target area to address the five-primary health-related social needs (HRSNs). For some services like affordable housing and delivered meals, demand outstrips supply, which creates waitlists. However, limited capacity is not the only challenge to supporting individu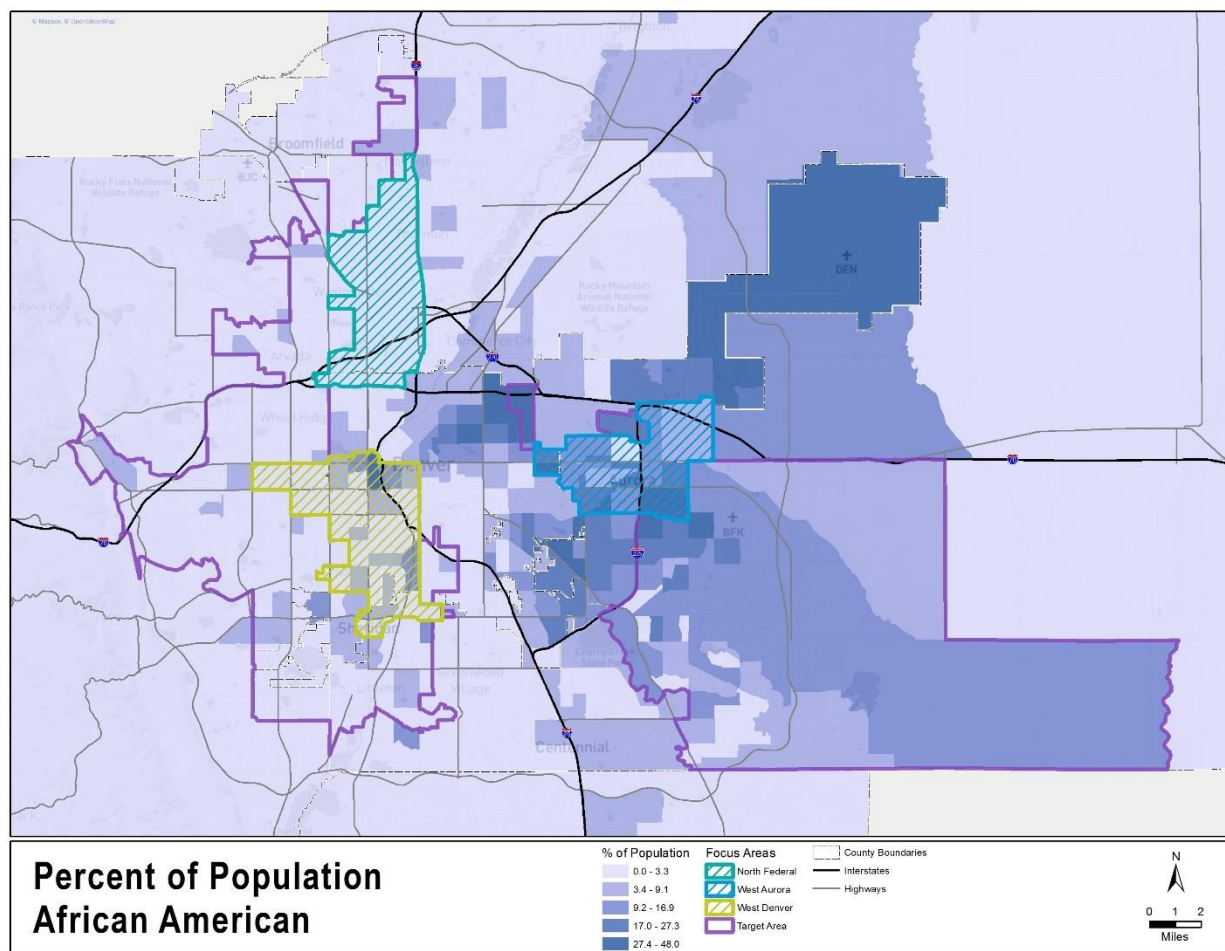als in need. This analysis highlights challenges to connecting populations with community-based resources. Problems of accessibility include extensive and burdensome application requirements, hours of operation, geographical distance and the intersectionality of social determinants. The intersectionality of social determinants refers to the inherent connectedness of social conditions that either promote or inhibit addressing an individual's HRSNs. Due to the complexity of experiencing social needs, compounded by barriers to accessing services, the intersection of multiple needs induces a compounding burden that makes access to services more difficult. For example, individuals need food to survive. Individuals without access to adequate transportation have limited access to food. On the other hand, if the individual can access transportation, the barrier to attaining food may be removed, addressing both HRSNs.

For all five HRSNs, another barrier to accessing services is faltering communication between service organizations and individuals and families in need. Project staff documented reasons including a lack of reliable phone service or conflicting priorities at home or at work, which make it difficult for individuals to follow up on recommended services. Communications barriers contributed, in part, to some individuals who received referrals not accessing available services.

The following sections describe the availability and accessibility of community resources dedicated to addressing the five HRSNs in the AHC target area.

Housing Situation

Key Points

- 12.6% of people reported a housing-related need.
- The Denver metro area affordable housing crisis continues. Waitlists are extensive. There is not enough affordable housing for individuals or families.
- The application process for affordable housing is decentralized, which makes searching for housing challenging and time-consuming.
- The availability of, and individuals' eligibility for, housing quality-related resources varies across counties.
- The availability of housing quality-related resources is contingent on funding which is not constant across all counties and community-based organizations.

Availability

Housing Security: Through federal, state and private funding, affordable and subsidized housing units for families, older adults and individuals with disabilities exist across the six-county region. As of September 2017, there were 17,013 affordable and subsidized housing units in the AHC target area: 1,981 units in the north Federal; 2,005 units in the west Aurora; and 7,874 units in the west Denver focus areas (Colorado Housing and Finance Authority, 2017). With the exception of a small area near the center of the west Denver focus area, neighborhoods with the highest density of subsidized housing units are outside the northeast corner of the west Denver focus area. In light of the greater socially and economically vulnerable populations residing within the three focus areas, the need for affordable housing outstrips the available capacity (see Figure 11).

While the target and focus areas include affordable housing units, the Denver region continues to suffer from an affordable housing crisis. Median rent increased by 35% between 2011 and 2018. Waitlists for subsidized housing range from three to five years depending on individual or family needs. Emergency shelters for individuals experiencing homelessness or interpersonal violence are available, but demand for these accommodations often exceeds supply.

Affordable Housing Units

Per Square Mile	Focus Areas		
Low	North Federal	County Boundaries	
Medium	West Aurora	Interstates	
High	West Denver	Highways	
	Target Area		
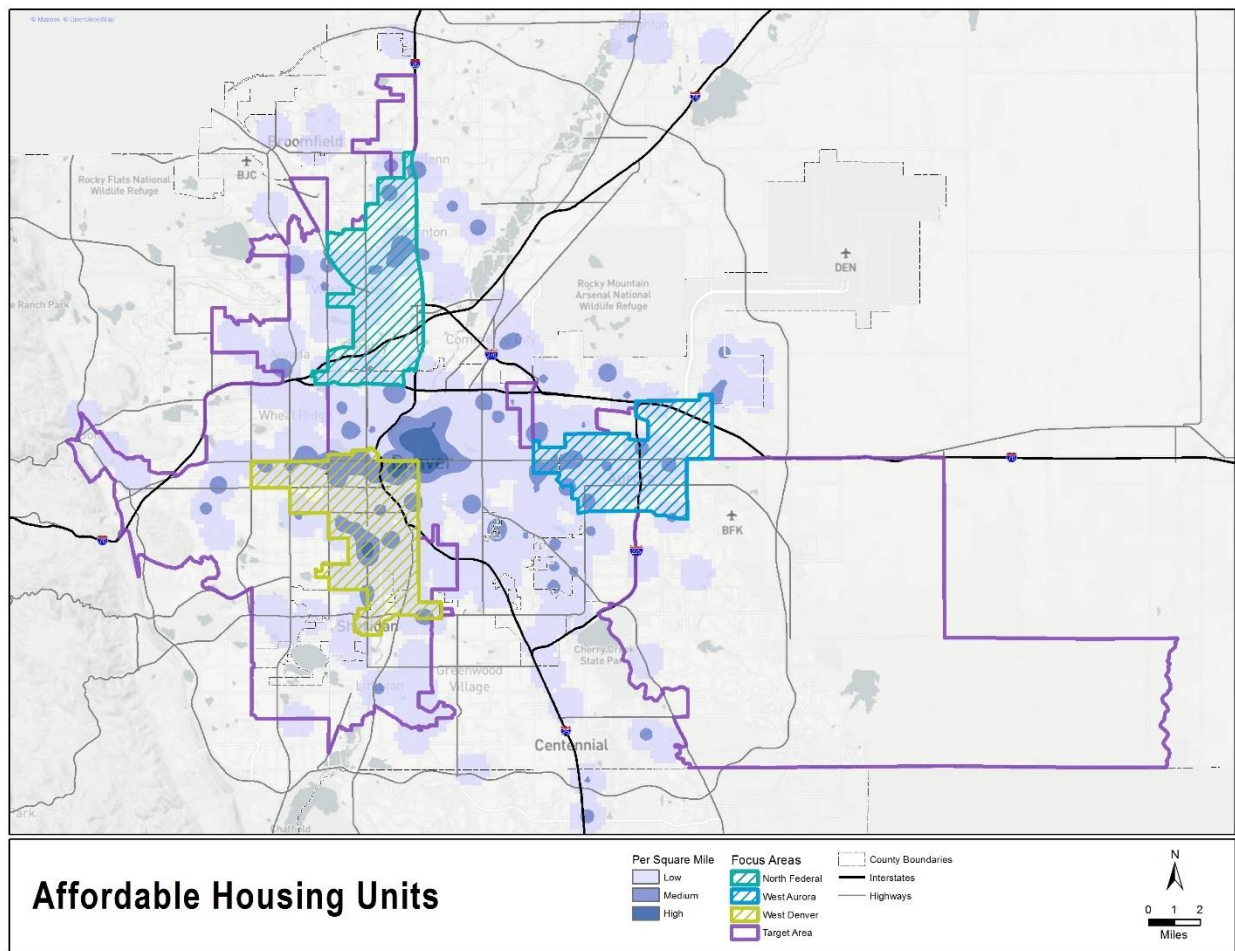
Figure 11: Density of affordable housing units: low: 14-362 per square mile; medium: 363-1,364 per square mile; high: 1,365-3,551 per square mile. Source: Colorado Housing and Finance Authority, 2017.

Thousands of the region's existing subsidized housing units will lose their restricted status in the next five, 15, 25 and 50 years (see Table 3). The recent boom in the housing market reduces the effect of incentives for developers to keep existing units in the pool of subsidized properties, suggesting there may be an even a greater shortage of affordable housing units in the years to come. 8,534 of the current restricted units have no expiration date, so these units may be expected to remain permanently affordable.

Timeframe	Total number of units	Number of single units	Number of multi-occupant units
Five years	4,755	2,938	1,817
15 years	4,000	2,320	1,680
25 years	5,886	3,333	2,553
50 years	11,833	7,368	4,465

Table 3. *AHC target area: Housing units to lose restricted status in five, 15, 25 and 50 years. Source: Colorado Housing and Finance Authority, 2017.*

Screenings completed between May 1, 2018, and Feb. 28, 2019, further indicate that while affordable housing may be available in the region, there's an insufficient supply of affordable units, or housing quality-related resources to meet all needs (see Figure 12). Housing-related needs were identified in all three focus areas. The relatively small number of screenings in the north Federal Boulevard focus area may explain the what appears to be more significant concentrations of housing needs in the other focus areas.
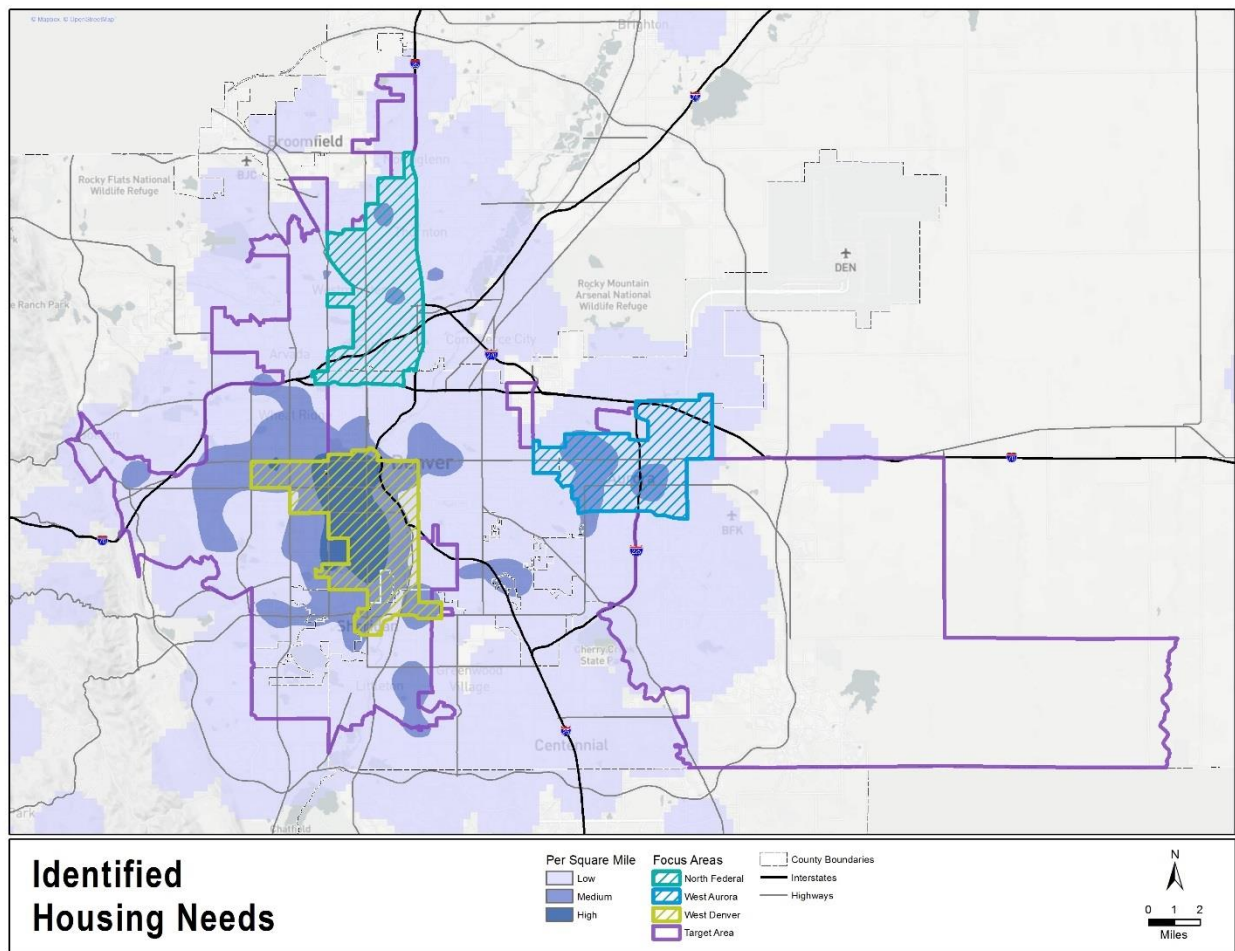
Figure 12: *Density of housing-related needs (security and quality) identified by screenings completed (May 1, 2018, to Feb. 28, 2019). Low: 0.18-4.5 per square mile; medium: 4.51-18.0 per square mile; high: 18.1-45.92 per square mile.*

Housing Quality: The region's local governments and community-based organizations offer various resources to address housing quality issues related to mold, pests, heating, water and plumbing, and appliances. Whether the service is provided by a county department or a community-based organization, eligibility differs in every county, and the type and availability of resources changes depending on yearly funding. Services may include low or 0% financing loans for major projects such as sewer line, plumbing repair and replacement, roof repair, heating, electrical and window repair, and structural repair. No-cost critical home repairs may include exterior painting, smoke detector replacement, furnace and hot water heater repair, and accessibility accommodations.

In partnership with the U.S. Department of Energy, the Colorado Energy Office distributes funding and Energy Outreach Colorado supports county departments and community-based organizations to offer energy-related housing improvements through the Weatherization Assistance Program.

Weatherization Assistance Program

The Weatherization Assistance Program provides no-cost assistance to eligible low-income households to improve energy efficiency and lower costs through installation of LED light bulbs, air sealing, insulation, furnace repair and replacement, storm windows and doors, solar photovoltaics and general energy conservation information. Services are implemented slightly differently depending on the county in which a household resides.

Colorado Affordable Residential Energy Program

Energy Outreach Colorado also operates the Colorado Affordable Residential Energy program which provides free energy efficiency upgrades to help lower energy use and energy bills. Services include energy audits, management of contractor quotes, energy conservation education, equipment replacement (such as insulation, light, heating, ventilation, air conditioning, low-flow fixtures) and instructions to access rebates and other funding sources.

Accessibility

Housing Security: The process by which individuals and families apply for affordable and subsidized housing is decentralized. Individuals and families submit applications for each housing complex, even if the housing complex operates under the same housing authority or administrative entity as others to which they've applied. While part of this decentralization is due to differing eligibility requirements and services at certain complexes, the process makes it challenging and time-consuming for people searching for housing.

Brothers Redevelopment is a community-based organization dedicated to providing affordable housing, housing counseling and other services to help individuals and families find affordable housing and housing-quality resources. Other organizations such as the DRCOG Area Agency on Aging and Mile High United Way's 2-1-1 call center operate assistance lines and online service directories with information about affordable and subsidized housing options. Many other community-based organizations provide information about housing options and may help people complete applications; however, limited housing stock reduces or delays access.

The primary resource people use to find emergency or transitional shelters is Mile High United Way 2-1-1 call center. Mile High United Way regularly tracks available beds in metro area shelters. People can search the online database or access real-time information by calling or using the online chat during

regular business hours. Individuals cite hours of operation and the necessity to have a working phone or internet connection as barriers to accessing the help center.

Individuals currently living in the community but planning for the future or in immediate need may contact Area Agency on Aging ombudsman, who have significant knowledge of the metro area's assisted living residences and skilled nursing facilities. Although many new assisted living residences are being built in the metro area, demand is often higher than supply, especially for individuals who cannot pay market rates because they are covered by Medicaid or are on fixed incomes.

Housing Quality: Due to limited and variable funding, and greater need than supply, individuals and families can find it difficult to access housing quality-related resources provided by community-based organizations and some counties. Application processes vary across organizations and counties, and certain services have waitlists. Accessing assistance for pest (bed bug) removal and major home repairs can be difficult if a household does not qualify under county or community-based organization eligibility criteria.

Weatherization Assistance Program

The Colorado Energy Office funds the Weatherization Assistance Program yearly in partnership with local counties and organizations. Households must be under 200% of the federal poverty level to qualify. Several public benefit programs automatically qualify households for assistance which facilitates the application process. Automatic eligibility programs include Supplemental Security Income, Low Income Energy Assistance Program (LEAP), Supplemental Nutrition Assistance Program (SNAP) and Social Security Disability Insurance (SSDI). Most often, people hear about the Weatherization Assistance Program through social workers, clinical navigators, social workers, case managers or community-based organization service providers. The Colorado Energy Office's website (colorado.gov/pacific/energyoffice/local-agencies) allows users to search for the local agency through which they can apply for assistance.

The Weatherization Assistance Program administering office may change according to funding cycle. Currently, Adams and Arapahoe county are covered by the Arapahoe County Weatherization Division; Broomfield county is covered by Boulder County Housing Authority's Longs Peak Energy Conservation; and the remaining AHC counties (Denver, Douglas and Jefferson) are covered by Energy Resource Center. For individuals and households attempting to access the program, agency changes may cause confusion or delay.

Colorado Affordable Residential Energy Program

The Colorado Affordable Residential Energy program is administered and operated by Energy Outreach Colorado in every AHC county except Broomfield. To qualify, a household must be at or below 80% of the

area median income within its county. For individuals and families, the eligibility qualification is economically accessible. For example, in the City and County of Denver, 80% of area median income for a household of one is $50,400 and $71,920 for a household of four (Energy Outreach Colorado, 2019). To qualify for other programs, such as the Weatherization Assistance Program or the Low-Income Energy Assistance Program, income eligibility is stricter: 200% and 165% of the federal poverty level, respectively.

Food

Key Points

- 23% of people reported a food need.
- A variety of public and community-based services are available to provide food resources for individuals of all ages.
- Accessibility barriers to services include lack of eligibility awareness, lack of transportation, functional limitations and operational factors (for example, the days and hours a business is open).
- The sufficiency of resources is another reported barrier to meeting individual and family nutritional needs.

Availability

Public Programs

Several federal and state programs provide food and nutrition-related resources to children, adults, families and older adults. Such programs include, but are not limited to, the Supplemental Nutrition Assistance Program (SNAP); Women, Infants and Children (WIC); The Emergency Food Assistance Program; the Commodity Supplemental Food Program (CSFP); and Colorado Works/Temporary Assistance for Needy Families. These programs are available statewide to all eligible individuals. School meals programs are also available to provide no- or reduced-cost breakfast and lunch for children in eligible households. Depending on the school district, meal services are available during the summer months when school is not in session.

Food Pantries

A large network of food pantries operates in the metro area (see Figure 14). Food pantries receive donations of fresh and shelf-stable foods from local grocers and restaurants. Food pantries often supplement their supplies by purchasing goods from the area's largest food bank, Food Bank of the Rockies, to ensure a balance of proteins, fruits, vegetables, dairy and grains. Each food pantry operates

differently, offering various quantities and types of foods. The days and hours of operation for each varies. Jewish Family Service of Colorado provides enough food (fresh and shelf-stable) for every member of a household for one week, and every household can visit the pantry once a month. Most food pantries limit the number of monthly visits a household may make.

Meal Delivery Programs

In the metro area, three no-cost meal delivery programs serve specifically older adults: Volunteers of America, the Town of Littleton Cares (TLC) Meals on Wheels and the City and County of Broomfield Meals on Wheels. Volunteers of America and City and County of Broomfield serve older adults (60 and older), and the Town of Littleton Cares Meals on Wheels serves older adults (60 and older) and adults of any age who are homebound. City and County of Broomfield serves Broomfield residents. Volunteers of America and the TLC Meals on Wheels combined serve the remaining AHC counties.

Generally, two service delivery options are available: one hot meal delivered each weekday or a week's supply of frozen meals delivered once a week. Frozen meals are also delivered for weekends. Hot meals are delivered for individuals unable to prepare or warm their own food or for individuals not interested in meal preparation. Frozen meals are for individuals unable to accept daily meal deliveries (for example, due to schedule conflicts) or for those interested in participating in meal preparation (warming in the oven or microwave). All meals are nutritionally balanced with minimal excess fats, sodium and sugar.

Project Angel Heart provides no-cost meal deliveries for individuals of all ages experiencing life-threatening illnesses and who have difficulty preparing food. Over 500 diagnoses are considered for eligibility. Meals are tailored to meet the individual's medical and nutritional needs, for example, a renal friendly diet. Frozen meals are delivered in weekly quantities (one meal for each day). Depending on the nutritional needs of the individual, weekend meals and breakfasts are also available. Project Angel Heart serves all counties in the AHC target area and makes accommodations, when possible, for individuals who live outside its service area if they can arrange for pickup within Project Angel Heart's boundaries.

Congregate Dining Centers

Volunteers of America operates congregate dining centers in Adams, Arapahoe, Denver, Douglas and Jefferson counties where older adults (60-plus) receive no-cost hot meals and socialize. Depending on the location, meals are served between one to five times a week during lunch hours.

Volunteers of America Congregate Meal Sites
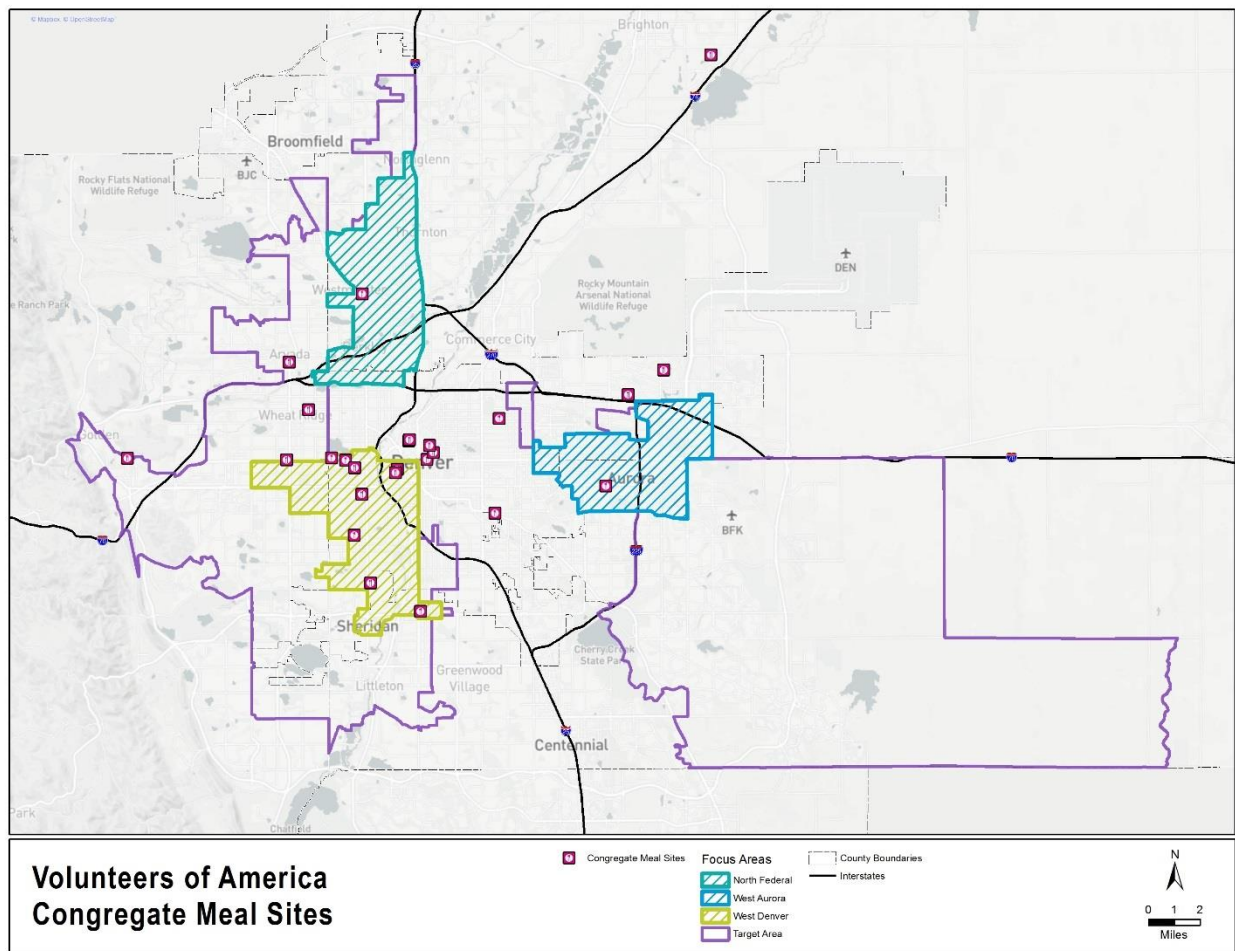
Figure 13: *Volunteers of America congregate meals sites for adults 60 and older.*

Accessibility

Public Programs

Public programs are available statewide to eligible individuals. Individuals can apply online for several through the state's online public benefits platform, Colorado PEAK (coloradopeak.secure.force.com), improving accessibility for those who have internet and computer literacy. However, many programs require applicants to interview in-person or visit a county human services office to apply. For people with limited transportation options or who live significant distances from their county human services office (see Figure 14), in-person application and recertification appointments can present a barrier to receiving services. Individuals with disabilities who experience difficulty attending in-person interviews may qualify for exceptions to complete interviews over the phone, which improves their access to benefits.

By calling a local community-based organization, Hunger Free Colorado, individuals may expedite access to the Supplemental Nutrition Assistance Program (SNAP). Hunger Free Colorado has staff available to

start SNAP applications over the phone. Some clinical providers also have expedited referral processes by which providers fax referrals to Hunger Free Colorado, which then reaches out to interested individuals and families via telephone. Applicants still must submit supporting documentation to their local human services office. Sometimes, clinical providers may have human services staff on-site to help with applications, which significantly improves efficiency in completing applications and access to benefits.

Once approved, SNAP recipients must visit their local human services office to pick up their electronic benefit transfer card, which functions as a debit card for their monthly SNAP benefits. Individuals who have functional challenges or transportation barriers have reported that visiting the human services office to pick up their benefit cards can be a challenge.

Those applying for the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) must visit one of the local offices across the region. To improve accessibility to WIC offices, the state set up a centralized website through which individuals can submit their information and request an appointment with their local WIC office (coloradowicsignup.com). For those without internet or computer literacy, staff from clinical sites, libraries or other community-based organizations can submit individuals' information on their behalf to request an appointment.

While there are exceptions, individuals report geographical distances to human services and WIC offices to apply, submit supporting documentation and recertify for benefits as barriers to service. Other barriers include office wait times and information sent in public benefit case letters that individuals report to be complicated or confusing.

Food Pantries

There are two main outlets for information on accessing food pantries in the metro area: Mile High United Way 2-1-1 call center and Hunger Free Colorado. Individuals can use Mile High United Way's online database, call center or online chat for a list of food pantries in their ZIP code. Hunger Free Colorado also operates a phone line during business hours to help people to find food pantries in their ZIP code. Clinical providers and community-based organizations often maintain their own lists of food pantries, which may not represent the most current food pantry information.

Commonly reported barriers to accessing food pantry services include operational hours that conflict with school or work schedules; geographical distances that require time-consuming travel on public transit; functional limitations or disabilities that make pick up and transport of food difficult. And while individuals with Medicaid waivers can arrange for non-medical transportation, limited assisted transportation is available for individuals with regular Medicaid for non-medical appointments, such as visiting food pantries. Seniors' Resource Center provides rides to older adults (60-plus) for nutrition-related trips to grocery stores and food pantries; however, due to limited capacity, medical and dental trips are

prioritized, constraining access to destinations such as food pantries. For more information on transportation availability and accessibility see "Transportation."

A significant proportion of food pantries in the target and focus areas operate along high-frequency public transit (those with stops that have at least four arrivals or departures every hour). Operating along public transit lines can somewhat reduce transportation barriers for individuals who live, and whose destinations are located, near high-frequency transit stops. However, food pantry operational hours and an individual's cognitive or physical limitations may still make it challenging for them to use pantry services. Some neighborhoods within the target and focus areas have no nearby food pantries or human services offices. Only three of the six human services offices within the AHC target area counties operate on or near high-frequency transit lines, suggesting those who need to attend in-person visits and do not own reliable transportation may experience a barrier to accessing these services (Figure 14). Such geographical gaps, commonly known as service deserts, significantly decrease accessibility of services.
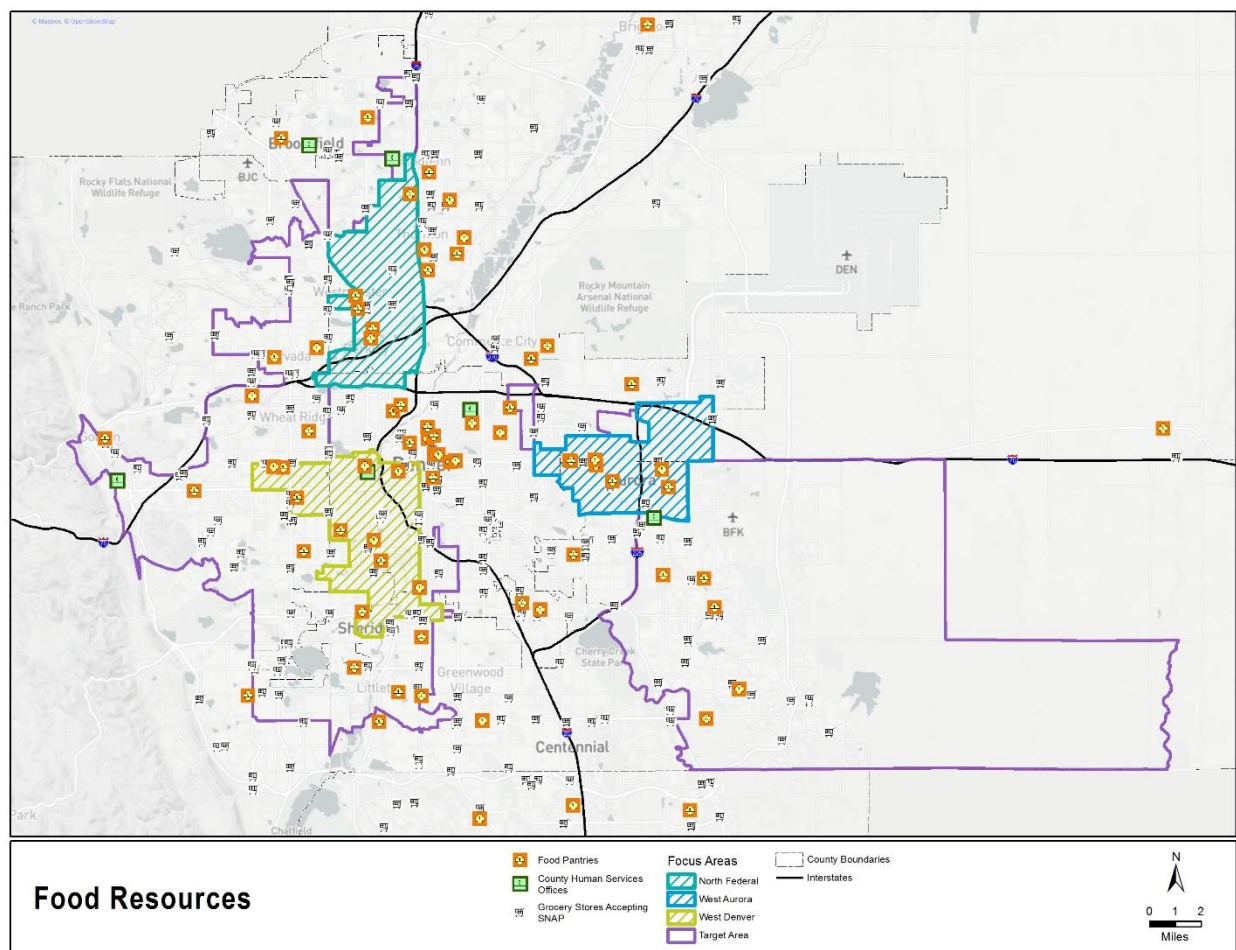
Figure 14. *Major food resources (food pantries, county human services offices and grocery stores) within the target and focus areas. Source: United States Department of Agriculture Food and Nutrition Service.*

Food Resources with High Frequency Transit

Legend:
- Food Pantries
- County Human Services Offices
- Grocery Stores Accepting SNAP
- 1/4 Mile Buffer Around High Frequency Transit Stations

Focus Areas
- North Federal
- West Aurora
- West Denver
- Target Area

- County Boundaries
- Interstates

0 1 2 Miles
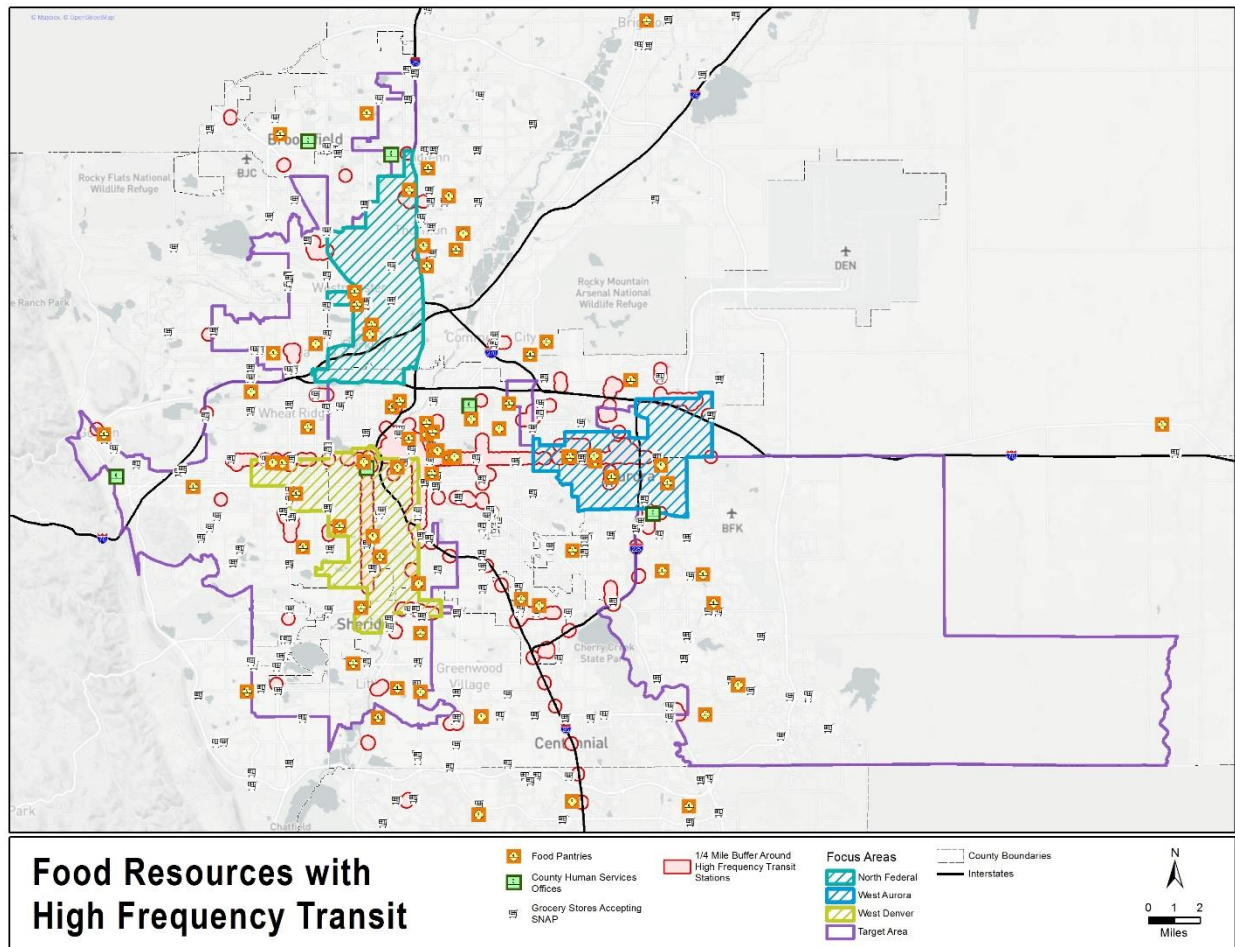
Figure 15: Major food resources (food pantries, county human services offices and grocery stores) located in relation to high-frequency transit. Grocery stores displayed include major chains. Smaller neighborhood stores with specialty foods or smaller selections, such as farmers markets, gas stations and carnicerias are not included. The Douglas County Human Services office is in Castle Rock, Colorado, (south of the city of Centennial) and is not included on this map.

Meal Delivery Programs

Individuals can call DRCOG's Information and Assistance phone line and Mile High United Way 2-1-1 call center for information about meal delivery programs. Because meals are delivered to the individuals' homes, there are fewer barriers to access these services than other food programs. No financial requirements must be met for eligibility. For two of the three programs, the most significant barrier to accessing meal delivery services are waitlists, often due to insufficient funding to meet demand. An

individual in need may only need to wait a few weeks before they receive services, but the time without adequate nutrition while they wait may negatively affect their health.

Individuals must also be home to receive their meal deliveries. If they are not home during designated times, depending on the program, they cannot receive their meals.

Congregate Dining Centers

Several congregate dining centers operate within age-restricted affordable housing complexes, increasing access for residents. For older adults (60-plus) who do not have congregate dining in their building, the most common cited barrier to service is transportation or functional limitations that make travel difficult.
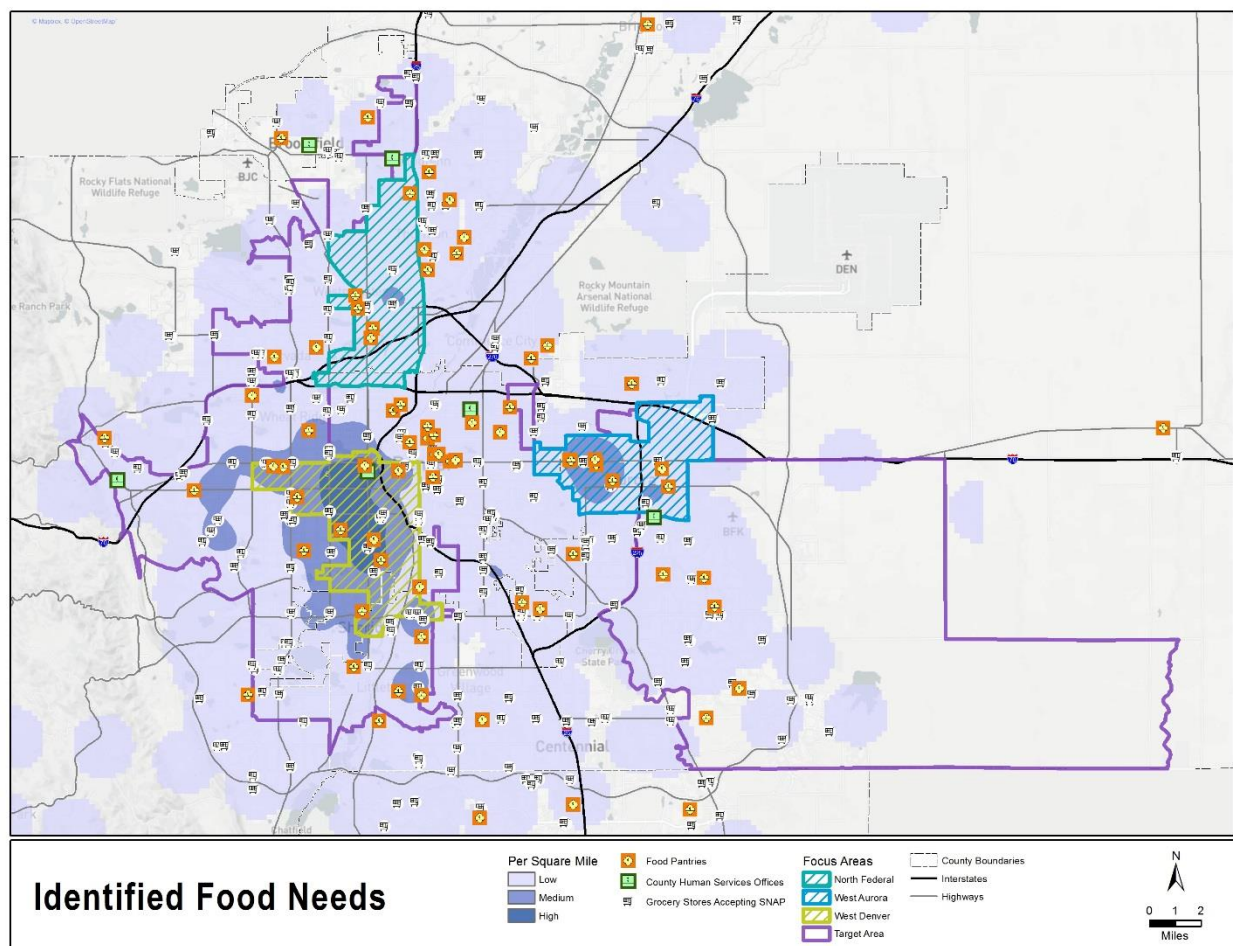

Figure 16: *Density of food needs identified by screenings completed (May 1, 2018, to Feb. 28, 2019). Low: 0.30-8.87 per square mile; medium: 8.88-32.83 per square mile; high: 32.84-75.41 per square mile.*

Screenings completed May 1, 2018, through Feb. 28, 2019, indicate food needs in all three focus areas. As with housing-related needs, fewer screenings in the north Federal Boulevard focus area may create the appearance of more food needs in west Denver and west Aurora.

Despite the variety of state, county and community-based services available, food is the mostly commonly identified need across the target area. 23.3% of total screenings completed identified a food need. Of beneficiaries receiving navigation services, 68% reported a food need. Qualitative feedback suggests the reality of food needs is a result of barriers in accessing these services as previously discussed, the intersectionality of needs and the insufficiency of resources. A household classified as receiving insufficient nutrition may be receiving SNAP, visiting food pantries and receiving delivered meals, but still cannot meet its daily nutritional needs. AHC clinical and community partners have noted that many households are forced to spend a significant portion of their budget on housing and utility costs, prioritizing shelter and electricity over meeting their daily nutritional needs. The household's food budget is squeezed so tightly that supplemental benefits such as SNAP and community-based services are not enough. Households which must choose between shelter, nutrition and other fundamental needs experience the intersectionality of health-related social needs in conjunction with the availability and accessibility of services to address those needs.

Utilities

Key Points

- 7.6% of people reported a utility need.
- The Low-income Energy Assistance Program (LEAP) is the primary public program available to subsidize energy costs or eligible households.
- Energy Outreach Colorado offers energy bill payment assistance in partnership with local agencies.
- Other community-based organizations offer financial assistance to supplement utility benefits or to assist households who otherwise do not qualify for assistance.
- Organizations that provide assistance for water bills are limited.
- Organizations administering utility financial assistance services may change depending on funding cycles and the amount of funding made available to them. Such administrative changes may create barriers for households attempting to identify, locate and access services.

Availability

Public Programs

Low-Income Energy Assistance Program

Colorado's Low-Income Energy Assistance Program (LEAP) is the primary program that provides financial assistance to pay a portion of a household's energy costs during winter months (November-April). Equipment repair and heating unit replacements is also available for eligible households. Assistance is not provided for portable or temporary heating units. The amount of assistance provided depends on various factors including the heating fuel costs and household income. The upper limit for household eligibility is 165% of the federal poverty level.

Community-Based Programs

Energy Outreach Colorado (EOC) is a community-based organization that provides financial assistance to pay energy bills. While a household can receive assistance from LEAP and EOC in the same year, during the winter months (November-April), households must first apply to LEAP before they apply to EOC. Eligible households can receive assistance from EOC once a year per fuel source. For example, if a household relies on gas and electricity to heat their home, it can receive assistance for each type of energy source once per year. EOC also provides energy education on simple measures to lower overall energy costs.

Other community-based organizations operate financial assistance funds to assist with energy bills, but funding is often contingent on donations that are not always consistent or sustained. As of this report's publication date, few agencies provide assistance to cover water bills.

Accessibility

Public Programs

Low-Income Energy Assistance Program

By calling the heat help line (1-866-HEAT-HELP), individuals can determine the local agencies that administer LEAP and EOC assistance in their counties. Depending on funding cycles, the local agency responsible for processing applications and administering assistance can change. Administration changes can be a barrier to accessing services if applicants submit their information to the incorrect agency. In some situations, applicants who apply to the incorrect agency do not discover their application has been lost until attempting to follow up on the status of their application.

One agency per county is designated to administer LEAP. Adams and Arapahoe counties each have an office location where individuals can pick up applications, ask questions and submit applications. Applicants may also submit applications via fax. In all other counties within the AHC target area (Arapahoe, Denver, Douglas and Jefferson) and most other Colorado counties, individuals must submit LEAP applications by fax, email or mail. As of this report's publication date, Discover Goodwill processes and administers LEAP assistance for the four other AHC counties listed. In all counties, applicants may print an online LEAP application instead of obtaining a copy from their local agency (colorado.gov/pacific/cdhs/how-do-i-apply). Applications are available in English and Spanish.

The Colorado PEAK website (coloradopeak.secure.force.com/) also accepts LEAP applications. However, for greatest efficiency in processing, the heat help line encourages individuals to apply directly to the current administering county.

It can take up to 30 calendar days for applications to be processed; 10 business days for households with emergency shut-off notices. Once they've submitted an application, applicants are encouraged to call to inquire whether they need to submit additional information. If an applicant receives a request for further information by mail, they may only have a few days to reply. A missed deadline for additional information may cause an application to be rejected, and the applicant must start the process from the beginning. For individuals, especially those in crisis situations, depending on mail for application follow-up severely limits access to utility assistance.

Community-Based Programs

Community-based organizations across the AHC target area partner with Energy Outreach Colorado to process applications and administer assistance to eligible households (see Figure 17). Through such partnerships, Energy Outreach Colorado makes utility assistance more accessible to households in need. In addition to the heat help line, households can use an online directory (energyoutreach.org/find-agency) to identify the local agencies which offer utility assistance. Energy Outreach Colorado maintains the directory and designates organizations with funding to help individuals find agencies accepting applications.

Local agencies may administer Energy Outreach Colorado funds in slightly different ways, making it difficult for individuals to find an agency that can help them. For example, an agency may limit the amount of assistance administered each month during a given funding quarter. Therefore, while the Energy Outreach Colorado directory may correctly indicate the agency has funding available, individuals may be notified that funding is unavailable because the agency-designated monthly allotment was already administered. Such variables in funding distribution causes significant barriers for households in accessing Energy Outreach Colorado assistance.

Some organizations that offer utility assistance require in-person appointments as part of their application process or other activities as a condition of receiving assistance, such as completion of a budgeting class. Such requirements may be well-intentioned. For example, they may screen the household for other potential services and help with long-term financial planning. However, these requirements may represent barriers for individuals who have limited transportation, work during regular business hours, or with functional limitations that make travel difficult.

To access other financial assistance programs for utility bills, people call DRCOG's Information and Assistance line, Mile High United Way 2-1-1 call line or other community-based organizations. Community-based organizations' ability to offer assistance often changes, making it difficult for referral agencies to maintain accurate lists and even more difficult for individuals attempting to access current information and assistance on their own. In addition, applicants often have to demonstrate they can cover the entire bill (with the assistance provided) and keep their account current in the future. Such requirements ensure responsible administration of funds, but can further limit access to assistance for households in crisis.

Screenings completed May 1, 2018, through Feb. 28, 2019, indicate medium and high-density utility needs centered in the west Denver and west Aurora areas. Following housing-related and food needs, the concentration of needs identified in these areas are largely due to the high density of AHC clinical sites operating in those areas.

As with housing and food, the screening data illustrates that although utility assistance is available, utility needs remain a concern for households. Qualitative feedback indicates that increased need for utility assistance may be due to increasing housing costs, reducing the household budget allotted for utilities and other needs. Other feedback suggests households experience challenges accessing available resources due to delayed communication between LEAP-administering offices and applicants, and difficulty locating a local Energy Outreach Colorado agency with funding available and which is accepting applications.
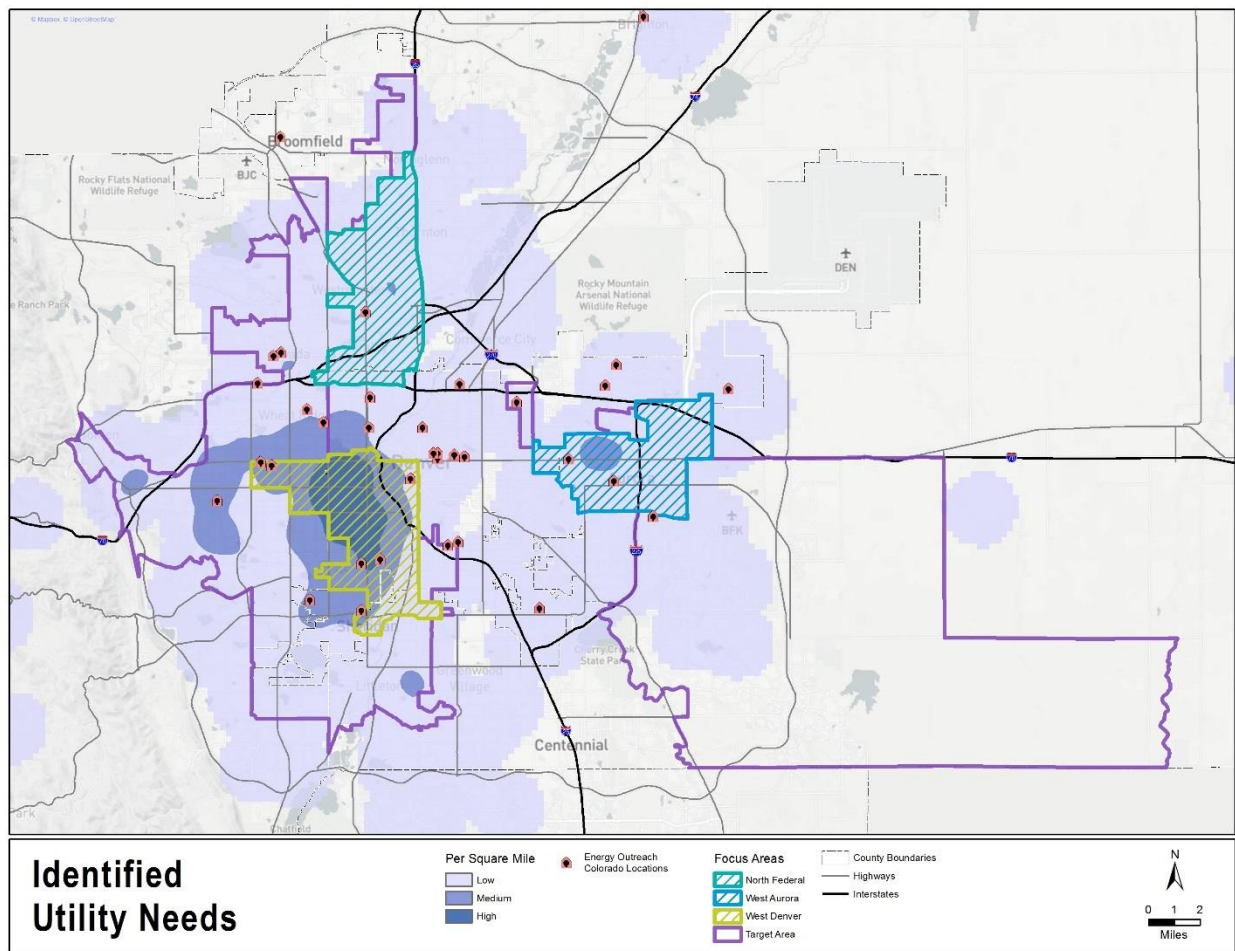
Figure 17: *Density of utility needs identified by screenings completed May 1, 2018 to Feb. 28, 2019. Low: 0.12-3.61 per square mile; medium: 3.62-13.36 per square mile; high: 13.37-29.87 per square mile.*

Transportation

Key Points

- 12.2% of people reported a transportation need.
- Transportation options in the region include public transit provided by the Regional Transportation District, Medicaid-funded, ride-hailing, school-based and community-based services are all transportation options in the region.
- While subsidized, ticket cost is still a reported barrier to accessing public transit.
- Outside of waivers, Medicaid and community-based services primarily offer services for medical appointments, significantly reducing access to transportation for other daily needs such as grocery trips and religious observances.

Availability

Public Programs

Regional Transportation District

The Regional Transportation District operates bus and rail services throughout the metro area with additional services and discounts for youth, individuals with disabilities and older adults. High-frequency transit lines run more frequently to accommodate a high volume of passengers (see Figure 15). Designated Park-n-Rides are available near several bus and rail lines so people living in outlying areas can commute using their own vehicles, park and travel the remainder of their route via public transit. In select areas outside the perimeter of the main metro area, RTD offers FlexRide. Passengers call FlexRide and are picked up by shuttle within approximately 10 minutes, then dropped off at the nearest main RTD bus or train service to complete the remainder of their trip.

Access-a-Ride provides curbside and door-to-door pick-up service with driver assistance for people with disabilities as long as their starting point and destination are within ¾ mile of RTD's regular service lines (with some restrictions). Riders may schedule Access-a-Ride service one to three days in advance.

Non-emergency medical transportation and non-medical transportation

Non-emergency medical transportation is available for eligible individuals enrolled in the state's Medicaid program to receive no-cost rides to medical appointments a limited number of times per year. Non-medical transportation is available for eligible individuals enrolled in Medicaid waiver programs to receive no-cost rides to non-medical destinations such as grocery stores. Generally, non-emergency medical and non-medical rides must be scheduled one week in advance.

Ride-Hailing Services: Lyft and Uber

Lyft and Uber both operate private ride-hailing services throughout the metro area. Users must have a credit or debit card and a smartphone with cellular service or Wi-Fi to book and pay for a ride. Rides are available on-demand or may be scheduled in advance.

School-Based Transportation

Public school districts offer no-cost transportation for students to and from schools (elementary to high school). Students must live within a defined district service area to receive transportation, otherwise transportation to school is the responsibility of the family.

Community-Based Programs

A variety of community-based organizations receive funding from the DRCOG Area Agency on Aging to provide no-cost transportation for older adults (60-plus) in all six AHC counties. Organizations include Adams County Department of Regional Affairs, Arapahoe County Community Resources, City and County of Broomfield, Douglas County Department of Community Development and Seniors' Resource Center. 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 available for daily living activities such as hair appointments, spiritual or religious services.

Accessibility

Public Programs

Regional Transportation District

While RTD subsidizes fares for youth, people with disabilities and older adults, cost is still a reported barrier to access public transportation. Another common barrier is first- and last-mile considerations in which an individual may not have the means to travel or walk between their starting point, bus and rail stops and their destination. When applying for special programs such as SeniorRide or Access-a-Ride, individuals report barriers to accessing RTD services in the form of paperwork, in-person appointments, and wait times for processing applications. For individuals living in areas such as the eastern plains of Adams and Arapahoe counties or in the mountains of Jefferson County, RTD services are limited.

Non-emergency medical transportation and non-medical transportation

To access non-emergency medical and non-medical transportation services, individuals must not only be eligible through Medicaid but also must complete enrollment forms with the relevant transportation service provider. Providers can change from year to year depending on which companies receive contracts from the state Medicaid agency. Individuals report barriers or delayed access to such services due to circumstances such as already-limited transportation access to a clinic, a lack of access to computers or fax machines and difficulty completing enrollment forms or getting an approval signature from a medical provider.

Ride-Hailing Services: Lyft and Uber

Ride-hailing services such as Lyft and Uber are often less expensive than taxi services, making such options more accessible to many people. However, individuals report barriers to using ride-hailing services such as a lack of reliable phone service and discomfort with smartphone applications.

School-Based Transportation

Due to various district policies such as Denver's School of Choice, a student may enroll in a school farther from their residence and which falls outside of the range of the district bus services. Therefore, district transportation service is not accessible to such students, and families are responsible for transporting their children to and from school.

Community-Based Programs

With no income qualifications or extensive applications to complete, community-based programs are often more accessible to older adults looking for transportation services. The most commonly reported barrier to accessing community-based transportation services is the requirement to schedule rides seven days in advance.
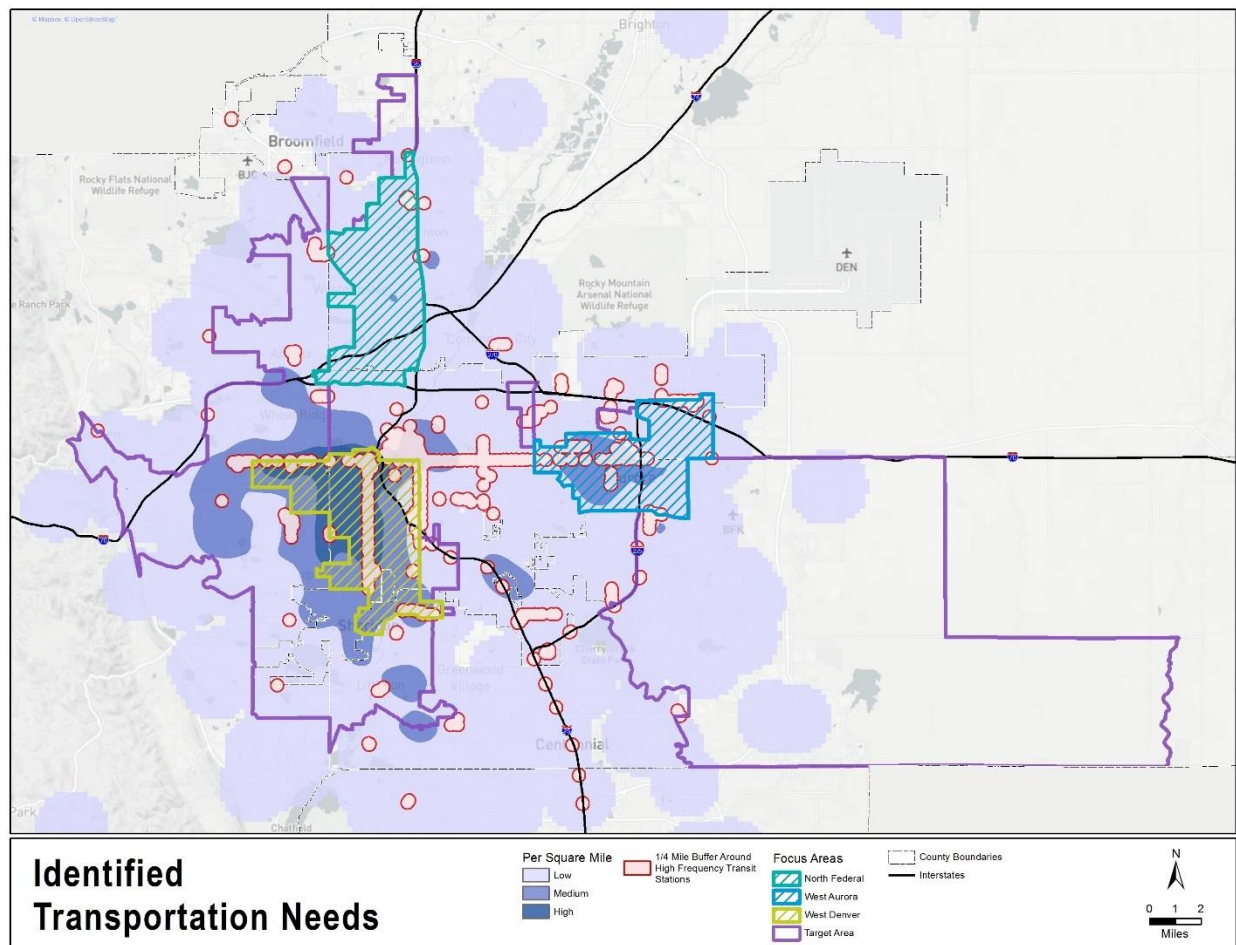

Figure 18: *Density of transportation needs identified by screenings completed May 1, 2018, to Feb. 28, 2019. Low: 0.14-4.31 per square mile; medium: 4.4-14.38 per square mile; high: 14.39-36.66 per square mile.*

Screenings completed May 1, 2018, to Feb. 28, 2019, indicate medium and high-density transportation needs centered in the west Denver and west Aurora areas. As with housing-related, food and utility needs, the concentration of needs identified in these areas are largely due to the high density of AHC clinical sites operating in those areas. Despite the availability of public transportation, Medicaid and community-based transportation, screenings consistently identify transportation as a need. Qualitative feedback suggests that the availability and accessibility of services are challenges to meeting the region's transportation needs.

Safety

Key Points

- 3% of people reported a safety need. However, many factors may contribute to the substantial underreporting of this need, so this percentage may not be an accurate indicator of safety's prevalence as a HRSN.
- County human services offices operate child and adult protective services for individuals experiencing abuse or neglect.
- In reports that indicate a need but do not meet the threshold criteria for CPS or APS involvement, or in situations in which a capable adult 70 or older denies assistance, individuals and families may struggle to access resources.
- Violence in interpersonal relationships is often challenging to discuss in clinical and community-based settings, which can limit identification of the need and connection to resources.

Availability and Accessibility

Child and Adult Protective Services

Within the AHC target area, every county human services office operates a child protective and adult protective services program for children and at-risk adults experiencing abuse or neglect. Individuals may report suspected abuse during business hours and, if eligibility criteria are met, a case manager will follow up to ensure appropriate resources and support are provided to address safety and well-being concerns. While the medical and social service community is well aware of child and adult protective service programs due to mandatory reporting laws, individuals and families do not always know how to identify or use services, which can inhibit access for those in need. If a case does not meet the threshold criteria to be assigned to child or adult protective services, or if a capable adult denies assistance from adult protective services, individuals and families may struggle to obtain and access resources to address their needs.

The National Domestic Violence Hotline

Individuals experiencing interpersonal partner violence may call the National Domestic Violence Hotline 24/7 for referrals to local community agencies. Local agencies provide safety planning and referrals to programs, services and shelters. The National Domestic Violence Hotline's website provides resources for safety planning, legal information and guidance for family and friends of survivors. Waitlists for some programs and shelters limit access for people in need. Many survivors are also not aware of available programs and services, and their safety circumstances often further limit the time and resources they have to pursue access to such services.

Overall

Qualitative feedback indicates that approaching safety-related discussions with individuals and families is challenging for a variety of reasons. Clinical and community-based staff are often not trained on asking safety-related questions and providing appropriate responses or direction to resources available. In the clinical setting, it can be challenging to have private discussions with individuals without the presence of other household members. Such challenges to safety-related conversations can limit individuals' or households' access to resources. Violence Free Colorado, a community-based organization, advocates for survivors and educates people and organizations across the region on interpersonal relationship violence and resources for overcoming barriers to access.

Community Service Gaps

This section lays out the characteristics of the population that was screened and provided with navigation services. It answers the following questions:

1. Do the demographic characteristics of the screened populations correspond to the AHC target population?
2. Are people who receive navigation services successfully connected to community services?
3. What is the access gap experienced by people trying to receive community services?

Do the Demographic Characteristics of the Screened Populations Correspond to the AHC Target Population?

Socioeconomic Characteristics of the Screened Populations

AHC partners screen individuals that correspond to the target population based on socioeconomic characteristics. On average, screened individuals are more vulnerable than the target population. They earn less income, are less likely to have a high school degree and are more likely to identify as a racial or ethnic minority. Of the screened population, 61.4% report an annual income of less than $35,000. In the

AHC target area, 27.1% of the population reports an annual income of less than $35,000. The screened population also reports less annual income than the overall AHC focus areas. The focus areas were identified as likely to contain concentrations of vulnerable populations due to social and economic census indicators. The average age of individuals screened by the AHC is lower than the average age for the entire AHC target area. This is likely due to the high number of pediatric patients screened at a clinical partner site.
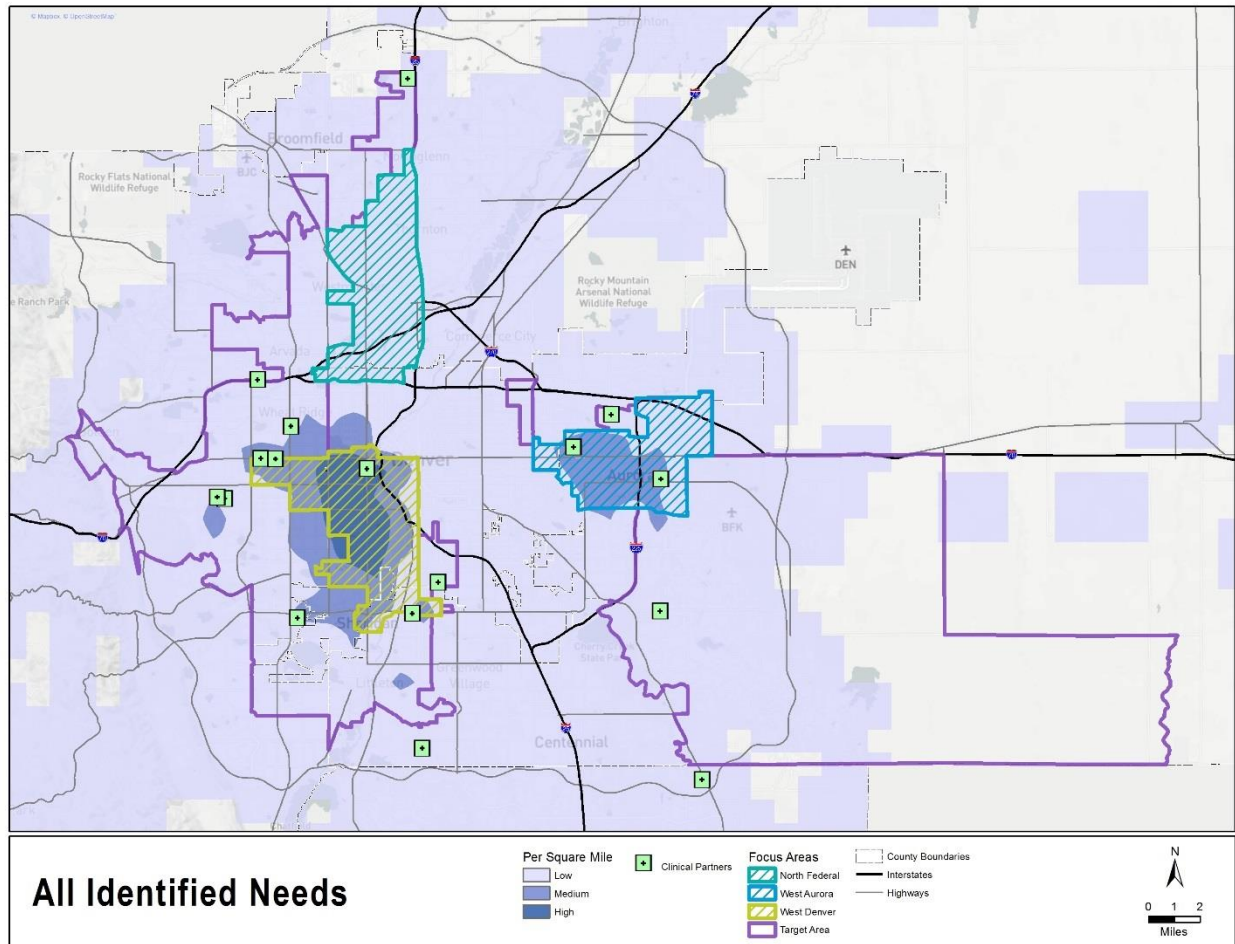

Figure 19: Density of all needs identified based on screenings completed May 1, 2018 to Feb. 28, 2019.
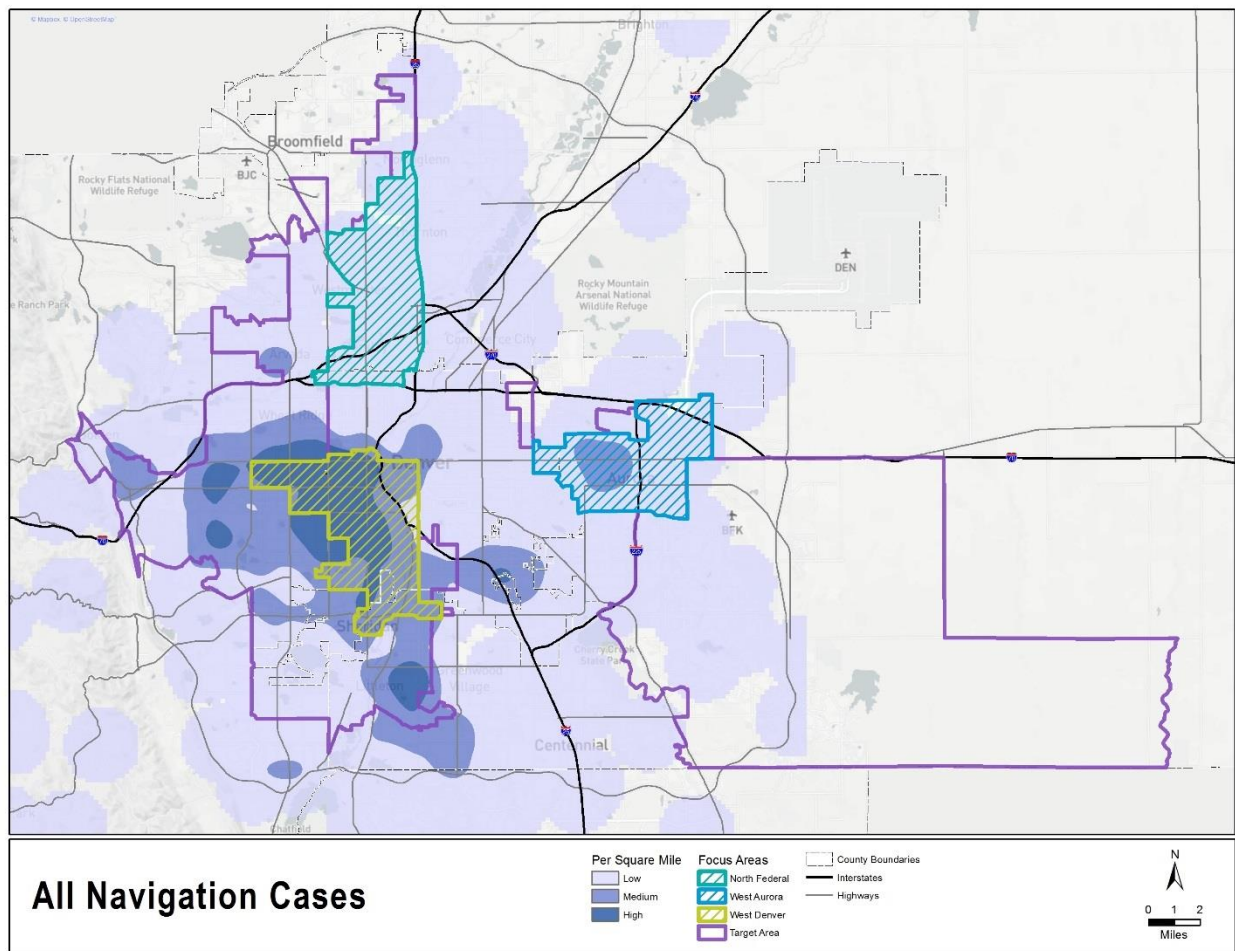
Figure 20: Density of navigation cases from May 1, 2018, to Feb. 28, 2019. Total records: 1,087; 17 (1.5%) in the north Federal Boulevard focus area; 34 (3.1%) in the west Aurora focus area; 325 (29.9%) in the west Denver focus area.

	Screened	Navigated	Screened (18 and older)	Navigated (18 and older)
Total	10,496	1,258	4,575	1,064
Median age	15	43	49	48
Age: Mean (standard deviation)	26.2(24.3)	42.7(22.4)	49.3(19.2)	49.2(17.8)
Female	59.6%	64.0%	62.4%	64.4%
Household size: Mean (standard deviation)	3.96(2.0)	2.96(2.2)	2.78(1.9)	2.68(2.2)
American Indian/Alaska Native	3.1%	2.1%	1.0%	1.0%
Black/African American	8.1%	6.8%	8.1%	6.6%
White	51.3%	58.2%	65.0%	66.0%
Asian	1.9%	0.7%	1.7%	0.8%
No answer	25.2%	13.0%	15.8%	10.1%
Hispanic, Latino/a or Spanish origin	51.7%	31.6%	23.3%	23.9%
No answer	12.4%	6.4%	12.8%	5.4%
Not White, non-Hispanic	62.9%	41.5%	35.3%	33.4%
White non-Hispanic	24.8%	48.4%	50.4%	56.7%
No answer	12.4%	10.1%	14.3%	10.0%
Of those 25 or older				
No school/only kindergarten	1.0%	0.4%	1.0%	0.4%
Grades 1-8	3.8%	3.0%	3.8%	3.0%
Grades 9-11 (some high school)	8.4%	11.5%	8.4%	11.5%

Grade 12/GED diploma	28.3%	30.9%	28.3%	30.9%
Some college (one to three years)	29.2%	33.9%	29.2%	33.9%
College (four or more years)	15.6%	13.9%	15.6%	13.9%
No answer	13.8%	7.0%	14.6%	6.4%

Income				
Less than $10K	21.3%	23.5%	18.3%	20.5%
$10K to less than $15K	9.6%	10.0%	9.6%	10.0%
$15K to less than $20K	8.8%	10.7%	8.9%	11.3%
$20K to less than $25K	10.1%	10.3%	9.4%	11.1%
$25K to less than $35K	11.6%	10.9%	8.9%	10.3%
$35K to less than $50K	8.4%	6.0%	7.3%	6.0%
$50K to less than $75K	3.3%	1.6%	4.0%	1.7%
More than $75K	1.3%	0.6%	2.4%	0.7%
No answer	25.7%	26.5%	31.2%	28.5%
Two or more emergency department visits	26.6%	100.0%	50.6%	100.0%

Table 4: Demographic characteristics of the population screened and the population receiving navigation services.

	Screened	Navigated	Screened (18 and older)	Navigated (18 and older)
Food need	23.2%	68.0%	25.3%	68.4%
Housing need	12.6%	46.8%	17.2%	50.6%
Transportation need	12.2%	49.4%	16.5%	50.6%
Utilities need	7.6%	27.3%	9.0%	28.5%
Any need	27.2%	100.0%	23.3%	100.0%

Status of identified needs				
Any need opt-out		1.4%		1.6%
Any need attempt failed		14.1%		16.2%
Any need resolved		32.4%		36.8%
Any need successful		6.0%		2.6%
Any need pending resolution		48.2%		44.4%

Table 5. Identified needs and progress of need statuses by screening and navigation populations. Statuses of health-related social needs (HRSNs) are reported by clinical navigators. Clinical navigators use self-reporting from beneficiaries to determine the status of HRSNs. See definitions of statuses below, provided by the Center for Medicare and Medicaid Innovation.

Socioeconomic Characteristics of the Population Receiving Navigation Services

The median age of the navigated population is much higher than that of the screened population. Among the screened population younger than 18, only 3% received navigation services, while among those 18 and older, 23% received navigation services. A potential reason for the disparity is that the beneficiaries 18 and younger, although enrolled in Medicaid, are less in need of navigation services than older beneficiaries. So far, the data has not suggested a definitive explanation for the disparity. The navigated

population has slightly less income than the screened population: 23.5% of individuals that received navigation services reported an annual income of less than $10,000, while only 21.3% of the screened population reported an annual income of less than $10,000. Of the population that received navigation services, 65.4% reported an annual income of less than $35,000. On the other hand, the population receiving navigation is more likely to be white and non-Hispanic than the screened population.

Geographic Characteristics of the AHC Population

Maps of screenings and navigations (Figure 20 and 21) show a significant AHC service rate among residents living in the west Denver focus area. A significant number of AHC screenings and navigations are occurring in the west Denver focus area. An estimated 7% of the Medicaid residents in the west Denver focus area were screened by the AHC clinical providers. This service rate seems significant given that screenings only occur when a patient presents to an AHC clinical partner site.

Service rates are smaller (1.51%) in the north Federal Boulevard focus area. The likely explanation is a lower density of AHC clinical sites in that area. Sparse AHC coverage in the north Federal Boulevard focus area suggests project staff should dedicate efforts to identifying operational improvements and new opportunities to reach more individuals in the area.

Areas	Medicaid	AHC screening	Screening/Medicaid
AHC target area	213,367	10,169	4.77%
West Denver	50,314	3637	7.23%
West Aurora	36,343	785	2.16%
North Federal Boulevard	28,235	427	1.51%

Table 6: AHC service rates. Source: Medicaid population, U.S. Census Bureau (American Community Survey, 2017); screenings, AHC data system.

Are People Who Are Navigated Successfully Connected To Community Services?

As of Feb. 28, 2019, the AHC enrolled 1,087 beneficiaries into navigation services. While the total number of beneficiaries using AHC navigation services is significant, the following analysis indicates the prevalence of HRSNs in the target area, and whether and how they are addressed.

HRSN status	Food need	Transportation need	Utilities need	Housing need
Total: N	858	627	351	599
Resolution pending: N (%)	411 (47.9%)	279 (44.5%)	155 (44.2%)	255 (42.6%)
Resolved: N (%)	266 (31%)	209 (33.3%)	126 (35.9%)	210 (35.1%)
Successful: N (%)	48 (5.6%)	25 (4%)	14(4%)	20(3.3%)
Unavailable: N (%)	9(1%)	4(0.6%)	7(2%)	11(1.8%)
Attempt failed: N (%)	116(13.5%)	101(16.1%)	46(13.1%)	96(16%)
Opt-out: N (%)	8(0.9%)	9(1.4%)	3(0.9%)	7(1.2%)

Table 7. *Status of health-related social needs (HRSNs) identified in navigation cases as reported by clinical navigators. Clinical navigators use self-reporting from beneficiaries to determine the status of HRSNs. See definitions of statuses below, provided by the Center for Medicare and Medicaid Innovation.*

HRSN Status	Definition
Resolved	The beneficiary reports that the identified need has been met.
Successful	The beneficiary made contact with a community service provider that should be able to address the unmet need within the beneficiary's open navigation period (one year from screening date), i.e. beneficiary was put on waitlist.
Unavailable	A community service is unavailable, or otherwise unable, to address the beneficiary's unmet need within her or his open navigation period. I.e., the person made contact with a community service provider that may be able to address the unmet need but was put on a wait list longer than one year, and there is no other community service available with a shorter waitlist.
Attempt failed	The navigator attempted to contact the person on at least three separate and consecutive occasions to resolve the unmet need but was unable to reach the beneficiary.
Opt-out	The beneficiary opted out of navigation services for the unmet need.

Table 8. Definitions of health-related social needs (HRSNs) statuses as outlined by the Center for Medicare and Medicaid Innovation.

Based on the summary statistics of the available data, there is a discrepancy between the number of people referred to community-based organizations to address needs and the number of people who receive services. Based on the available data, only 32.4% of identified HRSNs are marked as resolved by navigators; 6% of HRSNs are marked as successful; and 48.2% remain unresolved (resolution pending, unavailable, attempt failed or opt-out).

There are many explanations for the wide discrepancy between identified and addressed needs. Of all needs, 48.2% are pending, meaning the clinical navigator and beneficiary are currently working to address the need. Activities such as applications, referrals and phone calls to connect beneficiaries to services are time-intensive. Beneficiaries may have competing priorities or circumstances that reduce their motivation to participate in navigation services or, at a minimum, cause their participation to be delayed. Follow-up with beneficiaries to obtain status updates can be further challenging due to missed phone calls and inconsistent phone service. Among total needs, 14.1% are not resolved due to failed follow-up in which the clinical navigator made at least three attempts to contact the beneficiary without success. A total of 1.4% of needs indicate that the beneficiary opted out of navigation services, that is,

they preferred not to engage in navigation to address their need. One reason a beneficiary may opt out of services is to avoid benefiting from state or community-based services perceived as welfare services. For 1% of needs, an "unavailable" status was provided, indicating that AHC partners were unaware of a resource to sufficiently meet the beneficiary's need. An "unavailable" status might apply to a household that was already connected to available resources, but such resources were unable or insufficient to completely address the need and no alternative resource was identified.

Clinical navigators refer beneficiaries to community-based resources consistent with beneficiary needs, priorities and goals. Only a subset of total beneficiaries were referred to community-based organizations under contract with the bridge organization. As a result, data collected by the AHC on community service use is limited. Despite this limitation, the data collected informs quality improvement plans such as additional clinical navigator education on organizations' program eligibility and improving AHC referral processes to increase service uptake.

Among the 551 beneficiaries referred to contracted AHC community partners, 169 (31%) received a service. The gap between referrals and service delivery could be the result of incorrect referrals (such as when beneficiaries are not eligible for the organization's services), beneficiaries opting out of services after agreeing to an initial referral or beneficiaries not responding to outreach efforts (contracted community partners make three attempts). Although the sample is too small for any significant statistical inferences, it appears that the gap is more severe for transportation services than for food or housing.

HRSN	Unique beneficiaries - referred	Unique beneficiaries - served
Food	162	32
Transportation	103	redacted
Housing	286	137

Table 9: Beneficiaries referred to and served by AHC-contracted community service providers. Due to a limited number of clients, transportation data has been redacted to comply with HIPAA regulations. "Referred" indicates a navigator used the AHC streamlined process to refer the beneficiary to the community service provider, and the provider made at least three attempts following receipt of email referral to contact the beneficiary; "served" means at least one unit of service was delivered to the beneficiary.

What Is The Access Gap Experienced By People Enrolling In Community Services?

Representative Vignette

The quantitative navigation case and community service provider data collected is too limited to capture the complexity of HRSNs. A clearer picture of the challenges faced by individuals in addressing their HRSNs may be better realized through a qualitative approach in a representative vignette. The following vignette is based on input from clinical navigators, community service providers and bridge organization staff. The vignette represents the distinct and enduring opportunities and accessibility barriers experienced by individuals with HRSNs in the Denver region.

While the individual experiences of access to community or social services are personal, many commonalities affect the acceptance, duration and effect of community and social safety net services. The compounding intersectionality and iterative effects of HRSNs mean that multiple needs may have to be addressed before any positive effect can be realized. Moreover, the sequence in which those needs are addressed may not be based on an individual's wishes, severity of need, or magnitude of the documented positive health effect of addressing a particular HRSN. Rather, needs are often addressed based on the application processes that can be completed or the organizations with capacity. HRSNs affect a community's clinical, financial and social outcomes. To understand the target area landscape and develop stronger clinical-community linkages and a continuum of health, the consortium needs to understand individuals' experiences and barriers to addressing their needs. The following vignette is a representation of the actual barriers experienced by beneficiaries.

Consider Alex. He is on an organ transplant waitlist and told his navigator that "his life has taken a complete turn for the better since he began to address his social needs." Alex initially reported three HRSNs: food, transportation and utilities. He now receives SNAP and Meals on Wheels. He uses Access-A-Ride to save $25 to $40, which he previously spent per taxi ride. A community-based organization helped Alex pay his past-due utility bills, and eliminated his fear of having his power turned off. Alex told his navigator how much these services improved his quality of life and decreased the financial stress that previously clouded his days. The journey to enroll in the services to address his needs was profound. Let's explore the additional stress above his medical condition that Alex experienced while working to address his health-related social needs.

Alex lives in his own home. He reported three emergency department visits in the past 12 months. To address his transportation needs, Alex completed two applications, one with the Regional Transportation Department for Access-a-Ride and the other through the local agency operating the state's Medicaid non-emergency medical transportation. To address his food insecurity, Alex completed two applications, one with Volunteers of America for Meals on Wheels and one with his county human services office for the

Supplemental Nutrition Assistance Program (SNAP). Finally, to ensure his utilities weren't turned off, Alex completed an application with an agency that administers Energy Outreach Colorado funds.

Before discussing his plan with a navigator, Alex decided to address his food need first, his transportation needs, second, and finally his utility needs. However, his navigator suggested he fill out the non-emergency medical transportation application while he was at the clinic so his doctor could sign it, per program requirements. Alex's decision to address his utility issue last because he learned he was only eligible for the utility benefit once a year. To address all three needs, the enrollment process would probably take four to six weeks before services began. As a result of the delay, he decided to miss another utility payment and use the much-needed money for transportation and prescriptions, knowing that he could receive up to $1,000 in utility assistance for the year and the assistance would cover his bill the following month to get him on-track again. Despite his initial wishes, Alex agreed to pursue transportation services first after his navigator helped him understand application requirements and program benefits.

Alex went home, hoping to start his SNAP application. When his navigator called to check in a week later, Alex reported he hadn't applied for SNAP benefits because he did not have access to the internet. His navigator provided him a list of the documents he'd need to collect and told him his local library had a scanner and internet he could use to complete his application. The list his navigator provided indicated he was required to provide digital copies of his proof of identification, lease agreement, Social Security award letter as proof of income and three bank statements from the past three months demonstrating his income and assets were within the eligibility limits. Because he does not bank online, it took Alex two weeks receive his reprinted bank statements. Then, he found his Social Security award letter and his lease agreement.

Once he had his documents prepared, Alex went to the local library. He called a taxi because he did not want to wait a few days to get a ride through non-emergency medical transportation. It took a while and required the help of library staff, but Alex was able to scan and save his documents. He filled out the online SNAP application and uploaded his supporting documents. Two weeks after he submitted his application, a county human services worker called to schedule a phone interview to verify the information submitted. The half-hour call took place four weeks later, and Alex was approved for SNAP benefits. Three days later, he scheduled a taxi, went to the county office, and picked up his Electronic Benefits Transfer card.

In the interim, Alex signed up for Meals on Wheels. To apply for Meals on Wheels, Alex called what he thought was his local provider but learned that residents of his county were supposed to call a different provider. Alex called and scheduled a phone intake. A few days later, a provider employee called Alex and conducted a half-hour interview to verify his age and other demographic information. Alex requested, and was approved for, hot meal deliveries that would begin about a month later. Alex also learned a

congregate meal site a couple of miles away from his home offered hot meals during lunch hours, Monday through Friday.

Next, Alex completed the Access-a-Ride application. He called the RTD number his navigator provided. A voicemail instructed Alex to leave his name, address and phone number. A few days later, a paper application arrived by mail. The application instructed him to fill out a few sections and then ask his doctor to fill out the rest. This took some time. His doctor was willing to fill out the form, but it took more than 10 days to receive the completed form. Once his navigator learned his doctor finished the paper application, they faxed it to RTD. Alex received a phone call to schedule a separate assessment with RTD to verify his eligibility. RTD picked him up on the date of his assessment. Consistent with his doctor's assessment, Alex was found to have physical limitations and was approved for Access-a-Ride.

Finally, as expected, Alex received a shut-off notice in the mail from his electricity provider. After being unable to pay for several months, he was $800 in arrears. He called his navigator, who provided him a referral to a community organization. Alex called the community organization and left a message with his name, address, phone number and utility account number. The following day, he received a phone call from the organization. Alex agreed to attend a financial literacy class to learn the basics of budgeting and reducing expenses. He attended the class, the community organization paid his utility bill and he had finally addressed all his HRSNs.

Prioritizing and Developing Strategies to Alleviate Gaps

Based on feedback from the advisory board and bridge organization project staff, the AHC consortium will begin working to alleviate identified gaps in the coming year. Insufficient food is the No. 1 HRSN reported by beneficiaries. With 23.2% of all screenings and 68% of navigation beneficiaries indicating a food need, the advisory board determined that food security is by far the most immediate need to address. As a result, work to alleviate barriers to food resource accessibility will be prioritized. The AHC consortium will subsequently develop a plan to address transportation, housing, utilities and safety needs in the order of their prevalence in screening results.

The AHC's strategy to help people access food services is multipronged. First, the AHC will expand partnerships with community organizations that provide food services, such as food pantries. Such partnerships will help further streamline referral processes across the region and aggregate more data to help project staff more clearly understand service barriers and use. Next, the consortium will attempt to identify opportunities to expand access to food resources. Finally, the consortium will work to expand beneficiaries' knowledge of available resources through existing or new recommended practices.

Food Security - Increased Partnerships for Data Aggregation

In the coming months, project staff will use AHC community referral data and input from the advisory board and clinical navigators to expand partnerships with community service providers. This will help project staff meet the overall goal of determining the effect of addressing HRSNs on health care cost and quality outcomes. The data will also inform future decisions by the AHC advisory board.

New food service partners may include:

- Metro Caring
- Hunger Free Colorado
- religious communities
- Denver Botanic Gardens
- school food pantries
- youth organizations (for examples, Boys and Girls Clubs of Metro Denver)

Expand Access and Decrease Barriers

As the analysis has demonstrated, many beneficiaries experience barriers to accessing services. From the beneficiary perspective these barriers contribute to their stress and confusion, and decrease their motivation to address their HRSNs. The advisory board will focus on the following areas to decrease barriers:

- expanding hours of operation at food pantries where possible
- expanding organizations' eligibility criteria where possible
- decreasing paperwork requirements for beneficiaries
- continuing cross-linkage learnings - clinical and community-based organization staff visits at each other's sites

Expand Beneficiaries' Knowledge

Clinical navigators report many beneficiaries are unaware and unprepared for the application requirements and verifications required to access community and social services. Using the quality improvement process, the AHC consortium will provide beneficiaries with more information on application and program requirements to set realistic expectations, prepare beneficiaries and ideally improve beneficiary uptake of services.

Other Potential Solutions

Some ideas to address identified gaps do not fit into one of the predefined strategies but the advisory board and project staff have determined they are still worth pursuing. These include:

- Increase SNAP enrollment by expanding expedited referrals to Hunger Free Colorado.
- Co-locate human services and food pantry staff at clinical sites.
- Establish farmers markets at clinic sites with scheduled appointments for beneficiaries.
- Expand knowledge of Double Up Food Bucks, a program that doubles the value of SNAP benefits at farmers markets.

Other HRSNs

As detailed above, the intersection of HRSNs can be an exponential hurdle for beneficiaries in addressing all their needs. However, the complexity of the strategies proposed above necessitate a linear approach from the advisory board to address improvements in community-based service delivery. As a result, the advisory board will gather data, as well as input from partners and stakeholders, in the coming months to determine how to address additional HRSNs. Based on the current screening results, the advisory board will work on housing next, then transportation, followed by utilities and safety needs.

Conclusion

Through this analysis, the bridge organization determined that while gaps in the availability or capacity of community-based services exist, the more pronounced gap is the accessibility of community-based services. Census demographic data demonstrates the AHC screened and served a population with greater vulnerability, less income and higher need than originally expected. Moreover, while this analysis finds a variety of community services available in the region, availability does not necessarily equate to the accessibility or sufficiency of community services to adequately meet the needs of individuals and households. For example, while food or utility assistance may be available, due to extensive paperwork, processes and travel, time and persistence are often required to obtain assistance. Due to capacity or benefit limits, services rendered may not be sufficient to meet the entire need. In addition, when there is an intersectionality of social needs, barriers to assistance are intensified. For example, if an individual must travel to an office to receive housing assistance but does not have reliable transportation, the opportunity to receive such assistance is impeded by the intersection of the person's housing and transportation needs. Such challenges are further intensified if an individual has a disability, a serious medical condition, a job that conflicts with service hours or if they live in a multigenerational home and have additional responsibilities for children, parents or grandchildren.

Demand is growing significantly for community-based services combined with a concurrent decrease in supply due to a lack of appropriate investment and misunderstanding by decision-makers of the benefits provided to individuals who would benefit the most from community-based services. The current understanding in how to fund community-based services measures the financial costs associated with delivering services. An alternative understanding should be to evaluate community-based services as affordable investments to lower the exponential costs of clinical care and improve health outcomes. In the coming year, the AHC will focus on narrowing the accessibility gaps identified in this analysis to further improve the integration of clinical and community care and promote greater community health and well-being in the region.