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Executive Summary

The Denver Regional Accountable Health Community bridges clinical and community-based partners to identify and address unmet health-related social needs and enhance overall health and well-being of residents across the Denver metro area. Demographic and socioeconomic analysis of neighborhoods served by the Denver Regional AHC suggests that it is well-positioned to reach households that may benefit most from community-based services to meet health-related social needs. Food security persists as the No. 1 reported unmet need, followed by housing security and quality, transportation, utility assistance and safety. While specific capacity and service gaps vary, accessibility of services is the universally reported barrier. In Year 4 the Denver Regional AHC advisory board worked to improve availability and accessibility of services through its collaborative work groups. Based on data that reported a surge in people reporting housing security needs, in Year 5 the advisory board will prioritize closing gaps in the delivery of housing security resources. The Denver Regional AHC Quality Improvement Plan follows this report and details corresponding work group activities, results and recommendations.
Part I: Gap Analysis

Introduction

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

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

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

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

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

1. Demographic overview of the people living in the Denver Regional AHC area to better understand individuals and households that may benefit from community-based services.
2. Summary of the Denver Regional AHC screening results, including the prevalence of types and numbers of identified HRSNs.
3. Summary of available community-based resources, gaps and barriers to service, and strategies and opportunities for improvement.
4. The information in this report guides the Denver Regional AHC advisory board and project team to analyze existing community-based service gaps and barriers to care, prioritize gaps and develop possible solutions. In program Year 3, the Denver Regional AHC established work groups specific to each HRSN, those work groups then developed small-scale and replicable projects to test proposed solutions. The Denver Regional AHC Quality Improvement Plan reports on the outcomes and sustainability of these projects. In short, this gap analysis report is a foundational document to inform the direction of the Denver Regional AHC’s community-level quality improvement efforts to address gaps and barriers to using community-based services and HRSNs in the region.

Goals

Goals of the Denver Regional AHC include:

1) To improve clinical-community alignment for screening and referral.
2) To enhance community-level interventions to address HRSNs.

As part of a national effort funded by the Center for Medicare and Medicaid Innovation, the Denver Regional AHC aims to demonstrate the value and total cost savings of meeting Medicare and Medicaid beneficiaries’ HRSNs through community resources. By collecting data on identified needs, community services delivered and corresponding effects on health, the Denver Regional AHC project team uses the AHC model to gather evidence to inform future policy, allocation of funding and services to better address HRSNs and community health.
The Denver Regional Accountable Health Community’s mission and vision are:

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

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

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

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

**Timeline**
During Year 1 of operations (May 2017 through April 2018), the Denver Regional AHC advisory board established a strategic plan and prepared screening and referral workflows between clinical and community partners. Screening and referral commenced in Year 2 (May 2018 through April 2019), and Year 3 of Denver Regional AHC operations ended in April 2020. During Year 4, which ended in April 2021, the Denver Regional AHC continued operations, established new clinical and community partnerships, and completed the first phase of its work to address gaps and barriers to community-based services. Year 4 continued screening and navigation operations as well as community-level quality improvement initiatives, and saw the conclusion and evaluation of the Year 3 work groups to close gaps in the delivery of community services. Despite being affected by the COVID-19 pandemic and resulting public health emergency, Year 4 was successful — through screening and navigation, the project helped more than 3,400 people with HRSNs.
Community Profile: Denver Regional Accountable Health Community Service Area

The Denver Regional AHC includes Adams, Arapahoe, Broomfield, Denver, Douglas and Jefferson counties. The greatest number of individuals served by the Denver Regional AHC reside in the Denver metro area near clinical partner sites that initiate screening and navigation activities (Figure 1). During Year 4, the Denver Regional AHC project team saw a marked increase in the size of the geographic area where partners were using the AHC model to screen and navigate people.

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

The highest density of screened and navigated households spans from the western edge of Golden across the center of the metropolitan area to the eastern edge of Aurora along E-470. From the south to the north the area spans from Lone Tree in the south to Broomfield in the north.
Methods and Approach

Community Profile and Current State Assessments

Observations within this report, as well as supporting analyses, are informed by quantitative and qualitative data. Figure 1 depicts the six-county Denver Regional AHC area, based on the addresses of individuals who completed HRSN screenings at Denver Regional AHC clinical partner sites from the program model start to date, May 2018 through Jan. 31, 2021.

The American Community Survey 2015-2019 demographic and socioeconomic data of the six-county Denver Regional AHC area and HRSN screening results of Medicare and Medicaid beneficiaries from the program model start to date (May 2018 to Feb. 29, 2020) inform the “Current State Assessment of Population and Community Needs” (see page 12). More detailed methodology behind the community profile and current state assessment of population and community needs is provided in the Technical and Quantitative Data Appendix.

The “Current State Assessment of Service Availability and Accessibility” (see page 20) represents contributions from:

1) Community-facing staff screening and navigating individuals and households for HRSNs and community-based services.
2) The Denver Regional AHC advisory board and work groups composed of clinical and community-based organization leadership with other subject matter experts, gathered for facilitated discussions. See Qualitative Data Appendix for more details on qualitative data sources.

Advisory Board and Work Groups

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

Further organized into four smaller work groups, advisory board members collaborated to address gaps and barriers to community-based services related to the following HRSNs: food security; housing security and quality; utilities; and safety. Work groups met monthly to:

1) Prioritize gaps and barriers to community-based services.
2) Brainstorm and prioritize solutions.
3) Test solutions.
4) Evaluate for sustainability with the overall goal to improve availability and accessibility of services.

At least one clinical and community advisory board member sits on each work group along with other local subject-matter experts who volunteer resources and time.

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

The Denver Regional AHC advisory board opted not to convene a transportation work group, as there are several other transportation-related initiatives, projects and funding mechanisms already in place in the Denver Regional AHC service area. Alternatively, DRCOG’s Transportation Planning and Operations division developed the Coordinated Public Transit Human Services Transportation Plan. The Coordinated Transit Plan identified the transportation needs of individuals with disabilities, older adults and low-income individuals and families; provided strategies for meeting those needs; and prioritized transportation services for funding and implementation. The division prepares the Coordinated Transit Plan approximately every five years to contribute to closing gaps in transportation services through informing future transportation and mobility investments in the Denver region.
Quality improvement

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

Definitions

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

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

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

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

High-Risk: Per the national Accountable Health Communities model, individuals screened who report at least one HRSN and two or more emergency department visits in the previous 12 months are considered high-risk and eligible for navigation services. Navigation services include a person-centered action plan, referral and follow-up to connect the individual to community-based resources.

The HRSN screening tool identifies needs in the following ways:

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

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


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

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

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

Public health emergency: The Secretary of the U.S. Department of Health and Human Services may, under section 319 of the Public Health Service Act, determine that:

   a) A disease or disorder presents a public health emergency.
   b) A public health emergency, including significant outbreaks of infectious disease or bioterrorist attacks, otherwise exists.

Navigation: Community service navigation: Assistance provided to help a person with HRSNs that includes an in-depth assessment, patient-centered action planning and follow-up with the community-dwelling beneficiary until they have been matched with a community service provider that meets their needs or the need has been documented as unresolvable.
Strengths and Limitations

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

Strengths

- The HRSN screening is based on validated tools to promote the fidelity and reliability of results, assembled by a technical expert panel convened by the Centers for Medicare and Medicaid Services.
- The Denver Regional AHC convenes community and clinical partners in a coordinated effort to address community needs.
- Beyond its founding clinical and community-based partners, the Denver Regional AHC works with additional subject matter experts and service providers to identify and close gaps in community-based services to improve future availability and accessibility.
- The assessment of gaps and barriers to service is informed by community-facing staff who screen and navigate individuals and families on a daily basis to collect detailed insight into the persistent challenges of accessing services within existing systems.
- The American Community Survey 2015-2019 demographic data used in this report’s “Current State Assessment of Population Characteristics and Community Needs” (see provided detailed...
American Community Survey data allows for comparisons among areas of the region with high percentages of at-risk households to areas with high screening density.

**Limitations**

- HRSN screening results are specific to the Medicare and Medicaid beneficiaries screened at Denver Regional AHC clinical partner sites.
- To promote person-centered and trust in care, people are able to leave questions unanswered on the HRSN screening tool, thus screening results are not complete in all cases. For example, in domestic violence situations, a person may not be ready to disclose information or access services at the time of screening due to extenuating and personal circumstances. Moreover, safety-related screening results are underreported.*
- No specific funding exists for the Denver Regional AHC to pay for community-based services or for work groups to invest in additional community-based service capacity which requires offering existing resources and time for improvement efforts.
- Primary input from Medicare and Medicaid beneficiaries is not collected in this report’s assessment of identified gaps and barriers to service.
- The American Community Survey 2015-2019 demographic data used in this report’s “Current State Assessment of Population Characteristics and Community Needs” (see page 15) uses a five-year average of survey data. This leads to a lag of two to three years in American Community Survey data. The 2019 American Community Survey uses data from 2015-2019. Additionally, the American Community Survey questions do not closely enough resemble AHC survey questions to allow for detailed comparisons.
- In March 2020, everyone in the United States began to experience the ongoing disruption to lives and regular routines due to the COVID-19 pandemic and resulting public health emergency. The implementation of the AHC model in Denver was no exception. From March 2020 through January 2021 the number of clinical partner sites able to screen and navigate people was severely reduced. Also, due to the effects of the pandemic, the services available from community partners was severely curtailed due to issues related to the public health emergency, including limits on the number of people allowed to ride in a van or bus and the number of staff allowed to be inside a workplace at one time.
- The number of people who accessed clinical services decreased tremendously due to the public health emergency. The number of completed screenings dropped by 50% from the model baseline in April and May 2020 and remained low until program operations were evolved to counter the effect of the public health emergency in January 2021.

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

Summary

This section comprises two assessments:

2) Current State Assessment of Service Availability and Accessibility.

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

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

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

Current State Assessment of Population Characteristics and Community Needs

**Population Characteristics**

Complex, interrelated factors influence a community’s overall health and well-being. When evaluated across systems, socioeconomic factors contribute to approximately 40% of health outcomes compared with only 30% from health behaviors, 20% from clinical care and 10% from physical environment (Figure 2). By adapting a method to identify people who have many HRSNs and require high-cost health care called hot-spotting and social vulnerability indexing, this report evaluates the Denver Regional AHC’s effectiveness in reaching households that may benefit most from community-based services based on demographic and socioeconomic risk indicators collected in 2019 American Community Survey data. Furthermore, this Gap Analysis assesses whether the Denver Regional AHC clinical and community partners are well-positioned in the region to reach and serve households with potentially unmet HRSNs.

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In Table 1, demographic and socioeconomic indicators of Denver Regional AHC neighborhoods with higher screening rates are compared with:

a) Neighborhoods that may be considered at-risk for higher unmet HRSNs based on their demographic and socioeconomic characteristics.

b) Neighborhoods across the entire six-county Denver Regional AHC area.

These comparisons can reveal whether the Denver Regional AHC serves neighborhoods more similar to the general population or neighborhoods that may have increased risk of unmet HRSNs.

Neighborhoods served by Denver Regional AHC with demographic and socioeconomic indicators that most closely match those of at-risk neighborhoods are shaded in green. Neighborhoods with characteristics more similar to the general population are shaded in yellow. Neighborhoods with characteristics that fall somewhere in between at-risk neighborhoods and the greater region are shaded in grey. For example, 15% of households in Denver Regional AHC high-screened tracts reported income of less than the federal poverty level, which is nearly identical to the 16% exhibited in at-risk tracts, compared with 9% in the general population.

This report does not claim that these characteristics define an individual or household as vulnerable or at-risk. People are capable and resilient. Multigenerational households can benefit families. Being an older
adult or someone with a disability does not mean an individual is dependent. The demographic and socioeconomic indicators of Table 1 are included with the understanding that complex physical, social and economic factors affect an individual’s access to basic resources and their overall health. However, it is often people within these demographics or socioeconomic situations who experience more negative health outcomes⁶, and thus the Denver Regional AHC tries to better serve such community members in its efforts toward health equity.

<table>
<thead>
<tr>
<th></th>
<th>High-screened tracts</th>
<th>At-risk tracts</th>
<th>All tracts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total population</strong></td>
<td>663,719</td>
<td>717,871</td>
<td>2,832,969</td>
</tr>
<tr>
<td><strong>Total households</strong></td>
<td>253,508</td>
<td>247,730</td>
<td>1,088,718</td>
</tr>
<tr>
<td><strong>Mean household size</strong></td>
<td>2.6</td>
<td>2.9</td>
<td>2.6</td>
</tr>
<tr>
<td><strong>Percent of household with families</strong></td>
<td>58%</td>
<td>63%</td>
<td>64%</td>
</tr>
<tr>
<td><strong>Percent of grandparents with grandchildren under 18 living with their own grandchildren</strong></td>
<td>4%</td>
<td>5%</td>
<td>3%</td>
</tr>
<tr>
<td><strong>Percent of single-person households</strong></td>
<td>31%</td>
<td>28%</td>
<td>27%</td>
</tr>
<tr>
<td><strong>Percent of households with income below poverty level during last 12 months</strong></td>
<td>15%</td>
<td>16%</td>
<td>9%</td>
</tr>
<tr>
<td><strong>Percent of unemployed individuals</strong></td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td><strong>Percent of individuals employed</strong></td>
<td>67%</td>
<td>66%</td>
<td>69%</td>
</tr>
<tr>
<td><strong>Percent of individuals born outside the U.S.</strong></td>
<td>17%</td>
<td>23%</td>
<td>12%</td>
</tr>
<tr>
<td><strong>Percent of individuals who speak English less than ‘very well’</strong></td>
<td>13%</td>
<td>18%</td>
<td>7%</td>
</tr>
<tr>
<td><strong>Percent Latinx/Hispanic</strong></td>
<td>40%</td>
<td>49%</td>
<td>22%</td>
</tr>
<tr>
<td><strong>Percent of African American individuals</strong></td>
<td>8%</td>
<td>11%</td>
<td>5%</td>
</tr>
<tr>
<td><strong>Percent of households rent burdened (30% or more of household income spent on rent in the past 12 months)</strong></td>
<td>54%</td>
<td>57%</td>
<td>48%</td>
</tr>
<tr>
<td><strong>Percent of individuals with Medicaid coverage</strong></td>
<td>29%</td>
<td>33%</td>
<td>17%</td>
</tr>
</tbody>
</table>

Table 1. Demographic and socioeconomic indicators that may contribute to health-related outcomes compared across Denver Regional AHC-high screened tracts, at-risk tracts and the total Denver Regional AHC six-county area, American Community Survey, 2019. Green-shaded indicator represents neighborhoods served by the Denver Regional AHC that have characteristics that most closely match those of at-risk neighborhoods. Yellow-shaded indicator represents neighborhoods served by the Denver Regional AHC that have characteristics more similar to the general population. Grey-shaded indicator represents neighborhoods served by the Denver Regional AHC that have characteristics in between those of at-risk neighborhoods and of the general population in the Denver Regional AHC area. Detail on data methodology is included in Appendix A.

Result 1: This analysis indicates the Denver Regional AHC meets the goal of serving neighborhoods that may benefit the most from community-based services to address HRSNs. Specifically, the Denver Regional AHC serves neighborhoods with a higher proportion of the following individuals and households, compared with the general population (Table 1):

- Households with Medicaid health insurance.
- Households who are rent-burdened.
- Households receiving Supplemental Nutrition Assistance Program (SNAP) or other public benefits.
- Households identifying as Latinx/Hispanic.
- Individuals with less than a high school education.
- Individuals with a disability.
- Households with income below the poverty level.
- Households identifying as African American.
The poverty level does not relate to actual living expenses for a household. The 2020 federal poverty level for family of four was $26,200\(^7\), a meager income to support a household of any number of people in the Denver metro area. However, the DRCOG AHC project team believes in the general utility of the poverty level indicator.

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

Denver Regional AHC serves neighborhoods with a proportion of older adults similar to the general population (18% within the Denver Regional AHC area compared with 19% of the general population). By comparison, the share of the population in at-risk tracts classified as older adults (age 60 and older) is only 15%. As the Area Agency on Aging for the Denver region, DRCOG is responsible for the establishment and continued support of a comprehensive, coordinated system of community-based services to meet the needs of the region’s older adults.

While African American households make up 5% of the general population, African American households make up 11% of at-risk tracts and 8% of neighborhoods served by the Denver Regional AHC. This result is an improvement of three percentage points from the Year 3 gap analysis result. It demonstrates the success of the Denver Regional AHC in continuing efforts to improve its service to African American households.

**Result 2: Opportunities for greatest improvement to reach more:**

- Percent of unemployed individuals.
- Percent of individuals born outside the U.S.
- Percent of households with families.

The Denver Regional AHC serves neighborhoods somewhere between at-risk tracts and the general population for those born outside of the United States, multigeneration households and older adult households. Through continued expansion of clinical partnerships to contact beneficiaries digitally in Year 5, the Denver Regional AHC expects to improve and reach more of these individuals and households.

In addition to the American Community Survey’s five-year rolling average data, the HRSN screening tool collects demographic and economic information with corresponding HRSNs (Table 2). Demographic and

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economic information allows the Denver Regional AHC project team to better understand the characteristics of individuals and households screened with unmet needs.

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

<table>
<thead>
<tr>
<th>HRSN screenings: demographic/socioeconomic indicators</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age: Median (interquartile range)</td>
<td>14.7 years (7.7, 35.7 years)</td>
</tr>
<tr>
<td>Female</td>
<td>59%</td>
</tr>
<tr>
<td>Male</td>
<td>41%</td>
</tr>
<tr>
<td>Household size: mean (standard deviation)</td>
<td>4.0 (2.0)</td>
</tr>
</tbody>
</table>

Race: Note screening allows multiple selections.

<table>
<thead>
<tr>
<th>Race</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian/Alaska Native</td>
<td>5.0%</td>
</tr>
<tr>
<td>Asian</td>
<td>2.6%</td>
</tr>
<tr>
<td>Black or African American</td>
<td>12.7%</td>
</tr>
<tr>
<td>Native Hawaiian/Other Pacific Islander</td>
<td>0.6%</td>
</tr>
<tr>
<td>White</td>
<td>67.7%</td>
</tr>
<tr>
<td>Other</td>
<td>14.7%</td>
</tr>
<tr>
<td>No answer</td>
<td>27.2%</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>27.2%</td>
</tr>
<tr>
<td>Hispanic, Latinx or Spanish Origin</td>
<td>62.8%</td>
</tr>
<tr>
<td>No answer</td>
<td>13.5%</td>
</tr>
</tbody>
</table>
### Table 2. Demographic and socioeconomic indicators collected via health-related social need screenings completed by Denver Regional AHC clinical partners, project-to-date (May 1, 2018-Jan. 31, 2021).

Table 2 presents project-to-date screening data (May 1, 2018-Jan. 31, 2021) to conclude that the Denver Regional AHC serves the populations outlined in results 3-15.

**Result 3:** More children than any other age group (14.7 median age).
Interquartile range explanation (Table 2): The median age of screened individuals is 14.7 indicating that half of screenings were of an individual younger than 14.7 and half were of an individual older than 14.7 years. The 25th percentile is 7.7 years, meaning that one quarter of screened individuals were younger than 7.7 years old. The 75th percentile is 35.7 years, meaning that one quarter of screened individuals were older than 34.5. A median age of 14.7 years indicates that most screenings were completed for children. The interquartile range of 7.7 and 35.7 years further demonstrates the dataset represents a younger population; half of screened individuals were between 7.1 and 34.5 years old.

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

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

Result 6: A large majority of individuals who identified as white or Hispanic/Latinx/Spanish (67.7% white; 62.8% of Hispanic, Latinx or Spanish origin). 12.7% identify as Black/African American while other minority communities were less represented: 5.0% American Indian/Alaska Native and 2.6% Asian. 27.2% and 13.5% did not respond to race and ethnicity screening questions, respectively, suggesting a fair amount of demographic information is not accounted for.

Result 7: A varied population in terms of education level (of those 18 and older). 20.5% report less than a high school education. 66.6% report educational attainment between a high school degree and some years of college (38.3% high school diploma/General Educational Development diploma; 28.3% one to three years of college). Only 12.9% reported four years or more of college.

Result 8: A majority of households that have incomes lower than the poverty level (approximately 68.3%, at $26,200 per year assuming an average household of four). Only 4.1% of households reported annual income greater than $50,000.

Overall, the demographic and economic information gathered during HRSN screenings indicates the Denver Regional AHC serves a majority of multiperson households; more white, Hispanic/Latinx individuals than those from other races/ethnicities; households with a variety of educational levels; and mostly households near or below the poverty level. Further, compared with Year 3, the population served in Year 4 represents a large increase in the number of households that live below the poverty line and people who identify as Black or African American. In the next section, screening results depict the types and prevalence of needs identified for individuals and households screened for HRSNs in year 4.
### Community Needs: Prevalence of Health-Related Social Needs

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total screenings</strong></td>
<td>13,002</td>
<td>14,692</td>
<td>8,464</td>
<td>36,158</td>
</tr>
<tr>
<td>Screenings: 0 needs</td>
<td>8,625</td>
<td>9,900</td>
<td>4,990</td>
<td>23,515</td>
</tr>
<tr>
<td></td>
<td>66.3%</td>
<td>67.4%</td>
<td>59.0%</td>
<td>65.0%</td>
</tr>
<tr>
<td>Screenings: 1 or more needs</td>
<td>4,377</td>
<td>4,792</td>
<td>3,474</td>
<td>12,643</td>
</tr>
<tr>
<td></td>
<td>33.7%</td>
<td>32.6%</td>
<td>41.0%</td>
<td>35.0%</td>
</tr>
<tr>
<td>Screenings: 1 need</td>
<td>2,508</td>
<td>2,814</td>
<td>1,958</td>
<td>7,280</td>
</tr>
<tr>
<td></td>
<td>19.3%</td>
<td>19.2%</td>
<td>23.1%</td>
<td>20.1%</td>
</tr>
<tr>
<td>Screenings: 2 needs</td>
<td>1,176</td>
<td>1,326</td>
<td>980</td>
<td>3,482</td>
</tr>
<tr>
<td></td>
<td>9.0%</td>
<td>9.0%</td>
<td>11.6%</td>
<td>9.6%</td>
</tr>
<tr>
<td>Screenings: 3 needs</td>
<td>525</td>
<td>544</td>
<td>437</td>
<td>1,506</td>
</tr>
<tr>
<td></td>
<td>4.0%</td>
<td>3.7%</td>
<td>5.2%</td>
<td>4.2%</td>
</tr>
<tr>
<td>Screenings: 4 needs</td>
<td>163</td>
<td>104</td>
<td>94</td>
<td>361</td>
</tr>
<tr>
<td></td>
<td>1.3%</td>
<td>0.7%</td>
<td>1.1%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Screenings: 5 needs</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.1%</td>
<td>0.04%</td>
</tr>
<tr>
<td>Screenings: housing needs</td>
<td>1,586</td>
<td>1,564</td>
<td>1,384</td>
<td>4,534</td>
</tr>
<tr>
<td></td>
<td>12.2%</td>
<td>10.6%</td>
<td>16.4%</td>
<td>12.5%</td>
</tr>
<tr>
<td>Screenings: housing needs (security)</td>
<td>1,008</td>
<td>875</td>
<td>955</td>
<td>2,838</td>
</tr>
<tr>
<td></td>
<td>7.8%</td>
<td>6.0%</td>
<td>11.3%</td>
<td>7.8%</td>
</tr>
<tr>
<td>Screenings: housing needs (quality)</td>
<td>744</td>
<td>847</td>
<td>561</td>
<td>2,152</td>
</tr>
<tr>
<td></td>
<td>5.7%</td>
<td>5.8%</td>
<td>6.6%</td>
<td>6.0%</td>
</tr>
<tr>
<td>Screenings: food needs</td>
<td>2,978</td>
<td>3,354</td>
<td>2,401</td>
<td>8,733</td>
</tr>
<tr>
<td></td>
<td>22.9%</td>
<td>22.8%</td>
<td>28.4%</td>
<td>24.2%</td>
</tr>
<tr>
<td>Screenings: transportation needs</td>
<td>1,543</td>
<td>1,540</td>
<td>1,105</td>
<td>4,188</td>
</tr>
<tr>
<td></td>
<td>11.9%</td>
<td>10.5%</td>
<td>13.1%</td>
<td>11.6%</td>
</tr>
<tr>
<td>Screenings: utility needs</td>
<td>920</td>
<td>998</td>
<td>712</td>
<td>2,630</td>
</tr>
<tr>
<td></td>
<td>7.1%</td>
<td>6.8%</td>
<td>8.4%</td>
<td>7.3%</td>
</tr>
<tr>
<td>Screenings: safety needs</td>
<td>85</td>
<td>78</td>
<td>28</td>
<td>191</td>
</tr>
<tr>
<td></td>
<td>0.7%</td>
<td>0.5%</td>
<td>0.3%</td>
<td>0.5%</td>
</tr>
</tbody>
</table>
Table 3. Prevalence of health-related social needs identified by the AHC model screening tool. (Year 1: May 1, 2018-April 30, 2019; Year 2: May 1, 2019 to April 30, 2020; Year 3: May 1, 2020 to Jan. 31, 2021; Project-to-date: May 1, 2018 to Jan. 31, 2021). Higher risk is defined by having any number of health-related social needs and two or more emergency department visits in the last 12 months.

Result 9: More than half of screenings identified zero unmet HRSNs (59%), meaning that almost half of screenings accounted for all identified needs across the region.

Result 10: Of screenings with identified needs, 23% of households reported only one unmet HRSN.

Result 11: Food security is the top-reported unmet HRSN (28% of screenings with identified needs). Housing (security/quality, 16%) and transportation (13%) needs were reported at similar rates and were identified at approximately half the rate of food security.

Utilities are consistently the fourth most frequently reported unmet HRSN (8% of screenings with identified needs).

Safety-related needs consistently report at the bottom tier of needs (0% of screenings with identified needs). Safety needs are underreported, so this is only a cursory baseline of the potential need in the region.
**Result 12:** For the first time since the Denver Regional AHC began collecting data in 2018, housing security and housing quality were not correlated. In Year 4, reports of housing security needs surged to 11.3% of all screenings compared to 6.6% that reported housing quality issues. Reports of housing security concerns surged five percentage points from Year 3 (Table 3).

**Result 13:** Only 12% of total screenings were of high-risk individuals. However, of screenings with identified HRSNs, 29% were classified as high-risk. This suggests that individuals with HRSNs are more likely to visit emergency departments for medical treatment.

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

**Result 15:** Consistent with previous project years, the Denver Regional AHC results coincide with other Colorado screening trends. Rocky Mountain Health Plans manages the Accountable Health Communities model on Colorado’s Western Slope. As in the Denver region, Rocky Mountain Health Plans identified food security as the top reported need (24.8% of total screenings) followed by housing security/quality (16.3%), transportation (11.2%), utilities (7.8%) and safety (2.9%)\(^8\). These results demonstrate consistent unmet HRSNs both in urban and rural areas.

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\(^8\) Rocky Mountain Health Plans. (2020, February). *Accountable Health Communities Model Update.* [PDF].
Figure 3. Comparison of the number of health-related social needs identified per screening. (Year 1: May 1, 2018-April 30, 2019; Year 2: May 1, 2019 to April 30, 2020; Year 3: May 1, 2020 to Jan. 31, 2021).
Figure 4. Comparison of the types of health-related social needs identified per screening. (Year 1: May 1, 2018-April 30, 2019; Year 2: May 1, 2019 to April 30, 2020; Year 3: May 1, 2020 to Jan. 31, 2021).

Current State Assessment of Service Availability and Accessibility

This section introduces an assessment of the programs and services available to address HRSNs within the area served by the Denver Regional AHC. It represents the knowledge and resources used by the Denver Regional AHC clinical and community partners to address HRSNs. The assessment is not all-encompassing but represents the foundation upon which the Denver Regional AHC work groups was built to identify, prioritize and close gaps in community-based services.

For each HRSN, the following section includes a summary of the prioritized gaps, an assessment of current programs and services, gaps and barriers to service, and key strategies and opportunities for improvement. The Denver Regional AHC project team organized this assessment, but the content originates from Denver Regional AHC clinical and community partners as detailed under each HRSN. This assessment informs the Denver Regional AHC’s advisory board and project team efforts.
Food Security

Overview of Identified Gaps and Barriers to Service and Opportunities for Improvement

Community-facing staff who screen and navigate individuals and households to address unmet needs were surveyed about reported gaps and barriers to receiving service and key strategies and opportunities for improvement. Some of these identified gaps were particularly exacerbated by the COVID-19 pandemic and resulting public health emergency. Identified gaps and barriers to service include:

- Challenges getting to food resources.
- Dietary, cultural or taste needs and preferences.
- Lack of fresh foods available at food banks.
- Hours of operation of food pantries and resources.
- Language barriers.
- Hesitancy among immigrants to use food banks if they don’t have legal documents.

Suggested strategies and opportunities for improvement include:

- Increase availability services to food bank delivery.
- Establish more mobile food pantries.
• Provide funding for gift cards so clients with cultural and dietary sensitivities can purchase their own food.
• Increase supply of fresh foods at food banks.
• Increase number of stores offering grocery delivery using EBT.
• Enhance the ability of clients to order groceries who may not have access to a smartphone or computer.

Baseline Data and Key Metrics
28% of total screenings identified a food security need and 69% of screenings with identified needs reported a food security need, making food security the most prevalent need.

Assessment of Available Programs and Services
A list of primary resources Denver Regional AHC partners use to address food needs, organized in the Denver Regional AHC community resource inventory:

Public Programs:

• Commodity Supplemental Food Program.
• Colorado Works/Temporary Assistance for Needy Families (TANF).
• DoubleUp Food Bucks.
• Free and reduced-cost school lunches.
• Supplemental Nutrition Assistance Program (SNAP).
• The Emergency Food Assistance Program (TEFAP).
• Women, Infants and Children program (WIC).

Food Pantries:

• Adams County Food Bank.
• Bienvenidos Food Bank.
• Community Ministry of Southwest Denver.
• Denver Inner City Parish.
• Double Up Colorado.
• Food Bank of the Rockies.
• Jewish Family Service of Colorado.
• Little Flower Assistance Center.
• Metro Caring.
• Restoration Outreach.
• Southwest Improvement Council.
• The Action Center.
The Salvation Army Aurora Corps.

Meal Delivery Programs:

- City and County of Broomfield Meals on Wheels.
- Project Angel Heart.
- Town of Littleton Cares (TLC) Meals on Wheels.
- Volunteers of America.

Community-based organizations providing services or referrals:

- Benefits in Action.
- Broomfield Fellowship in Serving Humanity (FISH).
- DRCOG Area Agency on Aging.
- Congregate dining centers (for example, Volunteers of America).
- Hunger Free Colorado.
- Mile High United Way 2-1-1 Help Center.
- Seniors’ Resource Center.

Environmental scan

In spring of 2020, the food security work group initiated an assessment of other local, state and U.S. programs and promising practices related to service availability and accessibility to inform its community-level quality improvement efforts. The Denver Regional AHC project team helped with outreach, research and consolidation of content to complete the scan. See separate addendum submitted to the Centers for Medicare and Medicaid Services for additional information. In winter 2021, the Denver Regional AHC project team reviewed the environmental scan and made minor updates to reflect identified changes.

Housing Security and Quality

Summary

In addition to the survey conducted with 60 client-facing staff, the Denver Regional AHC project team solicited recommendations from the housing security work group at its final meeting of Year 4 to identify gaps in the delivery of community-based services.

The work group focused on one area in particular: What can be done over a longer-term period to increase affordability as the economy rebounds from the shock of the public health emergency? As a result, and based on the data from AHC screenings, reports and suggestions from client- staff, and the understanding of the fundamental link between housing and health, in partnership with other DRCOG programs the Denver Regional AHC will devote its Year 5 Quality Improvement effort to addressing housing security in the Denver Regional AHC target area.
The Denver Regional AHC project team will propose to the advisory board that a regional understanding of “inclusionary zoning” be developed by convening a conversation with local communities regarding establishing housing targets and standards in communities across the Denver Regional AHC target area.

Baseline Data and Key Metrics
16.4% of total screenings identified a housing need; 11.3% of those are security-related and 6.6% are quality-related. 40% of screenings with identified needs reported housing needs — an increase of five percentage points from Year 3 and nearly entirely consisting of reports of housing security issues.

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

Housing Security-Related Resources

- Local housing authorities.
- Community-based organizations offering housing counseling, rental assistance and other services:
  - Aging Well Resource Center.
  - Almost Home.
  - Atlantis Community.
Fourth-Year Gap Analysis

- B-Konnceted.
- Brothers Redevelopment.
- Center for People with Disabilities.
- City of Aurora Community Development Division.
- Colorado Housing Search.
- Denver County Temporary Rental and Utility Assistance.
- DRCOG Area Agency on Aging.
- Help and Hope Center.
- Jewish Family Service of Colorado.
- Mile High United Way 2-1-1 Help Center.
- South Metro Housing Options.

- Shelters, drop-in and resource centers include:
  - Colorado Coalition for the Homeless.
  - Comitis Crisis Center.
  - Denver Human Services: Motel Vouchers.
  - Denver Veterans Affairs Community Resource and Referral Center.
  - Family Promise of Greater Denver.
  - Family Tree.
  - Haven of Hope.
  - Lawrence Street Community Center.
  - New Genesis.
  - Sacred Heart House.
  - Salvation Army.
  - Samaritan House.
  - Senior Support Services.
  - The Gathering Place.
  - Urban Peak.

Housing Quality-Related Resources

- Brothers Redevelopment.
- Colorado Department of Public Health and Environment.
- Colorado Legal Services.
- City of Denver Healthy Families Healthy Homes.
- Denver Urban Renewal Authority.
- Douglas County Department of Community Development.
- Energy Resource Center of Colorado.
- Home Builders Foundation.
- Rebuilding Together Metro Denver.
- Senior Hub.
- Volunteers of America Handyman Program.
- Weatherization programs including:
  - Arapahoe County Human Services.
  - Boulder County Housing Authority Longs Peak Energy Conservation.
  - Energy Outreach Colorado.
  - Energy Resource Center.
  - Low Income Energy Assistance Program (LEAP).

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

The following chart comprises three sections:

1) Gaps and barriers to service, contributing factors, key strategies and opportunities for improvement as reported by community-facing staff who screen and navigate individuals and households to address unmet needs\(^1\).

2) The prioritized gap or barrier to service recommended by community-facing staff for the work group to address\(^2\).

3) The prioritized gap or barrier to service with key strategies and opportunities for improvement as determined by the work group\(^3\). See the “Housing Security and Quality: Gaps and Barriers to Service Data Sources” section in the Qualitative Data Appendix for list of contributing partners.

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

<table>
<thead>
<tr>
<th>Gaps and barriers to service</th>
<th>Factors contributing to service gaps</th>
<th>Key strategies and opportunities for improvement (short- and long-term)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited pest removal services for renters and homeowners.</td>
<td>• Limited funding for these services for both renters and homeowners.</td>
<td>• More funding for these services.</td>
</tr>
<tr>
<td></td>
<td>• Pest removal in apartments doesn’t always solve the problem – pest problem is often an issue with entire building.</td>
<td>• More affordable service providers for this work.</td>
</tr>
<tr>
<td>Limited services for tenants during eviction situations.</td>
<td>• Must wait to get help until they receive an eviction letter which delays ability to get needs met.</td>
<td>• More guidance and assistance to prepare for and handle these situations.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Lack of affordable housing.</td>
<td>• Limited housing stock, rising housing costs, and public health emergency has led to increase in number of individuals seeking affordable housing. • Poor housing quality, limited housing stock, and language barriers for immigrants and refugees arriving in the U.S. • Homeowners/buyers are challenged by rising home costs. • Multiple affordable housing applications and fees. • Different affordable housing options and instructions for applying are often unclear to individuals and community-facing staff. • Lack of affordable housing for felons.</td>
<td>• Increase affordable housing supply. • Single application and fee for individuals to apply for affordable housing. • Increase number of available housing subsidies. • Impose rent cap. • Education for staff on the different types of affordable housing and application process.</td>
</tr>
<tr>
<td>Limited advocacy for renters regarding environmental concerns.</td>
<td>• Few resources for people who are undocumented or renting month-to-month. • By raising issues, families on month-to-month leases could be put at-risk of losing their home. • Nonresponsive property management. • Limited knowledge and resources to address environmental concerns with family member landlord. There are often informal arrangements among family members with no formal lease. • Can get a free inspection in Denver County from Healthy Family Healthy Homes but no recourse if landlord refuses to.</td>
<td>• Increase availability and access to legal assistance, especially for environmental issues. • Legal recourse for landlords who don’t address environmental concerns.</td>
</tr>
</tbody>
</table>
### Fourth-Year Gap Analysis

<table>
<thead>
<tr>
<th>Prioritized gap or barrier to service recommended by community-facing staff for the work group to address:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lack of affordable, quality/safe housing for renters and homeowners.</strong></td>
</tr>
<tr>
<td><strong>Multiple affordable housing applications and individual application fees make it difficult and time-consuming to locate housing.</strong></td>
</tr>
<tr>
<td><strong>Education for individuals and community-facing staff around different types of affordable housing and how to apply.</strong></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Landlords with “threatening dynamics” inhibit renters from accessing resources due to fear of consequences.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rental/mortgage assistance programs are hard to access.</td>
</tr>
<tr>
<td>Application assistance for these programs for older adults and individuals with lack of technical knowledge.</td>
</tr>
<tr>
<td>Difficult for navigators to keep track of all county human services departments’ differing eligibility requirements for assistance.</td>
</tr>
<tr>
<td>When requesting assistance, households must demonstrate the situation is an emergency and that the household can sustain future rent.</td>
</tr>
<tr>
<td>Lengthy wait and processing times for rental assistance programs.</td>
</tr>
</tbody>
</table>

---

<table>
<thead>
<tr>
<th>Lack of awareness and availability of maintenance-related resources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Not knowing where to go for assistance.</strong></td>
</tr>
<tr>
<td><strong>Limited funding for assistance</strong></td>
</tr>
<tr>
<td><strong>Difficulty differentiating between the counties’ various levels of funding and services.</strong></td>
</tr>
<tr>
<td><strong>Renters/homeowners typically can’t afford to move or fix problems on their own.</strong></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Not knowing where to go for assistance.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Limited funding for assistance</strong></td>
</tr>
<tr>
<td><strong>Difficulty differentiating between the counties’ various levels of funding and services.</strong></td>
</tr>
<tr>
<td><strong>Renters/homeowners typically can’t afford to move or fix problems on their own.</strong></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Education for individuals and community-facing staff around different types of affordable housing and how to apply.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased funding options for home maintenance resources.</td>
</tr>
</tbody>
</table>

---
• Legal consequences for landlords who do not address environment concerns.

Key opportunities and strategies for improvement:
• Collective advocacy for local/state policy change efforts to increase supply of affordable housing units.
• Advocate for and develop a single point-of-entry application and fee for all affordable housing units.
• Provide education for community-facing staff about the different types of affordable housing in the community and how/when to apply.

Prioritized gap or barrier to service determined by the work group

Factors contributing to service gaps

Key opportunities and strategies for improvement determined by the work group

<table>
<thead>
<tr>
<th>Prioritized gap or barrier to service determined by the work group</th>
<th>Factors contributing to service gaps</th>
<th>Key opportunities and strategies for improvement determined by the work group</th>
</tr>
</thead>
</table>
| Lack of affordable housing. | • Limited housing stock, rising housing costs, and public health emergency has led to increase in number of individuals seeking affordable housing.  
  • Limited funding for affordable housing projects. | • Assisting municipalities to adopt inclusionary zoning policies to encourage housing development.  
  • Identify and inventory vacant land or unused properties that would be suitable for affordable housing. |

Environmental scan
In spring of 2020, the food security work group initiated an assessment of other local, state and U.S. programs and promising practices related to service availability and accessibility to inform its community-level quality improvement efforts. The Denver Regional AHC project team helped with outreach, research and consolidation of content to complete the scan. See separate addendum submitted to the Centers for Medicare and Medicaid Services for additional information. In winter 2021, the Denver Regional AHC project team reviewed the environmental scan and made minor updates to reflect identified changes.
Utilities

Overview of Identified Gaps and Barriers to Service and Opportunities for Improvement

Community-facing staff who screen and navigate individuals and households to address unmet needs were surveyed by Denver Regional AHC staff about reported gaps in and barriers to service and key strategies and opportunities for improvement. Some of the identified gaps were particularly exacerbated by the COVID-19 pandemic and resulting public health emergency. An overview of these identified gaps and barriers to service include:

- Understanding the difference between LEAP and EOC bill payment help.
- Limited or no resources for water bill help.
- Difficulty identifying organizations that receive EOC funding and have funding available.
- Lack of knowledge of available utility resources.
- Difficult/confusing LEAP and EOC application processes.
- Lack of resources/fear for undocumented clients needing assistance.

Suggested strategies and opportunities for improvement include:

- Streamline EOC and LEAP applications into one application.
• Secure more funding and resources for water bill assistance.
• Enable the ability to apply for EOC bill payment assistance through EOC instead of partner organizations.
• Enable the ability of Medicaid clients to apply for LEAP through Colorado’s online benefits application website (PEAK).
• Treat internet access as a utility, since lack of internet is a major barrier to accessing all resources.

Baseline Data and Key Metrics
8.4% of total screenings identified a utility need, 20% of screenings with identified needs reported a utility need, making utility assistance the fourth most prevalent need.

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

Community-based programs:

• Almost Home.
• Aurora Interfaith Community Services.
• Aurora Water Cares.
• Broomfield Fellowship in Serving Humanity (FISH).
• Catholic Charities and Community Services.
• Community Ministry of Southwest Denver.
• DRCOG Area Agency on Aging.
• Energy Outreach Colorado.
• Integrated Family Community Services.
• Senior Assistance Center.
• The Action Center.

Public programs

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

Environmental scan
In spring of 2020, the food security work group initiated an assessment of other local, state and U.S. programs and promising practices related to service availability and accessibility to inform its community-
level quality improvement efforts. The Denver Regional AHC project team helped with outreach, research and consolidation of content to complete the scan. See separate addendum submitted to the Centers for Medicare and Medicaid Services for additional information. In winter 2021, the Denver Regional AHC project team reviewed the environmental scan and made minor updates to reflect identified changes.

Safety

Overview of Identified Gaps and Barriers to Service and Opportunities for Improvement
Community-facing staff who screen and navigate individuals and households to address unmet needs were surveyed by Denver Regional AHC staff about reported gaps in, and barriers to, service and key strategies and opportunities for improvement. Some of these identified gaps were particularly exacerbated by the COVID-19 pandemic and resulting public health emergency. Identified gaps and barriers to service include:

- Lack of knowledge/confidence among staff regarding handling safety-related situations.
- Lack of domestic violence shelter space.
- Stigma (taboo topic).
- Immigrants afraid to report abuse due to fear of law enforcement/U.S. Immigration and Customs Enforcement.
- Lack of cultural competency with other cultures related to domestic violence.

Suggested strategies and opportunities for improvement include:

- Increased funding and space for more domestic violence shelters.
- Cultural competency trainings for staff.
- Education/training on how to handle safety-related situations.
- Increasing awareness and understanding to break down barriers and decrease stigma.

Baseline Data and Key Metrics
0.3% of screenings with identified needs reported a safety need, 1% of screenings with identified needs reported a safety need, making safety the least reported need. Due to the nature of the need, the Denver Regional AHC project team believes the issue is underreported.

Assessment of Available Programs and Services
A list of primary resources Denver Regional AHC partners use to address safety-related needs, organized in the Denver Regional AHC community resource inventory:

Child and Adult Protective Services: Every county human services office within the region operates a child protective and adult protective services program for children and at-risk adults experiencing abuse or neglect.
**Welfare checks:** Every county sheriff’s office provides welfare checks for at-risk adults or individuals in imminent risk of mistreatment.

Hubs providing referrals to local organizations, programs and services:

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

Community-based programs providing direct services:

- Rose Andom Center.
- SafeHouse Denver, Inc.

**Environmental scan**

In spring of 2020, the food security work group initiated an assessment of other local, state and U.S. programs and promising practices related to service availability and accessibility to inform its community-level quality improvement efforts. The Denver Regional AHC project team helped with outreach, research and consolidation of content to complete the scan. See separate addendum submitted to the Centers for Medicare and Medicaid Services for additional information. In winter 2021, the Denver Regional AHC project team reviewed the environmental scan and made minor updates to reflect identified changes.
Transportation

Overview of Identified Gaps and Barriers to Service and Opportunities for Improvement

Community-facing staff who screen and navigate individuals and households to address unmet needs were surveyed by Denver Regional AHC staff about reported gaps in and barriers to service and key strategies and opportunities for improvement. Some of the identified gaps were particularly exacerbated by the COVID-19 pandemic and resulting public health emergency. An overview of these identified gaps and barriers to service include:

- Unreliable transportation services.
- Limited resources for individuals who don’t have Medicaid, are not older adults or don’t have a disability.
- Lack of transportation for social-related needs.
- Lack of resources for car repair/car insurance/car payments, even when vehicle is needed for getting to and from work.
- Limited options within each transportation provider (for example, limited hours, days, trip reason or distance).
- Expense of public transportation.

Suggested strategies and opportunities for improvement include:
• Improve transportation reliability by holding transportation organizations accountable for late or missed rides.
• Increase funding and resources for transportation for social-related needs for individuals of all ages.
• Provide a free transit pass (EcoPass) to individuals participating in certain public assistance programs.
• Secure additional funding for vehicle repair for working individuals and families.
• Encourage transportation organizations to offer more flexibility with ride locations, hours and trip purpose.

Baseline Data and Key Metrics
13.1% of total screenings identified a transportation need. 32% of screenings with identified needs reported a transportation need, making transportation the third most prevalent need.

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

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

• A Little Help.
• City and County of Broomfield – Easy Ride.
• City of Littleton – Omnibus.
• Denver Regional Mobility and Access Council.
• DRCOG Area Agency on Aging.
• Hands of the Carpenter.
• Littleton Shopping Cart.
• Via Mobility Services.

Public programs: 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.

• Access-a-Cab.
• Access-a-Ride.
• Fixed route
• FlexRide
Fourth-Year Gap Analysis

- LiVE program
- Senior Ride

**Access2Care**: For Denver Health patients only.

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

**Ride-hailing services**: Lyft, Uber, HopSkipDrive

**Environmental scan**

In late spring and early summer of 2020, the Denver Regional AHC project team completed an assessment of other local, state and U.S. programs and promising practices related to service availability and accessibility to inform its community-level quality improvement efforts. The assessment was then updated in March of 2021. See separate addendum submitted to the Centers for Medicare and Medicaid Services for additional information.
Part II: Community-level Quality Improvement Report

Summary

Progress toward reducing barriers and gaps to community-based services through partnership and collaboration will be measured in part by Denver Regional AHC work group progress reports that analyze the change and improvement over time of each work group and their efforts. The progress reports are composed of Plan-Do-Study-Act worksheets documenting completed cycles. Additionally, the Denver Regional AHC administered advisory board and work group satisfaction surveys to establish the percent of members who are satisfied with the operations and effectiveness of the Denver Regional AHC project and work group activities, respectively. The annual Gap Analysis serves as a method of identifying gaps and barriers to community-based services and opportunities for improvement, as well.

To determine the success of the work groups in reaching their aim statements, each used work group-specific evaluation measures, such as pre- and post-training surveys, as detailed in the Quality Improvement Activities section of this plan. Additionally, the work groups participated in a partnership impact evaluation survey to analyze the overall, higher-level effect of the groups through their members’ and organizations’ participation and collaboration.
Introduction

The primary goal of the AHC project is to align and improve the care continuum between clinical and community providers for Medicare and Medicaid beneficiaries through screening for HRSNs and referrals and navigation for community-based resources. The secondary goal is to improve health outcomes and reduce total health care costs for community-dwelling beneficiaries by addressing unmet HRSNs by April 30, 2022.

The Denver Regional AHC operates under four strategic themes established by the advisory board: person-focused, partnership and collaboration, operational excellence and healthy communities. All community-level quality improvement activities fall under the theme of partnership and collaboration as outlined below.

Methods

Objective: Reduce barriers and gaps to community-based services.

Narrative: Implement or contribute to targeted, small scale, measurable, timely and replicable interventions, projects or efforts that increase access to and delivery of community services.

Outcomes:

- Providers effectively communicate pertinent individual and service information.
- Gaps in community-based service are reduced.

Measures (Source):

- Work group Progress Reports (completed work group Plan-Do-Study-Act worksheets).
- Percent of advisory board members who are satisfied with the operations and effectiveness of the Denver Regional AHC project (Denver Regional AHC Advisory Board Satisfaction Survey).
- Percent of work group members who are satisfied with the effectiveness of work group activities (Denver Regional AHC Work groups Satisfaction Survey).
- Work group-specific evaluation (pre- and post-training surveys).
- Partnership Impact Evaluation (Work groups’ partnership impact evaluation surveys).
Quality Improvement Activities

**Partnership and Collaboration Activities**

**Objective: Reduce barriers and gaps to community-based services.**

**Measure 1:** Percent of advisory board members who are satisfied with the operations and effectiveness of the Denver Regional AHC project (Denver Regional AHC advisory board satisfaction survey).

**Measure 2:** Percent of work group members who are satisfied with the effectiveness of work group activities (Denver Regional AHC work groups satisfaction survey).

**Measure 3:** Work group Progress Reports (completed work group Plan-Do-Study-Act worksheets).

**Measure 4:** Work group-specific evaluation (i.e., pre- and post-training surveys).

**Measure 5:** Partnership Impact Evaluation (work groups partnership impact evaluation surveys).

What are the roles and responsibilities for implementing activities? What is the expected timeline?

**Advisory Board**

The Denver Regional AHC project continues to be guided by its advisory board. The advisory board is composed of local and regional stakeholders, including representatives from all contracted clinical and community partner organizations. The advisory board meets quarterly, currently via a virtual platform, to review progress toward reducing barriers and gaps to community-based services.

Measure 1: Percent of advisory board members who are satisfied with the operations and effectiveness of the Denver Regional AHC project (Denver Regional AHC Advisory Board Satisfaction Survey). In July 2020, advisory board members completed the first annual Denver Regional AHC advisory board satisfaction survey. Out of 22 members who received the survey, 12 responded, representing a 55% response rate. Of the respondents, 91.66% agreed or strongly agreed with the following two prompts:

- “I am satisfied with the overall operations of the Denver Health AHC program including training, technical support and guidance, and partnership development.”
• “I am satisfied with the effectiveness of the Denver Regional AHC program to identify and address people’s social needs.”

Work groups

To guide community-level quality improvement efforts for Year 3 of AHC model implementation, the Denver Regional AHC Advisory Board convened four topical work groups in the following areas: food security, housing security and quality, utilities and safety. Prior to the launch of the work groups, the Denver Regional AHC project team contracted a team of consultants from John Snow, Inc., to assist with facilitation. The Denver Regional AHC project team and John Snow, Inc., worked together to design a project roadmap (Appendix C) to help guide the work groups’ efforts through March 2021. Over the first year, the work groups implemented or contributed to targeted, small scale, measurable, timely and replicable interventions, projects or efforts to increase access to and delivery of community services in order to achieve two primary outcomes:

1) Providers effectively communicate pertinent individual and service information.
2) Gaps in community-based service are reduced.

The work groups met monthly to discuss barriers to accessing services; prioritize which barrier to address; create a project intended to reduce the barrier; design and implement the project; and evaluate its effect. Although the first two meetings of each work group were proposed to be in-person to facilitate a strong, collaborative relationship among work group members, the rapid emergence of the COVID-19 pandemic and subsequent requirements for social distancing altered the plan to convene in-person meetings. The first meeting of each work group, except the Safety work group, was in person, and subsequent meetings were moved to a virtual platform. The John Snow, Inc., facilitators encouraged engagement among all work group members.

Based on both work group member feedback and input provided by community-facing staff, each work group began by prioritizing specific barriers and gaps to community-based services relevant to its HRSN. Bimonthly navigator meetings provided an opportunity for Quality Improvement project staff to conduct brainstorming sessions and focused discussions with navigators, care managers, nurses, and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) educators involved in the Denver Regional AHC to gather crucial information about gaps and barriers they witness and experience day-to-day.

Measure 2: Percent of work group members who are satisfied with the effectiveness of work group activities (Denver Regional AHC Work groups Satisfaction Survey). The Denver Regional AHC work groups satisfaction survey was administered by John Snow, Inc. approximately one-third of the way through the work groups’ year-long timeline. Of the 30 work group members who received the survey, 15
responded, representing a 50% response rate. Of the respondents, 93.34% agreed or strongly agreed with the prompt “I am still confident the project my work group chose will be effective.”

Recorded below are the activities completed by each work group through March 31, 2021, as they followed the work group project roadmap and shifted their focus to address the heightened sense of urgency caused by the COVID-19 pandemic and better help vulnerable populations in the changing landscape.

Food Security Work Group

Summary

What is being improved?

While many resources are available to beneficiaries experiencing food insecurity, there are significant challenges to accessing those resources, such as transportation and operating during traditional work hours. Additionally, community-facing staff struggle to maintain up-to-date lists of ever-changing community resources, organizations and information (for example, hours of operation). The COVID-19 pandemic and resulting social isolation measures further complicated accessing food resources, and the food security work group shifted its focus to address emerging challenges.
Goals
What is the expected outcome of the improvement project?
Aim statement: Increase access to food by bringing food and food-related resources to places where people already frequent for other services, such as health clinics.

Key Activities and Indicators
What implementation steps or changes need to occur to achieve the desired result? What key indicators and data sources will be used to establish a baseline and monitor progress over time? Did the change result in an improvement?

Shortly after the initial formation of the work groups, the food security work group planned and carried out a food resource fair in August 2019. The event, held at a Denver Regional AHC clinical partner site, STRIDE Community Health Clinic in Aurora, Colorado, brought a group of community partners together. Participants selected fresh and canned food to take home, received health and nutrition education materials, and obtained information about and had the opportunity to apply for Meals on Wheels, Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and Supplemental Nutrition Assistance Program (SNAP). More than 170 households and almost 500 individuals were served. Based on the success and lessons learned from the first food resource fair, the Denver Regional AHC conducted a second event in February 2020 at a second STRIDE location, serving 107 households and more than 440 individuals.

With the involvement of John Snow, Inc., and the emergence of the COVID-19 pandemic, the food security work group decided to take a step away from planning additional food resource fairs to develop an intervention that would be more sustainable, especially in light of social distancing requirements. After revisiting the needs prioritization process in order to understand how the work group may better assist individuals experiencing food insecurity and surveying its members to narrow down the group’s focus area, the work group chose to pursue a food pantry program at Denver Health Sam Sandos Westside Family Health Center, another Denver Regional AHC clinical partner site.

After several months investigating options with a local food bank partner and networking with possible funders, the work group was unable to overcome the operational and financial realities of launching such an intensive project. Additionally, distributing food through a clinic-based pantry was inconsistent with COVID-19 practices related to social distancing.

Over the course of the work group’s Year 3 and Year 4 operations, the Denver Regional AHC has used two measures to evaluate its efforts to reduce barriers and gaps to community-based services related to food security:

- Measure 3: Work group progress reports (completed work group Plan-Do-Study-Act worksheets).
  The Denver Regional AHC project team analyzes completed Plan-Do-Study-Act worksheets in
the work group progress reports annually in March. As of March 2021, two Plan-Do-Study-Act cycles pertaining to the food resource fairs were completed. No additional Plan-Do-Study-Act cycles were completed during Year 4 due to the postponement of the Denver Health Sam Sandos Westside Family Health Center food pantry project.

Beginning with its first event in August 2019, the food security Work group developed a comprehensive set of lessons learned that it applied to the second fair in February 2020. Specifically, the work group improved the check-in survey administered, the check-in process and event set-up and logistics. The first Plan-Do-Study-Act cycle produced a more streamlined planning process, and the second Plan-Do-Study-Act cycle resulted in a list of best practices and event model that can be replicated in the future at various clinical sites. While there was a smaller turnout at the second event due to colder weather and poor driving conditions, the February 2020 food resource fair was still successful.

The food security work group was also able to gather qualitative data from the food resource fairs, including a client testimonial. At the second event, a woman named Natalie* was driving past the clinic and praying for a way to find food for her children when she saw a sign advertising the event. After paying their bills for the month, she and her husband had no way to purchase food for their family. She credits the food security work group’s event with providing for her children when she did not know where else to turn.

[*Natalie signed a media consent form and allowed for her name and story to be shared.]

- **Measure 4: Work group-specific evaluation.** Although the other work groups’ endeavors were evaluated using methods such as pre- and post-training surveys, the food security work group’s efforts did not culminate in a singular project easily assessed using a before-and-after approach. Instead, the work group completed a partnership impact evaluation survey (Measure 5) to evaluate the overall, higher-level effect of the group through its members’ and organizations’ participation and collaboration. The results are contained in the food security work group’s evaluation plan (Appendix D). The other work groups completed similar surveys, and the results are analyzed in the “Partnership Impact Evaluation” section below.

**Barriers to Change/Recommendations**

Future efforts for the food security work group are dependent on the necessity of social distancing requirements. If such measures are lifted, work group members are interested in investigating the opportunity to collaborate with other agencies that have already developed a platform for collocating medical services and food resources. Any food pantry project will require sufficient funding to launch and maintain. The work group’s efforts with local foundations established the groundwork for it to pursue and secure funds in the future.
Additionally, the work group will use lessons learned from its two Plan-Do-Study-Act cycles and determine whether it will move forward with a third large food resource fair following the lifting of social distancing measures or if holding smaller, regularly scheduled events would be more sustainable and effective.

Housing Security and Quality Work Group

**Summary**

**What is being improved?**

In an effort to implement a project that is both realistic and scalable in the short time frame allotted to the housing security and quality work group, its members chose to focus on housing quality issues. The work group aimed to improve support and access to services related to renter rights and landlord obligations associated with housing quality.

**Goals**

**What is the expected outcome of the improvement project?**

Aim statement: Provide a framework to educate local providers and community members on the 2019 updated habitability statute to support healthy and stable housing for renters with connection to community and legal resources.
Key Activities and Indicators

What implementation steps or changes need to occur to achieve the desired result? What key indicators and data sources will be used to establish a baseline and monitor progress over time? Did the change result in an improvement?

As members worked through the various steps of the Denver Regional AHC work groups project roadmap, the housing work group pursued a project to educate community-facing staff, and by extension, their clients, about Colorado’s Implied Warranty of Habitability Law. The act updates existing habitability statutes to allow tenants to withhold rent if their housing is unsafe, allows renters to hire professionals to make necessary repairs, and permits tenants to request relocation if their current housing situation is unsafe. In an effort to combine policy and advocacy with providing services, the work group aimed to simplify for renters a policy they may not understand or be aware of.

Project: **Quick Guide to Colorado’s Implied Warranty of Habitability Law**

Creating the Quick Guide to Colorado’s Implied Warranty of Habitability Law represented an opportunity to address housing issues in the Denver area despite the COVID-19 pandemic. The Quick Guide explains what is covered under the Warranty of Habitability and what action renters can take if any quality issues or unsafe conditions are present in their homes. The document also includes a list of resources for navigating the process.

Over the course of the work group’s year in operation, its efforts to reduce barriers to and gaps in community-based services related to housing security and quality were evaluated using the following two measures:

- **Measure 3: Work group Progress Reports (completed work group Plan-Do-Study-Act worksheets).** The Denver Regional AHC analyzes completed Plan-Do-Study-Act worksheets in work group progress reports annually in March. As of March 2021, the Denver Regional AHC Quality Improvement team completed two Plan-Do-Study-Act cycles for the housing security and quality work group. The initial Plan-Do-Study-Act cycle took place in conjunction with the first step in the work group’s iterative evaluation process, the convening of a steering focus group to elicit initial feedback on a draft of the Quick Guide. The work group edited the guide based on suggestions and requests provided by community-facing staff that participated in the steering focus group before releasing it to Denver Regional AHC navigation staff for a six-week pilot period.
  Following the pilot period, the work group convened a final focus group. Based on the results gathered, the Quality Improvement team completed a second Plan-Do-Study-Act cycle before finalizing the housing work group’s Quick Guide.
• Measure 4: Work group-specific evaluation. To ensure the Quick Guide was a useful educational tool and job aid for navigators and other community-facing staff, the housing security and quality work group took an iterative approach to evaluating the Quick Guide. To gather qualitative data about the product, the work group convened a steering focus group and then a final focus group following the pilot period.
  o Steering focus group: The steering focus group was composed of five navigators from various Denver Regional AHC clinical sites. The navigators reviewed the most recent draft of the Quick Guide and provided feedback, such as initial reaction to seeing the guide, thoughts on its format and readability, major content not included. Based on their input and requests, the work group edited the draft of the Quick Guide used during the pilot.
  o Final focus group: Following a six-week pilot period, a final focus group met to share its experience using the guide. Eight navigators from four Denver Regional AHC clinical sites participated in the second focus group, and a social worker from a fifth clinical site provided additional feedback via email. Overall, the response was positive, and no substantial changes were made to the final version of the document.

• Additional details and results are included in the housing security and quality work group’s evaluation plan (Appendix E).

Barriers to Change/Recommendations
The biggest barrier the housing quality and security work group faced during its year-long operation was time, a luxury those experiencing homelessness or facing eviction do not have. To access resources, individuals endure long waiting lists, and efforts to change legislation or build additional housing take years. In light of the time constraint and the effects of COVID-19, the work group provided more immediate assistance in the form of education and advocacy.

In order to ensure the Quick Guide to Colorado’s Implied Warranty of Habitability Law remains accessible and accurate, the Housing Security and Quality Work group developed a sustainability plan (Appendix F). As part of its plan, DRCOG transferred ownership of the Quick Guide to Brothers Redevelopment, which will act as long-term host for the document. Brothers Redevelopment will be responsible for annual and ad-hoc updates of the Quick Guide, with the support of other work group member organizations. Additionally, based on feedback provided by community-facing staff during the housing quality and security work group’s focus groups, the Quick Guide is being translated into Spanish to enable navigation staff to more easily help their Spanish-speaking clients. The Spanish version of the guide will be available on Brothers Redevelopment’s Colorado Housing Connects website.
Utilities Work Group

Summary

What is being improved?
The process for accessing and applying for utility assistance can be complicated and challenging for both community-facing staff and those seeking assistance. There is also a lack of training and education on available utility resources among both beneficiaries and navigation staff. Furthermore, the utilities work group recognized the effect of the COVID-19 pandemic as the need for utilities assistance has increased and community-facing staff are no longer able to provide in-person help.

Goals

What is the expected outcome of the improvement project?
Aim statement: Develop an online training around the eligibility and application process for the Low-Income Energy Assistance Program (LEAP) and Energy Outreach Colorado (EOC) to increase knowledge about the programs and the resources needed to apply.
Key Activities and Indicators

What implementation steps or changes need to occur to achieve the desired result? What key indicators and data sources will be used to establish a baseline and monitor progress over time? Did the change result in an improvement?

In spring 2020, utilities work group members conducted an environmental scan analyzing the organizations that were already providing utility resources education opportunities to community-facing individuals, the training class content and whether expanding such education would be a useful and appropriate project. The scan revealed a significant gap in resources to educate navigation staff on the differences between the LEAP and EOC bill payment assistance programs, the application process and requirements.

Project: “LEAP and EOC Basics” training and Colorado Energy Assistance Quick Guide

To respond to the identified gap, utilities work group members developed and hosted an online training, as well as developed a job aid to educate community-facing staff. The Colorado Energy Assistance Quick Guide contains information on how to apply for both the LEAP and EOC bill payment assistance programs, outlines common application mistakes, and describes additional benefits that can be attained by applying to the programs. The guide is color-coded by program, and the information is presented in an easily readable flowchart-style. To help launch and distribute the quick guide, EOC hosted four free kickoff training sessions in November 2020. Over 240 individuals registered for the training, representing more than 100 organizations.

Over the course of the work group’s first year, its efforts to reduce barriers and gaps to community-based services related to utilities were evaluated using the following three measures:

- Measure 3: Work group progress reports (completed work group Plan-Do-Study-Act worksheets). As of March 2021, the Denver Regional AHC Quality Improvement team completed one Plan-Do-Study-Act worksheet for the utilities work group. The Plan-Do-Study-Act cycle detailed the steps executed to create the Energy Assistance Quick Guide and host the “LEAP and EOC Basics” trainings and analyzed the results of the pre- and post-training surveys used for the work group-specific evaluation. A second Plan-Do-Study-Act cycle was not undertaken during the work group’s year-long operation.

- Measure 4: Work group-specific evaluation. In order to determine the Utilities work group’s success in meeting its aim statement, individuals were asked to complete a pre-training survey as part of the registration process for “LEAP and EOC Basics,” as well as a post-survey after completing the sessions. The results showed people who attended the trainings increased their knowledge in key areas, including the differences between the LEAP and EOC bill payment assistance programs, eligibility requirements, and the application process. Additionally, respondents indicated that the Colorado Utility Assistance Quick Guide was a helpful tool for both
the LEAP and EOC bill payment assistance program application processes. The full results of the surveys, as well as the results of the Utilities Work group’s partnership impact evaluation survey are included in the evaluation plan (Appendix G).

**Barriers to Change/Recommendations**

During the gap identification process, community-facing staff and individuals pursuing utility assistance continuously expressed frustration with the complicated application process for several programs, including EOC and LEAP. While the Utilities Work group is unable to change the applications themselves due to state and federal requirements for obtaining energy assistance, educating health and service providers on the process will empower them to better help their clients.

To ensure the resources developed by the work group reach as many individuals and organizations as possible, a recording of the “LEAP and EOC Basics” training and the Colorado Utilities Assistance Quick Guide have been posted on DRCOG’s Aging and Disability Resource Center’s [Network of Care site](#). The Aging and Disability Resource Center will act as the long-term host for the resources and will coordinate with EOC staff to ensure any ad hoc or annual updates are made to the Quick Guide. Additionally, EOC plans to use a contact list created based on the trainings roster and the distribution list used to disseminate the training link and Quick Guide to advertise annual trainings each October. Complete details are available in the Utilities Work group’s sustainability plan (Appendix H).
Safety Work Group

Summary

What is being improved?
Data from the first three years of the AHC model shows safety is consistently the least reported of the five HRSNs. Community-facing staff has reported they are often uncomfortable asking the four safety-related questions, and beneficiaries similarly feel uneasy when answering. Upon further discussion, the navigators revealed they do not know how to respond when safety needs are identified and are unclear regarding their clinics’ policies and procedures and their legal obligations to report child abuse, elder abuse and domestic violence, resulting in a lack of confidence and consistency in connecting beneficiaries to safety resources.

Goals

What is the expected outcome of the improvement project?
Aim statement: Universal education to promote screening and referral for domestic violence-related needs in order to increase access to services.

Key Activities and Indicators

What implementation steps or changes need to occur to achieve the desired result? What key indicators and data sources will be used to establish a baseline and monitor progress over time? Did the change result in an improvement?
To better identify the specific knowledge areas, gaps and barriers to target as part of its educational intervention, the work group developed a survey for community-facing staff. The survey asked questions such as:

- Are you aware of the 2017 law change regarding mandatory reporting?
- Do you know where to refer beneficiaries?
- Are you aware of next steps once a safety issue has been identified?

The safety work group emphasized the need to clearly define the intent of the survey to ensure respondents understood the purpose of collecting data. Additionally, the work group voted to narrow its focus from all safety concerns to domestic violence and reflected this goal in its aim statement.

Project: Domestic Violence Medical Reporting Options Training and Domestic Violence and Trauma-Informed Care Training

Based on the results of the survey, the safety work group designed a training curriculum composed of two parts:
Fourth-Year Gap Analysis

- Domestic Violence Medical Reporting Options Training led by Violence Free Colorado: A training on medical reporting requirements and options when dealing with someone experiencing domestic violence. Violence Free Colorado hosted four sessions of the training in November 2020 with over 60 participants.
- Domestic Violence and Trauma-Informed Care Training led by Family Tree, Inc.: A training on trauma-informed care to increase participants’ confidence and improve effective communication skills for working with survivors of domestic violence. Family Tree, Inc. hosted three sessions of the training in November and December 2020 with over 75 participants.

Over the course of the work group’s first year, its efforts to reduce barriers and gaps to community-based services related to safety were evaluated using the following two measures:

- Measure 3: Work group Progress Reports (completed work group Plan-Do-Study-Act worksheets). As of March 2021, the Denver Regional AHC Quality Improvement team completed one Plan-Do-Study-Act for the Safety Work group. The Plan-Do-Study-Act cycle detailed the steps executed to develop the Safety Work group’s training curriculum and host the two trainings. Furthermore, the Plan-Do-Study-Act analyzed the results of the pre- and post-training surveys used for the work group-specific evaluation. A second Plan-Do-Study-Act cycle was not undertaken during the work group’s year-long operation.
- Measure 4: Work group-specific evaluation. To evaluate the safety work group’s progress toward meeting its aim statement, participants in the two trainings were asked to complete pre- and post-training surveys. The survey results demonstrated that individuals who participated in the Domestic Violence Medical Reporting Options Training improved their knowledge about the legal requirements for medical reporting and how to help connect clients experiencing domestic violence to resources. Participants in the Domestic Violence and Trauma-Informed Care Training improved their knowledge about how to identify abusive behaviors, barriers to leaving an abusive relationship, how to support survivors of domestic violence and using trauma-informed language. The work group included its full detailed analysis in its evaluation plan (Appendix I).

**Barriers to Change/Recommendations**

The safety work group strongly recommended the curriculum it developed and the trainings be used in tandem with each other. This safety resource package consists of the following:

- Domestic Violence Medical Reporting Options Training recording.
- Domestic Violence Medical Reporting Options Training PowerPoint slides.
- Domestic Violence and Trauma-Informed Care Training description and scheduling contact information.
Similar to the utilities work group’s resources, the safety work group’s curriculum was posted on the Aging and Disability Resource Center’s Network of Care site, with the Aging and Disability Resource Center acting as long-term host. While the Domestic Violence and Medical Reporting Options Training was recorded and posted for future viewing and reference, the work group recommended that due to the personal and interactive nature of the Domestic Violence and Trauma-Informed Care Training, recording it was not appropriate. Instead, contact information for Family Tree, Inc., was included along with a description of the training so organizations can schedule future sessions. Family Tree, Inc., has funding to host additional trainings through 2021. Further information is available in the safety work group’s sustainability plan (Appendix J).

While the safety work group chose to target community-facing staff’s lack of confidence and knowledge when dealing with beneficiaries’ safety needs, navigators have also repeatedly reported that the largest barrier to identifying these needs and connecting individuals to safety resources is stigma. The work group recognizes that reducing the stigma around domestic violence cannot occur solely within the clinical setting and will take longer than a year-long project to effectively address. However, safety work group members believe that providing targeted education and increasing navigators’ confidence will help produce attitude change that will make beneficiaries more comfortable responding to safety prompts and accessing safety resources.
Transportation Work Group

Summary
To address transportation as part of the Denver Regional AHC’s community-level quality improvement efforts, the informal transportation work group used the qualitative and quantitative data available from the AHC to author a document analyzing gaps in and barriers to accessing transportation services.

What is being improved?
The report evaluated transportation needs from an HRSN perspective and informed the Coordinated Transit Plan, a component of the 2050 Metro Vision Regional Transportation Plan.

Goals
What is the expected outcome of the improvement project?
While the transportation group did not formalize an aim statement, its goal was to create a document that includes a set of strategies and recommendations to improve human services transportation in the Denver region.
Key Activities and Indicators

What implementation steps or changes need to occur to achieve the desired result? What key indicators and data sources will be used to establish a baseline and monitor progress over time? Did the change result in an improvement?

The transportation work group prepared a report based on existing and emerging solutions to address service gaps, both in Colorado and across the nation. The report presents key strategies and priority recommendations for improving transportation services for people who are most in need.

Project: Strategies and Recommendations for Transportation Service Improvements report

In order to communicate the findings and recommendations included in the transportation work group’s report, as well as publicize the 2050 Metro Vision Regional Transportation Plan among Denver Regional AHC stakeholders, the Denver Regional AHC project team hosted a briefing in early March. The meeting represented an opportunity for the Denver Regional AHC project team and staff from DRCOG’s Transportation Planning and Operations division to share the goals of the plan with clinical and community-based organizations involved with the Denver Regional AHC and to gather feedback about the plan.

- Measure 3: Work group progress reports (completed work group Plan-Do-Study-Act worksheets). As of March 2021, there has not been an opportunity to complete Plan-Do-Study-Act worksheets for the transportation work group.
- Measure 4: Work group-specific evaluation. In lieu of evaluating the Strategies and Recommendations for Transportation Service Improvements report, the Transportation Work group instead looked at metrics gathered during the 2050 Metro Vision Regional Transportation Plan briefing to analyze the impact the meeting had on bringing together Denver Regional AHC clinical and community partners to discuss transportation issues and plans in the Denver region. A total of 38 individuals joined the meeting, and 21 people participated in a polling activity to measure the following:
  - How well do you think the plan will improve safety, active transportation, air quality, multimodal mobility, freight and regional transit?
  - How important to you is safety, activity transportation, air quality, multimodal mobility, freight and regional transit?
  - Overall, how well does the plan align with your ideal transportation system?
  - In what ways does the plan least align with your ideal transportation system?
  - In what ways does the plan most align with your ideal transportation system?

The polling results and input were then shared with DRCOG’s Transportation Advisory Committee, Regional Transportation Committee and Board of Directors to use when they take action on the 2050 Metro Vision Regional Transportation Plan in April 2021.
Barriers to Change/Recommendations
One of the largest barriers to health-related transportation change and improvement in the Denver region is the number and scale of competing priorities among beneficiaries, health care providers, funders, lawmakers and stakeholders. However, by involving clinical and community-based organizations in the 2050 Metro Vision Regional Transportation Plan process and inviting public health partners to participate in the public comment period for the plan, the Denver Regional AHC project team emphasized the need for human services transportation improvement.

Partnership Impact Evaluation
An overall goal of the AHC model is to enhance integration and partnership of clinical and community-based organizations to address HRSNs. While the majority of the work groups used work group-specific evaluation methods, including focus groups and pre- and post-training surveys, to determine their success in accomplishing their aim statements, the Denver Regional AHC Quality Improvement team wanted to evaluate the overall effect of the partnerships at a higher level. To do so, each work group reviewed the Partnership Impact Evaluation Guide by Amy Mickel, Ph.D., and Leigh Goldberg and then ranked 11 partnership impacts, including foundational impacts (for example, new trust and connections between organizations), operational impacts (such as resource sharing), and outcome impacts (such as collaborative culture and efficiency). Based on the ranking activity, the Denver Regional AHC Quality Improvement team developed work group-specific partnership impact evaluation surveys for members to complete.

- Measure 5: Partnership impact evaluation (work groups’ partnership impact evaluation surveys).
The results of each work group’s partnership impact evaluation survey, as well as the impact averages for all four work groups, are outlined in Table 2 below. Overall, work group members ranked scale (3.61 average), creativity (3.56 average) and resource sharing (3.68 average) highly. The lowest scored impacts – efficiency (3.14), expanded connectivity (3.13 average), added capacity (3.2 average) and improved connectivity (3.29 average) – showed the difficulty the work group members had in large part due to COVID-19. Effectively responding to changing community needs resulting from the public health emergency and developing projects and products that would simultaneously benefit those in need and increase members’ capacities to successfully do their jobs was challenging. Additionally, work group members felt the ability to both expand and increase the quality of the connections among members and their respective organizations was stifled by the virtual meeting environment.
## Table 2. Partnership impact evaluation survey results

### Foundational impacts

**Scale**: The work group was successful at engaging in joint decision-making to enhance integration and partnership of clinical and community-based organizations to address health-related social needs.

<table>
<thead>
<tr>
<th>Impact</th>
<th>Food security</th>
<th>Housing</th>
<th>Utilities</th>
<th>Safety</th>
<th>Work groups’ average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food security</td>
<td>3.5</td>
<td></td>
<td></td>
<td></td>
<td>3.61</td>
</tr>
<tr>
<td>Housing</td>
<td>3.33</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utilities</td>
<td>3.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety</td>
<td>3.8</td>
<td></td>
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</tr>
</tbody>
</table>

**Efficiency**: The work group was successful at effectively and efficiently responding to changing community needs, such as the impact of COVID-19.

<table>
<thead>
<tr>
<th>Impact</th>
<th>Food security</th>
<th>Housing</th>
<th>Utilities</th>
<th>Safety</th>
<th>Work groups’ average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food security</td>
<td>N/A</td>
<td>2.67</td>
<td></td>
<td></td>
<td>3.14</td>
</tr>
<tr>
<td>Housing</td>
<td>3.6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utilities</td>
<td>3.6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Collaborative culture**: The work group was successful at influencing work group members to more deeply value and integrate collaborative practices, such as pooling diverse ideas to solve complex problems and accessing resources to develop new solutions.

<table>
<thead>
<tr>
<th>Impact</th>
<th>Food security</th>
<th>Housing</th>
<th>Utilities</th>
<th>Safety</th>
<th>Work groups’ average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food security</td>
<td>3.67</td>
<td>3.0</td>
<td></td>
<td>3.2</td>
<td>3.32</td>
</tr>
<tr>
<td>Housing</td>
<td>3.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utilities</td>
<td>3.4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety</td>
<td>3.2</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Expanded connectivity**: The work group was successful at expanding the networks of work group members and their respective organizations at local, regional or national levels.

<table>
<thead>
<tr>
<th>Impact</th>
<th>Food security</th>
<th>Housing</th>
<th>Utilities</th>
<th>Safety</th>
<th>Work groups’ average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food security</td>
<td>3.33</td>
<td>3.0</td>
<td>2.8</td>
<td>3.4</td>
<td>3.13</td>
</tr>
<tr>
<td>Housing</td>
<td>3.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utilities</td>
<td>2.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety</td>
<td>3.4</td>
<td></td>
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</tbody>
</table>

### Operational impacts

**Creativity**: The work group was successful at applying creative and innovative ideas to address complex problems.

<table>
<thead>
<tr>
<th>Impact</th>
<th>Food security</th>
<th>Housing</th>
<th>Utilities</th>
<th>Safety</th>
<th>Work groups’ average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food security</td>
<td>3.5</td>
<td>3.17</td>
<td></td>
<td>3.6</td>
<td>3.56</td>
</tr>
<tr>
<td>Housing</td>
<td>3.17</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utilities</td>
<td>3.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety</td>
<td>3.6</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Resource sharing**: The work group was successful at sharing human capital, knowledge, data, funding or other resources.

<table>
<thead>
<tr>
<th>Impact</th>
<th>Food security</th>
<th>Housing</th>
<th>Utilities</th>
<th>Safety</th>
<th>Work groups’ average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food security</td>
<td>3.83</td>
<td>3.67</td>
<td></td>
<td>3.6</td>
<td>3.68</td>
</tr>
<tr>
<td>Housing</td>
<td>3.67</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utilities</td>
<td>3.6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety</td>
<td>3.6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Added capacity**: The work group was successful at increasing work group members’ capacities to successfully do their jobs in the future.

<table>
<thead>
<tr>
<th>Impact</th>
<th>Food security</th>
<th>Housing</th>
<th>Utilities</th>
<th>Safety</th>
<th>Work groups’ average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food security</td>
<td>N/A</td>
<td>N/A</td>
<td>2.8</td>
<td>3.6</td>
<td>3.2</td>
</tr>
<tr>
<td>Housing</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utilities</td>
<td>2.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety</td>
<td>3.6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Partner culture awareness</strong>: The work group was successful at valuing the respective cultural differences of other members and their organizations.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Food security</strong>: 3.5</td>
<td><strong>Housing</strong>: N/A</td>
<td><strong>Utilities</strong>: N/A</td>
<td><strong>Safety</strong>: N/A</td>
<td><strong>Work groups’ average</strong>: 3.5</td>
<td></td>
</tr>
</tbody>
</table>

**Outcome impacts**

<table>
<thead>
<tr>
<th><strong>Improved connectivity</strong>: The work group was successful at increasing the quality of connections among work group members and their respective organizations.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Food security</strong>: 3.5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Trust</strong>: The work group was successful at increasing trust among work group members or their respective organizations.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Food Security</strong>: 3.33</td>
</tr>
</tbody>
</table>

Results scores were calculated using the following response values: Strongly agree = 4, Agree = 3, Disagree = 2, Strongly disagree = 1

Food security n = 6, Housing n = 6, Utilities n = 5, Safety n = 5

Each work group spent a portion of their February 2021 meetings analyzing and discussing the results of their partnership impact evaluation surveys, including areas for improvement and lessons learned over the course of the work groups’ operation. Two of the most often cited takeaways include the following:

- In order to foster and maintain engagement, work group members and potential members should be informed of the benefit to them and their organization that will result from their participation; specifically, a tangible benefit, such as the Colorado Energy Assistance Quick Guide, would help incentivize potential members.
- To ensure a deeper connection between work group members and their respective organizations and to help members expand their networks, a combination of in-person and virtual meetings would be ideal. A hybrid model would help capitalize on the benefits of the particular format or platform, such as brainstorming sessions in-person.

All results of the partnership impact evaluation surveys, as well as the complete lessons learned reports, are included in each work group’s evaluation plan (Appendices D, E, G, and I).
Appendix A: Technical and Quantitative Data

Community Profile: Denver Regional AHC Service Area Map

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

Current State Assessment of Population and Community Needs

Identification of at-risk census tracts

Using 2015-2019 American Community Survey Five-Year tract level estimates, Denver Regional AHC project team calculated 11 measures for each census tract in the regional AHC service area.

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

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

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

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

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

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

**Appendix B: Qualitative Data**

**Current State Assessment of Service Availability and Accessibility**

Between March 15, 2021, and March 22, 2021, Denver Regional AHC staff conducted an electronic survey to update the data from the Year 3 Gap Analysis to identify gaps and barriers to services to address in Year 5. Survey participants were 60 community-facing staff who screen and navigate individuals and households were surveyed and 30 responses were received and analyzed by Denver Regional AHC staff. These individuals represent six clinical partner sites that administer screenings (Denver Health Sam Sandos Westside Family Health Center, Denver Health Emergency Department, Doctors Care, Tri-County Health Department and STRIDE Community Health Center).

**Environmental Scans**

See separate addendum coinciding with the publication of this report to view environmental scans for each HRSN work group.
Appendix C: Work groups Project Roadmap

Step 1. Identify the gaps:
What gaps and barriers to service exist for your health-related social need (HRSN)?
What are factors contributing to these service gaps? (Root Cause Analysis)

Step 2. Environmental Scan:
What's already happening in the community to address these gaps and barriers? Where is it happening? What is the geography?
Who else should be part of this discussion and/or workgroup?

Step 3. Prioritize gaps:
Based on what you've learned, which specific gap(s) do you want to address?

Step 4. Develop an aim or goal statement:
What is the expected outcome of the workgroup’s improvement project?

Step 5. Brainstorm solutions:
What are possible strategies and solutions to achieve this aim? What is within our power to test? Who will be involved?

Step 6. Prioritize solutions:
Based on resources (space, time, finances, staffing, etc.) – what solution is most feasible within the given time frame and has the potential to make a tangible impact?
Choose the project/intervention to move forward. (SMART)

Step 7. Define how impact will be evaluated:
Discuss ways to evaluate the impact of the project.
How will we measure whether we achieved our aim?

Step 8. Plan key activities for project and timeline:
What are the next planning, implementation, and evaluation steps to carry out the project?
Who is responsible? Expected timelines?

Step 9. Do:
Carry out the planned project and implement measurements.

Step 10. Study:
Evaluate. What did we learn? Did we achieve our aim?

Step 11. Act:
Determine next steps. If the aim was achieved, how do we make the intervention sustainable?
Can we improve the intervention further?
If we were not successful, we return to the drawing board for alternative solutions.
Appendices D-J:

- Appendix D: Food Security Work Group | Evaluation Plan
- Appendix D: Food Security Work Group | Appendix A: (Part 2) Lessons Learned
- Appendix E: Housing Work Group | Evaluation Plan
- Appendix E: Housing Work Group | Appendix A: Steering Focus Group Results
- Appendix E: Housing Work Group | Appendix B: Final Focus Group Results
- Appendix E: Housing Work Group | Appendix C: (Part 1) Partnership Impact Evaluation
- Appendix E: Housing Work Group | Appendix C: (Part 2) Lessons Learned
- Appendix F: Housing Work Group | Sustainability Plan
- Appendix G: Utilities Work Group | Evaluation Plan
- Appendix G: Utilities Work Group | Appendix A: Pre- and Post-Training Survey Results
- Appendix G: Utilities Work Group | Appendix B: (Part 1) Partnership Impact Evaluation Results
- Appendix G: Utilities Work Group | Appendix B: (Part 1) Lessons Learned
- Appendix H: Utilities Work Group | Sustainability Plan
- Appendix I: Safety Work Group | Evaluation Plan
- Appendix I: Safety Work Group | Appendix A: Pre- and Post-Training Survey Results
- Appendix I: Safety Work Group | Appendix B: (Part 1) Partnership Impact Evaluation Results
- Appendix I: Safety Work Group | Appendix B: (Part 2) Lessons Learned
- Appendix J: Safety Work Group | Sustainability Plan