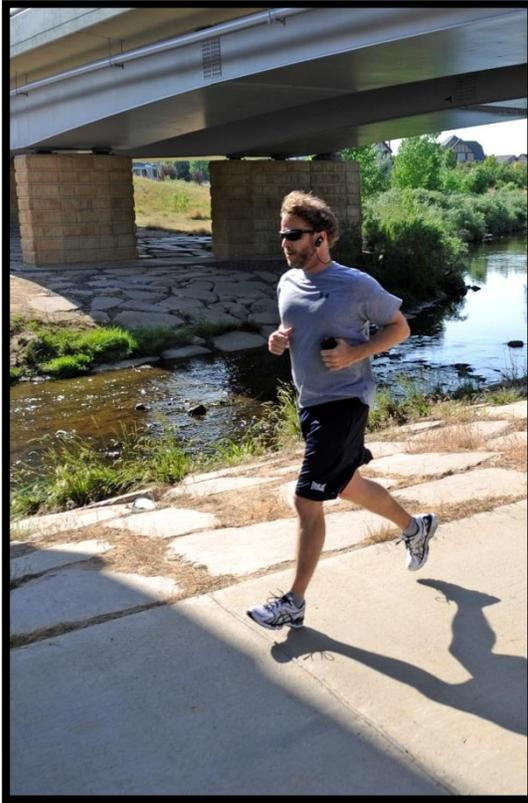


# BE HEALTHY DENVER:

DENVER'S COMMUNITY HEALTH IMPROVEMENT PLAN, 2013-2018



*Be Healthy Denver*  
COMMUNITY HEALTH MATTERS

FEBRUARY 4, 2014



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## LETTER FROM MAYOR HANCOCK

*Michael B. Hancock*  
MAYOR



*City and County of Denver*

OFFICE OF THE MAYOR  
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DENVER, CO 80202-5390  
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January 7, 2014

Dear Neighbors:

Thank you for engaging and participating in the community health input meetings. It gives me great pleasure to present to you our five-year Community Health Improvement Plan (CHIP), which outlines all the actions and steps needed to increase the health and well-being of our residents for years to come. This CHIP will serve as a long-term, systematic effort to address public health issues in Denver based on our health assessment and best practices.

Your participation has helped to identify the public health priorities for the City and County of Denver for the next five years, as well as create our CHIP. The CHIP provides a collective vision for the health of Denver. It is the result of one of the most interactive and extensive processes conducted around the state. With your help, we identified two priorities in our community:

- Access to Care, including Behavioral Health, and
- Healthy Eating and Active Living, including the Built Environment

Our steering committee and task forces have dedicated a significant amount of time and effort to making sure our goals and objectives are achievable, but also – and most importantly – measurable so that we can remain accountable to our community, as well as measure our progress over time. This report reinforces existing partnerships while also encouraging new collaborations with other agencies and funders in our community that strive to make Denver the healthiest city in the nation.

This report is also a call to action for policymakers, nonprofits and Denver residents in a time of health care reform. The Affordable Care Act presents unique opportunities to expand insurance coverage and provide greater access to those residents in our community who have typically been underserved. The plan also calls for a stronger collaboration with our schools and local government to ensure that we provide opportunities for healthy eating and active living in the places we live, work and play.

We look forward to partnering and developing new collaborations to make Denver a healthy place for all our residents.

Respectfully,

A handwritten signature in black ink, appearing to read "Michael B. Hancock", with a long horizontal line extending to the right.

Michael B. Hancock  
Mayor

## EXECUTIVE SUMMARY

Denver's Community Health Improvement Plan (CHIP) is designed to guide governmental and community-wide efforts to improve the health of Denver residents, reduce health disparities in the city, and lower health care costs over the next five years. It provides an umbrella under which the efforts of numerous organizations, groups, and individuals can be aligned around the following two priority health areas, identified by a multi-stakeholder steering committee and Denver community members themselves:

**(1) Access to Care, including Behavioral Health;** and

**(2) Healthy Eating and Active Living (HEAL), including the Built Environment.**

The CHIP contains a detailed Action Plan, summarized below, with a five-year goal and a set of objectives for each of these priority areas, strategies for meeting each objective, and metrics for measuring progress. The *Be Healthy Denver* core team invites partner organizations throughout Denver to organize specific interventions around these CHIP goals and objectives, to be part of this community-wide effort to improve access to care in Denver and to realize a healthier and more vibrant city.

The Action Plan can be fully implemented only through the collective efforts of many organizations and individuals throughout the city. Collaboration and partnership are essential for success, and extend beyond organizations to include members of the Denver community. By involving partners and community members at all stages in the CHIP process, *Be Healthy Denver* continues to learn from the valuable experience embedded in communities, including those whose health is most impacted, and to identify collaborative strategies to address the city's most important health challenges.

Denver CHIP Action Plan
<b>Access to Care</b>
<b>5-YEAR GOAL: By December 2018, at least 95% of Denver residents will have access to primary medical care, including behavioral health care.</b>
<b>Indicators:</b> <ol style="list-style-type: none"><li>1. Percentage of Denver residents with health care coverage.</li><li>2. Percentage of insured/ uninsured residents with a Primary Care Provider (PCP).</li><li>3. Percentage of insured/uninsured residents who have had a PCP visit in the last 12 months.</li></ol> Data Sources: American Community Survey, Colorado Health Access Survey
<b>Enrollment and Coverage</b>
<b>Objective A1:</b> Increase the number of Denver residents with health care coverage by supporting implementation of the Affordable Care Act (ACA); 40,000 Denver residents enroll in Medicaid and subsidized insurance by July 1, 2014 and 94% have health care coverage by December 31, 2018.
<b>Provider Capacity</b>
<b>Objective A2:</b> Assess and build the capacity of safety net providers in Denver to deliver primary, specialty, and behavioral health care to persons newly covered starting in 2014, and to those who remain uninsured.
<b>Care Coordination and System Collaboration</b>
<b>Objective A3:</b> Create a health alliance of important stakeholder organizations in Denver, to increase access to care, better coordinate health care services, and decrease health care costs.

<b>Denver CHIP Action Plan</b>
<b>Healthy Eating and Active Living (HEAL)</b>
<b>5-YEAR GOAL: By December 2018, the percentage of children and adolescents in Denver who are at a healthy weight will have increased by five percentage points.</b>
<b>Indicators:</b> <ol style="list-style-type: none"> <li>1. Percentage of children 2-5 years of age using Denver Health and Kaiser Permanente health systems who are at a healthy weight.</li> <li>2. Percentage of Denver Public Schools (DPS) students, kindergarten through 9<sup>th</sup> grade, who are at a healthy weight.</li> <li>3. Percentage of DPS students, 6-12<sup>th</sup> grade, meeting recommended physical activity levels (60 minutes/day, 7 days per week).</li> </ol> Data Sources: Denver Health and Kaiser Permanente Electronic Health Records, DPS Body Mass Index (BMI) data, Denver Health Kids Colorado Survey
<b>Community</b>
<b>Objective H1:</b> Increase the number of safe and active environments that support physical activity for Denver communities.
<b>Objective H2:</b> Increase access to nutritious foods and beverages in underserved areas.
<b>Child Care Centers</b>
<b>Objective H3:</b> Increase the number of licensed child care centers with an optimized Healthy Eating and Active Living (HEAL) environment, through strengthened physical activity and nutrition standards and guidelines.
<b>Schools</b>
<b>Objective H4:</b> Increase quality physical education and opportunities for moderate to vigorous physical activity in schools.
<b>Objective H5:</b> Increase access to healthy foods and beverages in schools.
<b>City and County Government</b>
<b>Objective H6:</b> Incorporate health considerations and analysis in city policy, processes, and planning.
<b>Objective H7:</b> Develop and implement a targeted <i>Be Healthy Denver</i> marketing campaign for Healthy Eating and Active Living (HEAL).

The Action Plan contains numerous strategies and metrics for measuring progress in meeting these CHIP goals and objectives. These will be tracked regularly by the *Be Healthy Denver* core team and made available to the community and to partners at the *Be Healthy Denver* website, BeHealthyDenver.org. A mid-term evaluation will be conducted in 2016 to assess progress in meeting the goals and objectives and to suggest any needed adjustments to the Action Plan for the remaining implementation period. A final evaluation will be conducted in 2018 to assess progress again, identify lessons learned, and make recommendations for Denver's next CHIP.

The first step in the CHIP process was to carefully evaluate 14 key health issues in Denver through a Community Health Assessment (CHA), *Health of Denver 2011*, completed in March 2012 and available at BeHealthyDenver.org. On this foundation, a collaborative process including the formation of a multi-stakeholder steering committee, community meetings held throughout the city, and two youth focus groups helped to identify Access to Care and HEAL as the top two priority health topics on which to focus community health improvement efforts in Denver over the next five years. Both topics have a major impact on the health of Denver residents, and both can be improved by community- and policy-level interventions.

Two task forces were formed in February 2013 to study the current status of Access to Care and HEAL in Denver, and to propose strategies for making significant gains in each area. The task forces included wide representation from governmental organizations, health care organizations and providers, community-based organizations, foundations, research institutions, and schools. They met for seven months in 2013 to develop the Action Plan, which will coordinate city-wide efforts to improve Access to Care and HEAL over the next five years.

### ***Be Healthy Denver Mission and Vision***

*Be Healthy Denver* is a collaborative effort between Denver Environmental Health, Denver Public Health, and numerous partner organizations and individuals throughout the city. Its mission is to improve the health of all Denver residents, through collaboration to resolve complex public health issues. *Be Healthy Denver* envisions a Denver that provides ample opportunities for all residents to be healthy, regardless of their race, ethnicity, income level, or the neighborhood in which they live.



## CONTRIBUTING ORGANIZATIONS AND INDIVIDUALS

The *Be Healthy Denver* team would like to thank the following individuals and organizations who participated in CHIP planning process, including members of the *Be Healthy Denver* Steering Committee, the members of the Access to Care Task Force and the Healthy Eating and Active Living (HEAL) Task Force, and a core group for staff members from Denver Environmental Health and Denver Public Health.

We would also like to thank the many citizens who participated in community meetings and focus groups, and the Colorado Department of Public Health and Environment (CDPHE) for its guidance and expertise, and for funding a portion of the efforts.

Special thanks go to Drs. Bill Burman and Ned Calonge for chairing the Access to Care Task Force, to Doug Linkhart and Dale Flanders for chairing the HEAL Task Force, and to Dr. Lisa McCann and Michele Shimomura for drafting this report and an abbreviated version for the community.

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<b>Bridget Beatty</b>	Denver Public Schools
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<b>Alisha Brown</b>	Stapleton Foundation
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## BE HEALTHY DENVER COMMUNITY VISION

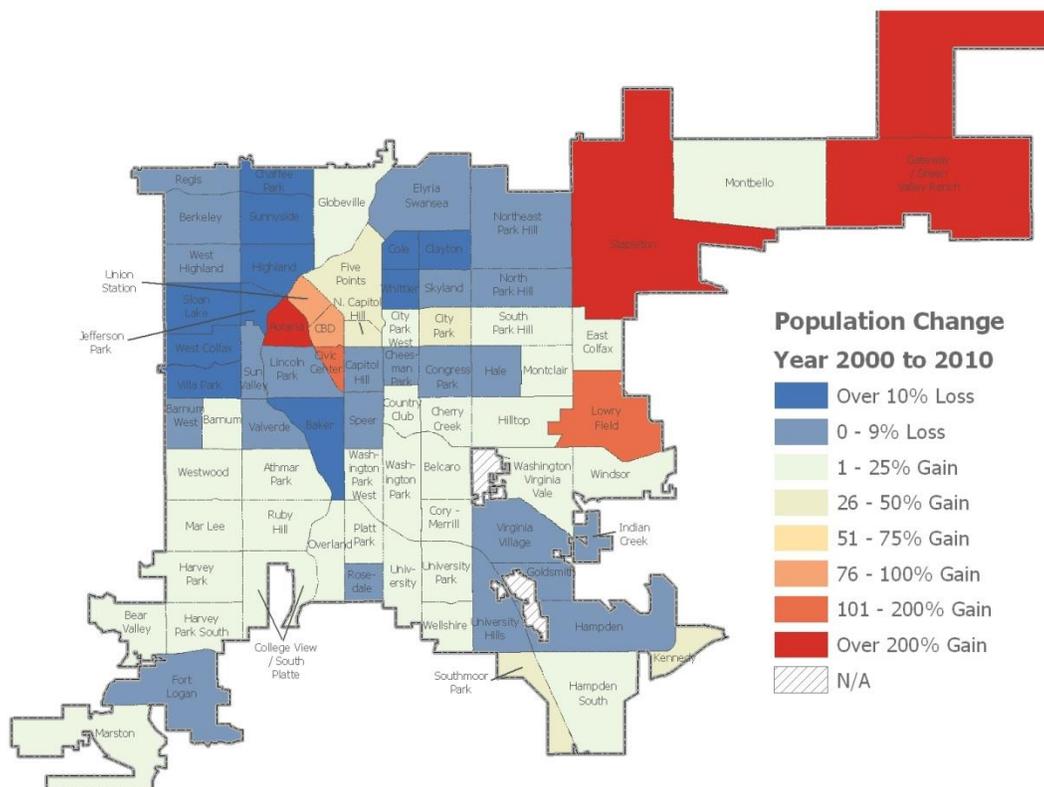
*Be Healthy Denver* is a collaborative effort between Denver Environmental Health, a department of the City and County of Denver, Denver Public Health, a department of the Denver Health and Hospital Authority, and numerous partner organizations and individuals throughout the city. Its mission is to improve the health of all Denver residents, through collaboration to solve complex public health issues that cannot be solved by any single organization. Collaboration extends beyond organizations to include communities and individual residents. *Be Healthy Denver* envisions a Denver that provides ample opportunities for good health for all residents, regardless of their race, ethnicity, income level, or the neighborhood in which they live.

## COMMUNITY PROFILE: CITY AND COUNTY OF DENVER

The City and County of Denver, located in the center of the larger Denver metropolitan area, is rapidly growing. Its population in the 2010 Census was 600,158, having increased by 7.6% since 2000. Denver has 79 official neighborhoods and 11 city council districts. The largest increases in population have been in the northeastern part of the city, particularly the areas of the former Lowry Air Force base and the former Stapleton International Airport (Map 1).

**Map 1: Neighborhood Population Change, 2000 to 2010**

Source: U.S. Census

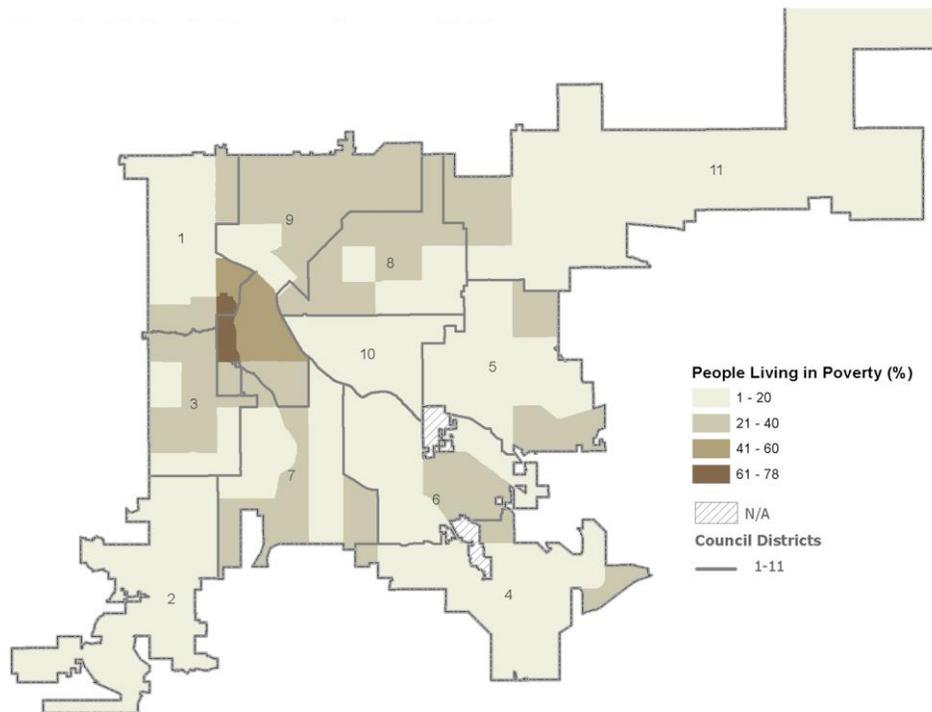


The median age in Denver was 33.7 years at the 2010 Census.<sup>1</sup> Sixty-nine percent of Denver residents identified themselves as being white, 10% black, 3% Asian, 1% Native American, 12% of other races, and 4% of mixed races. Thirty-two percent of Denver residents identified themselves as being Hispanic or Latino. Of the 263,107 households in Denver, almost 8% are linguistically isolated, meaning that no one over age 14 in the household speaks English well.<sup>2</sup>

Economic, educational, and environmental factors all impact health. The average household income in Denver was \$68,342 in 2010,<sup>3</sup> but poverty was more prevalent in the western and northern parts of the city (Map 2). Between 2007-2011, the average unemployment rate in Denver was 8.3%, but there were disparities in unemployment rates among people of different races. Whites had an unemployment rate of 6.7%, whereas Hispanics had a rate of 12.1%, blacks 15.6%, and Asians 6.2%.<sup>4</sup> In 2010, 16% of adults in Denver had not completed high school, but educational attainment is also disparate across different parts of the city, with lower attainment in the western and northern areas.<sup>5</sup>

### Map 2: Denver Residents Living in Poverty, 2010

Source: American Community Survey



Factors in the built environment, such as the availability of bike lanes, sidewalks, and grocery stores, affect the health and welfare of Denver residents, but these factors are also distributed unevenly in different parts of the city. In Denver, 79% of residents live within half a mile of a park, and nearly 75% of children live within half a mile of a city-owned playground, but the walkability of neighborhoods differs, based on factors such as safety, adequate sidewalks, proximity to retail destinations, and the neighborhood's ambiance.<sup>6</sup>

## Health Successes in Denver

Denver has seen several major public health successes. Deaths by the three leading causes, namely cardiovascular disease, cancer, and injuries, continue to decrease.<sup>7</sup> Decreases in cancer deaths are linked to reductions in tobacco use over the past 20 years, and to improvements in screening tests for cancer at earlier stages when treatment is more effective. The rates of homicides and deaths from motor vehicle accidents have substantially declined. Deaths attributed to infectious diseases such as HIV have declined. New HIV infections have decreased, as effective treatment has improved the health of those with HIV and reduced the risk of transmitting the virus.<sup>8</sup>

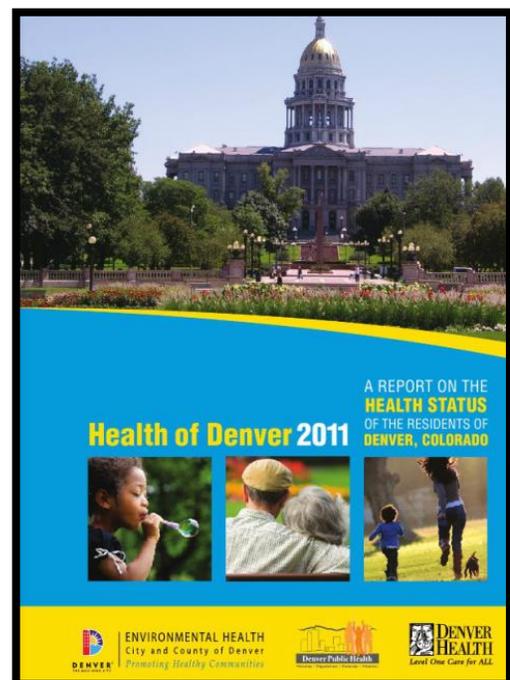
There have also been improvements in the quality of the environment, which has a strong impact on health. Denver's air and water quality continue to improve, and there have been notable improvements in the built environment, with more Denver residents now able to walk, ride bicycles, and use parks and recreation spaces than ever before.<sup>9</sup> However, continued vigilance is needed to protect the natural environment and further develop the built environment in ways that support healthy eating and active living.

## Health Concerns in Denver

*Health of Denver 2011* revealed several major areas of health concern in Denver, including access to health care, mental health, substance abuse, tobacco use, and obesity.<sup>10</sup> Many of the strategies for preventing common diseases, such as detecting and treating high blood pressure to prevent heart disease, require access to health care. Yet roughly one in five Denver residents lacks health coverage. Moreover, one in 10 are underinsured, with health insurance plans that do not cover the costs of necessary medical expenses and leave them with excessive out-of-pocket costs.<sup>11</sup> Even more lack dental insurance. Across the state, nearly 40% of Coloradans lack dental insurance, and one in three has not been to a dentist within the past year.<sup>12</sup> Oral health is strongly tied to overall health, such that poor oral health poses additional health risks.

Mental illness and substance abuse are common among Denver residents. Denver's rate of suicide (17.4 per 100,000 residents) is well above the national average (11.5 per 100,000 residents), yet access to mental health care and substance abuse treatment remains very limited.<sup>13</sup> Mental illness and suicide are also a concern for Denver's children, with 25% of middle and high school students at Denver Public Schools having reported feeling depressed and 13% having seriously considered suicide during the 2011/2012 school year.<sup>14</sup> The continued abuse of alcohol and rising rates of prescription drug abuse are also worrisome trends in Denver. Youth substance use is prevalent, with 28% of middle and high school students at Denver Public Schools having reported using alcohol and 19% having reported using marijuana in the previous month.<sup>15</sup>

Although adult tobacco use in Denver, at about 18%, is slightly lower than the national average, the rate for young adults aged 18-24 years, at 31%, is much higher than the national average of 19%.<sup>16</sup> Denver's tobacco use rates are also well above the national *Healthy People 2020* objective of 12%.<sup>17</sup> Smoking and exposure to tobacco smoke remain a major health problem, given that tobacco is a risk factor for many chronic diseases, such as cardiovascular disease, cancer, and respiratory diseases.



While Denver's rates of overweight and obese adults are low compared to the US as a whole, its rates for overweight and obese children are similar to the national rates, and will soon translate into higher rates for all age groups unless action is taken to reverse the trend. During the 2012/2013 school year, 31% of school-aged children in Denver (kindergarten through 9<sup>th</sup> grade) were either overweight or obese, consistent with the national average of 33%.<sup>18</sup>

The percentage of obese adults in Denver more than doubled in the last two decades, from less than 10% in 1990 to 20% in 2009; 34% of Denver adults were overweight in 2009, for a total of 54% of adults who were at an unhealthy weight, either obese or overweight.<sup>19</sup>

Healthy eating and active living contribute to achieving and maintaining a healthy weight, which can be measured by a person's Body Mass Index (BMI), calculated from mass and height. Eating five servings of fruits and vegetables per day and limiting calories from added sugars, including from sugar-sweetened beverages like soda, sports drinks, and juice, are recommended.<sup>20</sup>

Regular exercise can also help maintain a healthy weight. The Centers for Disease Control and Prevention (CDC) recommends that children have at least 60 minutes of physical activity daily, and that adults should exercise at least 150 minutes per week<sup>21</sup>. However, approximately 20% of Denver adults engage in no leisure-time physical activity at all, and 74% consume fewer than the recommended five servings of fruits and vegetables per day.<sup>22</sup> These recommendations are especially important for Denver's children, to prevent obesity and teach healthy behaviors. Only one in two middle and high school boys, and one in three girls report engaging in 60 minutes of physical activity for five or more days per week.<sup>23</sup>

These facts regarding overweight, obesity, and unhealthy behaviors signal significant cause for concern for the future health of Denver residents. The growing obesity epidemic threatens to reverse recent improvements in the rates of cardiovascular disease, and increases the risk of diabetes and some forms of cancer.

## PUBLIC HEALTH SYSTEM CAPACITY AND PERFORMANCE IN DENVER

Denver's local public health efforts are conducted through a cooperative effort by Denver Environmental Health, a department of the City and County of Denver that provides regulatory and environmental public health services and health promotion activities, and Denver Public Health, a department within the Denver Health and Hospital Authority (DHHA) that provides personal- and population-oriented public health services and health promotion activities. Both departments receive grant funding for community health activities, particularly in the public health prevention and promotion core service area. Together they promote the health and well-being of Denver residents and provide environmental and public health services for the Denver community.

Denver Environmental Health, Denver Public Health, and the Colorado Department of Public Health and Environment (CDPHE) completed a formal review of public health capacity in Denver in August 2011, which showed that the 10 Essential Public Health Services defined in the National Public Health Performance Standards (NPHPS)<sup>24</sup> are being provided through the two local departments. To conduct the review, each department first conducted on its own the National Association of County and City Health Officials' (NACCHO) local county health department survey. With these results in hand, the two departments came together to review their respective responses to the survey, with staff from CDPHE's Office of Planning and Partnership present to assist. Two additional, more comprehensive surveys were completed in 2013 from NACCHO and the Colorado Association of Local Public Health Officials (CALPHO) in 2013. These surveys helped Denver Environmental Health and Denver Public Health to make an inventory of the financial resources and full-time staff members contributing to the provision of each of the 10 Essential Public Health services in Denver, including areas of governance.

Denver’s public health system also includes a broad array of organizations beyond Denver Environmental Health and Denver Public Health (see Figure 1). Denver’s safety-net providers are important contributors, and include Denver Health with its hospital and large network of community health clinics and school-based clinics, other hospitals such as Exempla St. Joseph Hospital, health care systems such as Kaiser Permanente, primary care clinics such as the Stout Street Clinic, Inner City Health Center, Clínica Tepeyac, and the Colorado Alliance for Health Equity and Practice (CAHEP), and behavioral health care providers such as the Mental Health Center of Denver (MHCD) and Servicios de la Raza.

**Figure 1: Public Health System in Denver**



Other important contributors include Denver’s huge array of nonprofit and community-based organizations that offer a variety of services to low-income Denver residents and play important roles in health promotion.

Several health-related foundations and organizations provide significant funding for innovations in health care and public health, including the Colorado Trust, the Colorado Health Foundation, Caring for Colorado, and Livewell Colorado.

Additional important contributors to the public health system include organizations that work to improve access to health data, such as the Colorado Health Institute, the Center for Improving Value in Health Care (CIVHC), and the Colorado Regional Health Information Organization (CORHIO). Educational institutions such as the Colorado School of Public Health play an important role by training public health workers. Denver Public Schools plays a vital role in supporting children’s health and well-being, encouraging healthy behaviors, and tracking health data for Denver’s children.

Finally, collaborative relationships with other metro-area health departments, such as Tri-County Health Department covering Adams, Arapahoe, and Douglas Counties, Jefferson County Public Health, and Boulder County Public Health, help to address metro-wide health concerns.

## COMMUNITY HEALTH IMPROVEMENT PLANNING PROCESS

### CHIP Timeline

The Community Health Improvement planning process began with Denver’s most recent Community Health Assessment (CHA), *Health of Denver 2011*, completed by a core team from Denver Environmental Health and Denver Public Health, with the support of other subject-matter experts and over 100 community partners.<sup>25</sup> *Health of Denver 2011* reported on the status of 14 health topics in Denver, using over thirty data sources, and provided important baseline data for formulating the CHIP. The report was widely distributed to stakeholders, community leaders, and community members, and is available at [BeHealthyDenver.org](http://BeHealthyDenver.org). Findings were presented to health care providers and interested community groups in a series of outreach events (see Appendix A for a list of events).

The momentum generated by *Health of Denver 2011* carried into the initial phases of developing this CHIP. Because CHAs are conducted every three years in Denver, two more will be completed, in 2014

and 2017, while the CHIP is being implemented. Table 1 shows a timeline for the periodic CHAs and the CHIP.

Early in the CHIP process, Denver Environmental Health and Denver Public Health selected “Be Healthy Denver” to brand these collective efforts to improve health in Denver and provide an umbrella under which organizations, communities, and individuals can come together to jointly address the prioritized health areas defined in the CHIP, as well as other health issues in the city.



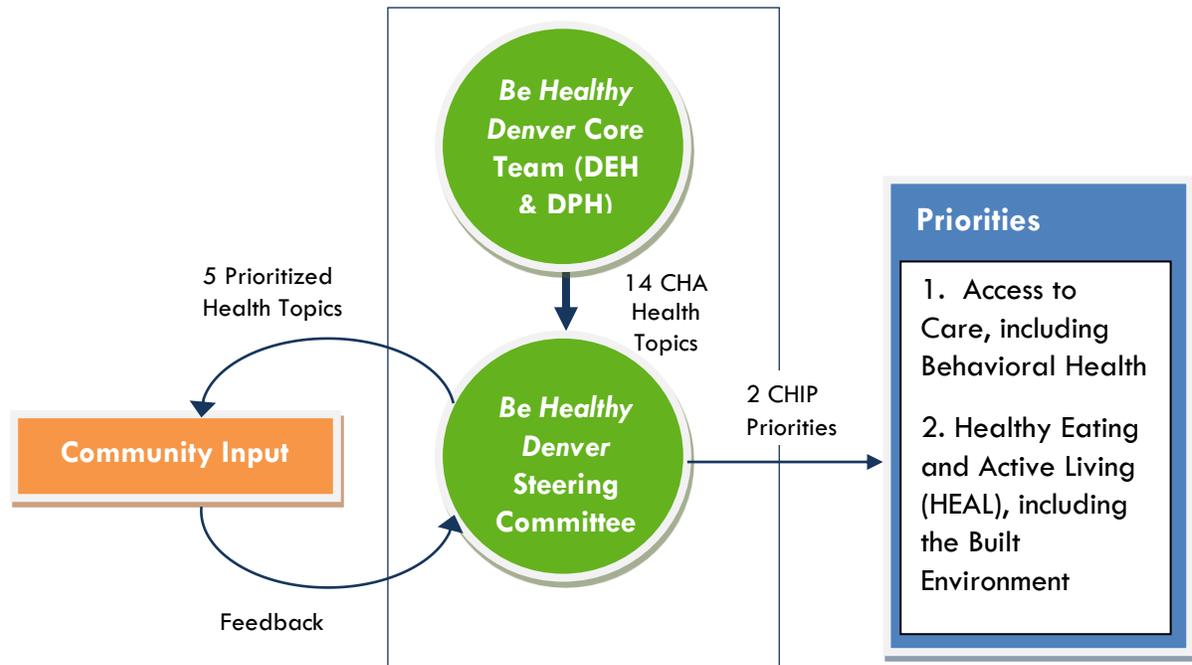
Table 1: Denver CHIP Timetable		
Item	Date	Action
CHA	Mar. 2012	Health of Denver 2011 released
CHIP Planning	Jun. 2012	CHIP Steering Committee convenes
	Jul. 2012	Steering Committee selects five initial health topics
	Sep.-Oct. 2012	Seven community meetings, two focus groups, online survey
	Nov.-Dec. 2012	Steering Committee selects Access to Care and HEAL
	Feb.-Sep. 2013	Two Task Forces meet and develop plans
	Oct.-Nov. 2013	Task Force plans consolidated into a draft CHIP
	Nov. 2013	Steering Committee and Task Forces review draft CHIP
	Jan. 2014	CHIP released
CHIP	2013-2018	CHIP implementation
CHA	2014	CHA to be completed
CHIP Report	2016	CHIP Mid-Term Report to be completed
CHA	2017	CHA to be completed
CHIP Report	2018	CHIP Final Report to be completed

### Prioritization Phase I: Be Healthy Denver Steering Committee

The Be Healthy Denver core team began planning for the CHIP early in 2012 by identifying a Steering Committee to lead the prioritization process, composed of important stakeholders from governmental and community-based organizations with an interest in improving health in Denver. A list of the Steering Committee members, many of whom had contributed earlier to *Health of Denver 2011*, is listed in the section on Contributing Organizations and Individuals.

The Steering Committee was asked to identify five priority health topics from among the 14 topics in *Health of Denver 2011*. These topics would then be submitted to the community for a second round of prioritization to decide on the final topic areas to be included in the CHIP. This prioritization process is summarized in Figure 2.

**Figure 2: Prioritization Process**



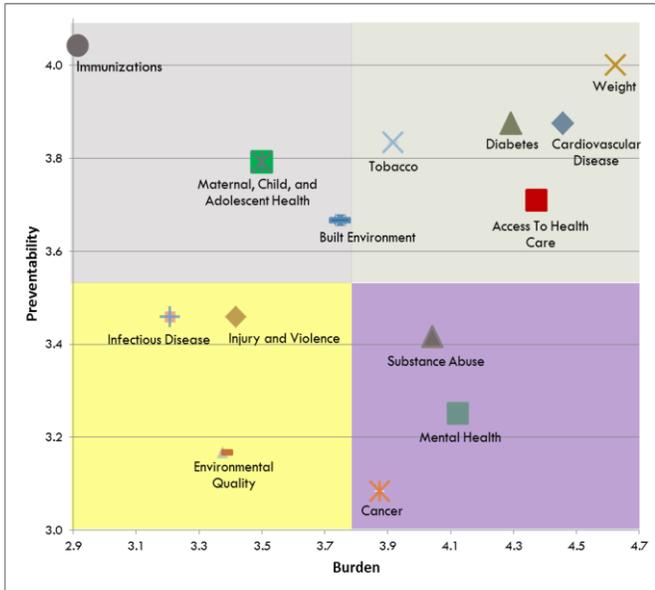
The core team from Denver Environmental Health and Denver Public Health supported the work of the Steering Committee and the community meetings, by organizing meetings and providing background materials. Engaged Public, a local consulting firm, facilitated both the Steering Committee and Community meetings, to ensure a neutral environment for dialogue and an unbiased selection of priorities.

*Be Healthy Denver* was officially launched in May 2012 with the first meeting of the Steering Committee. Two criteria were used for the Steering Committee’s first prioritization of health topics. The first criterion was the *burden* represented by the health topic, and the second was its *preventability*, or the ability to effect a change through interventions. These concepts are further defined in Appendix B.

Through an online survey, the Steering Committee members ranked each of the 14 health topics for burden and preventability on a scale of five, with one being low and five being high. Figure 3 shows the results of the survey. Using these results, and through a facilitated discussion, the Steering Committee combined some of the original health topics to develop five initial health priorities for consideration by the community: Access to Care; the Built Environment; Maternal, Child, and Adolescent Health; Mental Health and Substance Abuse; and Unhealthy Weight.



**Figure 3: Initial Health Topics Rated by Steering Committee for Burden and Preventability**



**FIVE INITIAL HEALTH PRIORITIES**

**Access to Care**

**The Built Environment**

**Maternal, Child, and Adolescent Health**

**Mental Health and Substance Abuse**

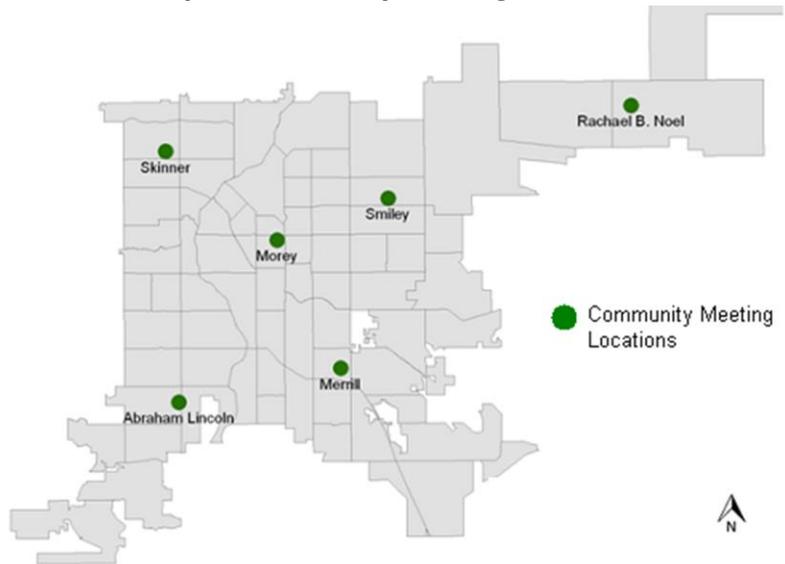
**Unhealthy Weight**

**Prioritization Phase II: Community Meetings**

In September and October 2012, *Be Healthy Denver* held six community meetings throughout Denver to gather community input and discuss possible community-based interventions for each of the five prioritized health topics. Map 3 shows the locations of the meetings, all of which were held in Denver Public Schools facilities.

Before each meeting there were informational booths, activities, and food was provided for the attendees. The meetings themselves were 90 minutes long and consisted of an interactive presentation on the five prioritized health topics, with examples of possible community-level interventions, followed by a facilitated discussion with community members to gather their input and vote on the topics.

**Map 3: Community Meeting Locations**



To encourage participation, the meetings were held on various days of the week and at different times of the day; a meal and children’s activities were provided before each meeting (see Appendix C for meeting details). At three of the meetings, free child care was provided to encourage the attendance of parents with young children, and at two of the meetings, a concurrent session was held in Spanish to encourage the attendance of Spanish speakers.

One hundred twenty Denver residents attended the community meetings. Each participant used a “clicker,” or wireless voting device, which allowed the facilitator to register responses instantly during the meetings. These results were used to stimulate further discussion on the relative importance of each problem, and on possible interventions.

For each of the five health topics, the facilitator asked participants the following questions:

1. How important it is for Denver to make progress on improving this health topic?
2. What do you propose as potential solutions to address this health topic?

The participants then worked in small groups to discuss these questions. After all five topic areas had been discussed in the small groups, the facilitator asked participants the following questions in order to rank the topics:

1. Knowing what you know now, which of these five health areas is most important?
2. Knowing what you know now, on which of these health areas can Denver communities have the greatest impact?

These questions served as a means for community members to assess the topics according to their *health impact* (question 1) and the *ability to change* them (question 2), similar to the process that had been used by the Steering Committee to narrow the topics from 14 to five based on the criteria of *burden* and *preventability*. Figure 4 shows the results of the community voting on the five health topics. Community members ranked Access to Care and Unhealthy Weight highest in health impact, and Built Environment with the greatest ability to change.

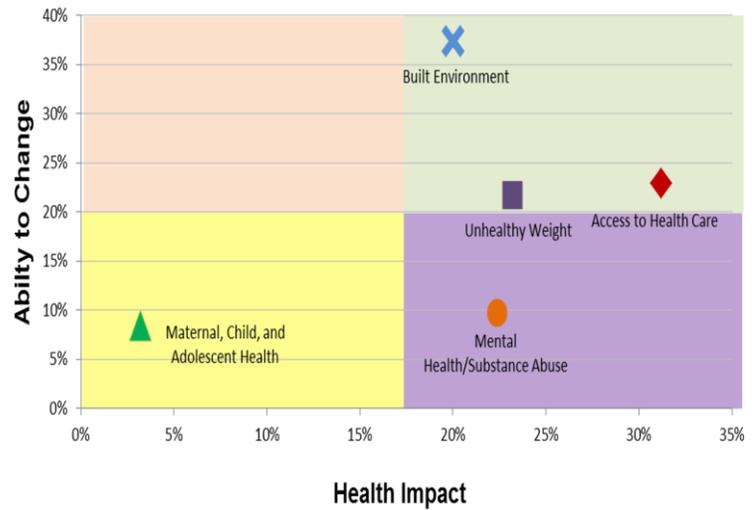
The rankings for both health impact and ability to change varied by location. Access to Care was rated highest for health impact in four of the six locations, except in the northwestern and southeastern parts of the city, where community members perceived Unhealthy Weight as being highest in health impact. There was no strong pattern in the rankings by location for ability to change, except for a somewhat high ranking for the Built Environment in all areas.



Community members were also asked to propose and discuss possible interventions or solutions for the five prioritized health topics. Over 130 interventions were proposed. Table 3 lists the most common suggestions.



**Figure 4: Community Meeting Ratings for Health Impact and Ability to Change**



**Table 3: Community Suggestions for Addressing the Five Priority Health Topics**

Access to Care
Assistance with Medicaid enrollment and applying for insurance
Create groups with an interest in promoting preventive care; collaboration between health organizations, schools and churches
Free neighborhood medical and dental centers
School-based family clinics that open evenings and weekends; health fairs in schools
Create alternatives for undocumented people who have no access to care
Mobile health screening sites during accessible hours

Built Environment
Safe, affordable, and interconnected pedestrian routes, bike routes, and public transportation
Increase safety (lighting, etc.) in transportation areas and public places
Affordable recreation centers
Healthy foods in low-income areas

<b>Maternal, Child, and Adolescent Health</b>
Parenting skills classes
School-based programs to reduce violence
Safe sex programs with parental interaction
Community-based gang reduction programs
1 on 1 peer mentoring programs
School-based health centers in every high school
Free contraception to all high school students through school-based health services

<b>Mental Health / Substance Abuse</b>
School-based health centers; mental health, drug and alcohol counselors; improve availability & accessibility to mental health services
Train the public to recognize mental health problems and refer people to services
Access to behavioral health screening and interventions by integrating these services with physical health services
Education programs for youth and parents to learn about the consequences of using alcohol and drugs
Outreach programs aimed at reducing the stigma of seeking mental health services
Teen education programs using the peer opinion leader model

<b>Unhealthy Weight</b>
Access to affordable, healthy foods in all neighborhoods
Create accessible, free recreation programs for adults, teens, and children; provide physical activities to low income families in the winter
Promote walking and install more bike racks at businesses, schools, and public places
Require daily, well-designed physical education at schools
Nutritional campaigns to teach families how to cook in a healthier way
Tax high-caloric foods
Create a city "Turn off the TV day"

To gather input from community members who could not attend the community meetings in person, *Be Healthy Denver* posted the presentation and survey on-line at [BeHealthyDenver.org](http://BeHealthyDenver.org). The online tool gathered 51 responses by November 2012, which were aggregated with the responses from participants in the community meetings. Figure 5 illustrates the combined results. The results were very similar for in-person and online responses, but the online responses ranked Mental Health and Substance Abuse higher in ability to change.

In addition to the community meetings and online survey, *Be Healthy Denver* conducted two youth focus groups and participated in a “Cabinet in the Community” meeting with Denver Mayor Michael Hancock.

In September and October 2012, two focus groups were held with 25 volunteer youths of high-school age from Groundwork Denver, a local non-profit organization, and the Mayor’s Youth Commission.

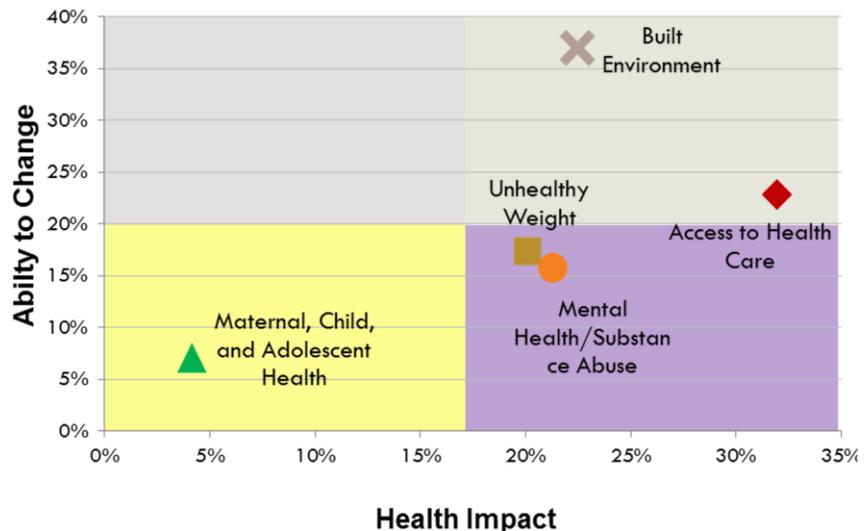
The dominant themes of the youth focus groups were the built environment and mental health services. Many youths rely on public transportation, as well as walking and biking, to get around the city. They

stressed the need to have access to bike paths, B-cycle stations in convenient locations and methods of payment other than credit cards, and safety education for pedestrians, bicyclists, and motorists.

Regarding mental health, many youth participants indicated that they needed more knowledge about existing resources, as many youths are unaware of the mental health resources available to them in schools or through crisis lines.

At the “Cabinet in the Community” meeting, one of Mayor Hancock’s scheduled community meetings, a short presentation was made on the five priority health topics, and 67 community members voted on the topics they thought were most important. Because they were not asked the same questions about health impact and ability to changes as were participants in the other community meetings, the responses of this group could not be aggregated with the others. As in the other community meetings, the Built Environment (22% of votes) and Access to Care (20% of votes) were high on the list of priorities, but mental health (28% of votes) was considered the most important topic by this group.

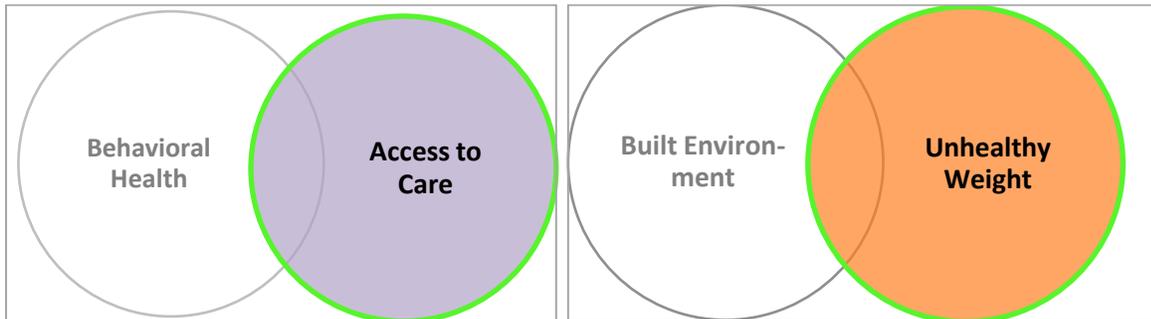
**Figure 5: Combined Ratings for Health Impact and Ability to Change**



### Prioritization Phase III: Identifying Final Priorities

In November 2012, the *Be Healthy Denver* core team presented the results of the community meetings to the Steering Committee. After a facilitated discussion, Committee members voted on the top two priority areas. Access to Care and Unhealthy Weight were selected. However, the Committee noted that there were clear relationships between these two and other priority areas. For example, Access to Care includes access to Behavioral Health care (mental health and substance abuse treatment) as well as physical health care, while Unhealthy Weight is clearly related to aspects of the Built Environment (see Figure 6).

**Figure 6: Priority Areas Overlapping with Other Health Topics**



To accommodate these interactions, the Steering Committee in its subsequent meeting in December 2012 renamed the priority areas as (1) Access to Care, including Behavioral Health, and (2) Healthy Eating and Active Living (HEAL), including the Built Environment.

### ***FINAL CHIP HEALTH PRIORITY AREAS***

Access to Care, including Behavioral Health

Healthy Eating and Active Living (HEAL), including the Built Environment

### **Formation of the Task Forces**

In February 2013, *Be Healthy Denver* convened two task forces to develop an action plan for each priority health topic. Dr. Bill Burman of Denver Public Health and Dr. Ned Calonge of the Colorado Trust co-chaired the Access to Care Task, while Doug Linkhart of Denver Environmental Health and Dale Flanders of Kaiser Permanente co-chaired the HEAL Task Force. Members of both task forces are listed in the section on Contributing Organizations and Individuals.

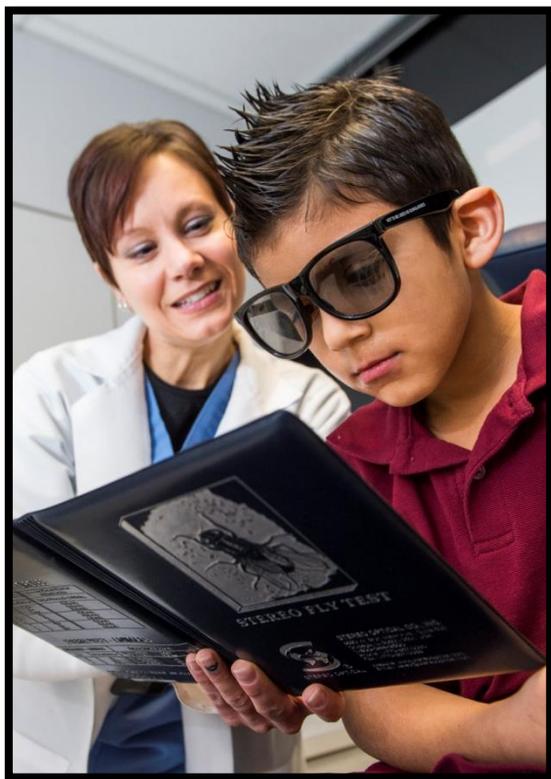
The Access to Care Task Force included medical care providers, behavioral health care providers, governmental organizations, and community-based organizations serving low-income Denver residents. It convened seven meetings between February and September 2013. This Task Force devoted much of its time to assessing access to care issues in Denver, through an extensive environmental scan of current enrollment practices for Medicaid and other medical assistance programs, and of current capacity challenges faced by safety net providers of primary care, specialty care, and behavioral health care. Results of these survey efforts are available at [BeHealthyDenver.org](http://BeHealthyDenver.org).

The work of the Access to Care Task Force was also influenced by the unprecedented window of opportunity afforded by the Patient Protection and Affordable Care Act (ACA) to increase health care coverage through enrollment in Medicaid and subsidized health insurance plans through Connect for Health Colorado, the state's new health insurance exchange, starting as early as October 1, 2013. To take advantage of this opportunity, the Access to Care Task Force engaged in early implementation activities to facilitate enrollment and coverage, alongside formulating the Access to Care Action Plan.

The HEAL Task force included governmental organizations, community-based organizations, health care organizations, foundations, research institutions, and representatives from Denver Public Schools. It convened four meetings between February and June 2013 and two smaller work group meetings between June and August 2013.

Each task force used a similar process of convening a series of stakeholder meetings of the whole task force, and designating a smaller, core group to help organize the larger group and prepare documents and reports as needed. However, given some important differences in the nature of the two priority areas, the two task forces used different approaches in their work, and produced different types of recommendations.

The HEAL Task Force was able to build on a strong body of literature on best practices, as well as numerous ongoing HEAL efforts by community partners in Denver (see Appendix F for a description of some of these efforts). The Task Force reviewed strategies and best practices implemented in other cities, especially those that have been successful in reducing childhood obesity, such as New York and Philadelphia. It also conducted an environmental scan of strategies currently being implemented in Denver to promote healthy weight in children, principal among which are the Mayor's Children's Cabinet, the Denver Public Schools Health Agenda 2015, and several LiveWell Colorado projects. The HEAL Task Force had representatives from many of these organizations and programs, who helped to formulate the HEAL Action Plan. A list of national best practices and the results of the local environmental scan are available at [BeHealthyDenver.org](http://BeHealthyDenver.org).



## Access to Care, Including Behavioral Health

### Access to Care Five-Year Goal

The Access to Care Task Force set a five-year goal that aligns with Denver's 2020 Sustainability Goal related to health,<sup>26</sup> namely that by December 2018, at least 95% of Denver residents will have access to primary medical care, including behavioral health care.

#### ACCESS TO CARE FIVE-YEAR GOAL:

**BY DECEMBER 2018, AT LEAST 95% OF DENVER RESIDENTS WILL HAVE ACCESS TO  
PRIMARY MEDICAL CARE, INCLUDING BEHAVIORAL HEALTH CARE**

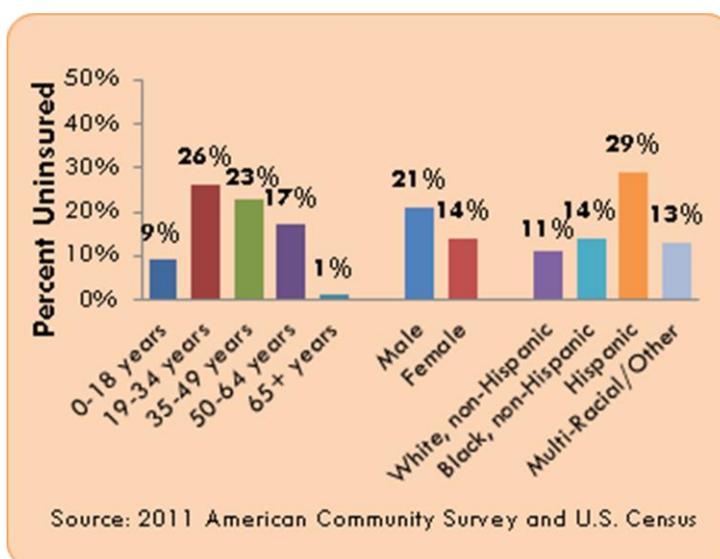
Access to care is not guaranteed by having health care coverage, although the two issues are closely linked. Although many people will gain health care coverage through Medicaid and subsidized insurance in the coming years, some may continue to face challenges in accessing care unless the capacity to care for the newly covered in Denver is increased. Additionally, some 20,000 undocumented Denver residents will not be eligible for the new forms of coverage<sup>27</sup> and will continue to need assistance from Denver's safety net clinics to access health care.

### Insurance Coverage and Access to Care in Denver

Approximately 104,000 persons in Denver, or nearly one in five persons, lack health insurance,<sup>28</sup> and an even higher number lack dental insurance, making it difficult for many to obtain medical, behavioral health, and dental care. Many others are underinsured, which inhibits them from accessing care and exposes them to high financial risks in the event of a major health crisis. Moreover, the various types of care, such as primary care, mental health care, and substance abuse treatment, continue to be split between different systems, with little coordination regarding the care of individual patients. The result is expensive, poorly coordinated care and poor health outcomes.

Although all parts of the Denver community are affected by its high rates of uninsured, some segments of the population are more likely to be uninsured than others, and to face greater challenges in accessing health care. Younger adults are more often uninsured than other age groups, men more than women, and Hispanics more than whites, blacks, and other races (see Figure 7). Single people are more often uninsured than married, divorced, or separated people.<sup>29</sup>

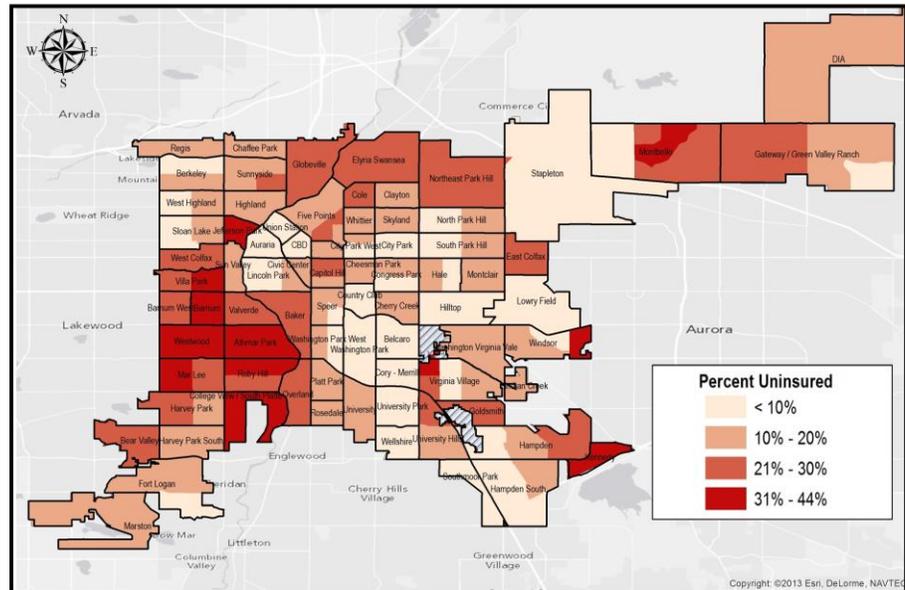
**Figure 7: Uninsured in Denver**



Whereas 17% of Denver's overall population is uninsured, 26% of adults ages 19-34 years, and 23% of adults ages 35-49 are uninsured. 21% of men are uninsured, compared to 14% of women. Hispanics have the highest rate of uninsurance of any race or ethnic group (29%), compared to whites (11%), blacks (14%), and other races (13%).<sup>30</sup>

Lack of insurance also varies across different parts of the city. Map 4 shows the distribution of uninsured in Denver, illustrating that rates of uninsured vary from less than 10% in some parts of the city to more than 30% in others, with the lack of insurance most prevalent in the western and northern neighborhoods.<sup>31</sup>

**Map 4: Percent Uninsured in Denver County by Census Tract**



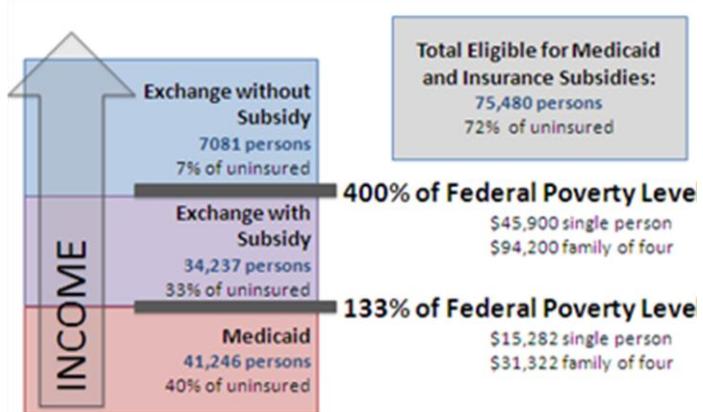
Source: American Community Survey, 2008-2012

**New Coverage Opportunities in 2014**

The expansion of health care coverage in 2014 under the ACA provides an unprecedented opportunity to increase access to care in Denver. The ACA already expanded health coverage for two groups in 2010. Young adults were allowed to stay on their parents' plans until age 26, and children with pre-existing conditions could no longer be denied health insurance coverage. The law also contains many provisions for promoting prevention and wellness, protecting consumers, improving health care quality and system performance, and curbing the rising costs of health care.

In 2014, the ACA will significantly expand Medicaid to be strictly income-based, provide governmental assistance for many people to purchase health insurance through Connect for Health Colorado, and eliminate denials of health insurance coverage for all persons with pre-existing conditions. More than 75,000 Denver residents, or 72% of the uninsured population, are expected to qualify for either Medicaid or subsidized insurance through Connect for Health Colorado (see Figure 8).<sup>32</sup>

**Figure 8: Denver Residents Eligible for New Forms of Coverage in 2014**



Source: American Community Survey, 2011

More than 41,000 persons in Denver, or 40% of the uninsured, will qualify for Medicaid, while more than 34,000 persons, or 33% of the uninsured, will qualify for insurance subsidies at Connect for Health Colorado. About 7000 persons, or 7% of the uninsured, will be required to purchase insurance without governmental support, but should be able to do so for less than they could before the implementation of the ACA. Undocumented persons will not be eligible for expanded coverage under Medicaid or Connect for Health Colorado.

**Table 4: Income Levels to Qualify for Medicaid and Insurances Subsidies in 2014**

		
<b>Household Size</b>	<b>Medicaid: Up to 133% of FPL</b>	<b>Subsidies: Up to 400% of FPL</b>
<b>1</b>	\$15,282	\$45,960
<b>2</b>	20,628	62,040
<b>3</b>	25,975	78,120
<b>4</b>	31,322	94,200
<b>5</b>	36,668	110,280
<b>6</b>	42,015	126,360
<b>7</b>	47,361	142,440
<b>8</b>	52,708	158,520

Table 4 lists income levels at which people with varying household sizes will qualify for Medicaid - up to 133% of the Federal Poverty Level (FPL) - and for insurance subsidies at Connect for Health Colorado - up to 400% of the FPL). Nearly all people currently covered under the Colorado Indigent Care Program (CICP) will qualify for Medicaid in 2014, and many parents whose children are currently covered under Medicaid or the Child Health Plan Plus (CHP+) will be eligible either for Medicaid or insurance subsidies.

**Barriers to Enrollment**

Enrollment services, as well as outreach and advocacy to encourage people to approach enrollment sites for assistance, will be essential for getting these large numbers of newly eligible persons enrolled in the new forms of coverage and on their way to accessing health care. Reaching eligible but not enrolled persons has long been challenging, even before the current expansion in coverage options. As such, vigorous efforts will be needed by many organizations and individuals in the Denver to ensure that residents are aware of the new forms of coverage, and how to enroll on their own or get assistance to do so.

Denver currently has 48 Certified Application Assistance Sites (CAAS) offering in-person assistance for enrollment in Medicaid and CHP+, and 23 new assistance sites providing in-person assistance for persons wishing to purchase insurance at Connect for Health Colorado. Fifty organizations involved in enrollment and other services to low-income Denver residents were surveyed by the Access to Care Task Force about their current enrollment practices for Medicaid, CHP+ and other medical assistance programs, and their preparations for the forthcoming ACA changes. Respondents noted a number of current barriers to enrollment and access to care, related to the clients themselves, organizational issues at the assistance sites and with state IT systems, and accessing care once clients gain coverage. These barriers are summarized in Table 5 below. More detailed results of this survey are available at BeHealthyDenver.org.<sup>33</sup>

**Table 5: Barriers to Enrollment and Access to Care Prior to the Expansion of Coverage in 2014**

Enrollment Barriers Related to Clients	Enrollment Barriers Related to Organizations	Challenges in Accessing Care after Acquiring Benefits
<ul style="list-style-type: none"> <li>• Transience</li> <li>• Culture and language barriers</li> <li>• Not understanding eligibility criteria</li> <li>• Documentation requirements</li> <li>• Misunderstanding correspondence received from authorities</li> <li>• Not qualifying for Medicaid</li> <li>• Inability to afford insurance</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of resources for processing cases</li> <li>• Challenges with the Colorado Benefits Management System (CBMS)</li> <li>• Challenges with the Colorado Program and Eligibility Application Kit (PEAK)</li> <li>• Long processing times and other problems in the processing of applications</li> </ul>	<ul style="list-style-type: none"> <li>• Lotteries and waiting lists for access to health and behavioral care providers</li> <li>• Confusion regarding benefits</li> <li>• Missing re-determination dates</li> <li>• Non-Denver patients attempting to use Denver safety net clinics</li> </ul>

Many of these barriers are likely to be exacerbated with the large numbers of people seeking to enroll in Medicaid and the new insurance plans in 2014. Additional barriers to enrollment that are likely to be encountered with the expansion of coverage include:

- Confusion and lack of knowledge about the ACA and the new forms of coverage
- Mistrust of government programs, especially given the strong political opposition and negative media attention surrounding the ACA
- The large number of plans (150) to choose from on Connect for Health Colorado
- A potential lack of interest in purchasing insurance even with the subsidies offered, given that the penalty for lack of insurance will be very low in the first year - \$95 or 1% of household income, whichever is greater.

### **Projected Gaps and Challenges in Access to Care**

While enrollment in health coverage is an important factor for accessing care, it is not sufficient to ensure that people will have access to the health care providers they need. In order to assess the current capacity of safety net clinics and health care providers to handle the projected influx of newly enrolled individuals in 2014, and to identify the gaps and challenges the clinics are likely to face, the Task Force undertook a set of key informant interviews with 27 directors and clinic managers at 17 safety net clinics and organizations in Denver providing primary care, specialty care, mental health care, substance abuse treatment, and dental care to low-income residents. A full report of the findings of these interviews is available at [BeHealthyDenver.org](http://BeHealthyDenver.org).<sup>34</sup>

Ten of the organizations interviewed (59%) had waiting lists for patients to access services for the first time, with an average wait time of four weeks. Eleven organizations (65%) were forced to turn people away regularly or deny service, most often due to a lack of staff and resources and the need to prioritize the patients or clients they can accommodate. Fourteen organizations (82%) indicated that they were planning to take additional Medicaid patients in 2014, and eleven (65%) were planning to accept patients with insurance purchased at Connect for Health Colorado. Table 6 summarizes the key gaps and challenges identified by these providers as they look forward to the expansion of coverage in 2014.

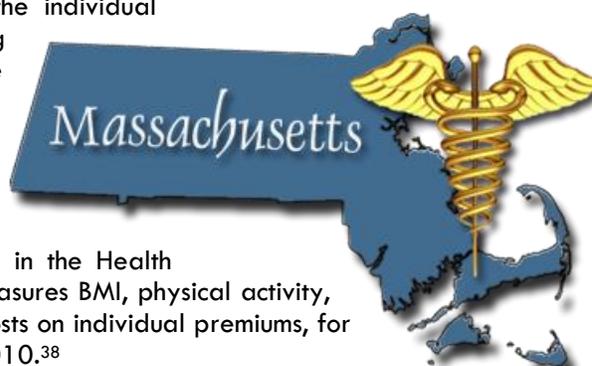
**Table 6: Projected Gaps and Challenges in Access to Care with Expanded Coverage in 2014**

Gaps: New Programs	Gaps: Organizational Capacity	Gaps: Patients/Clients
<ul style="list-style-type: none"> <li>• Lack of information and misunderstandings about the ACA within organizations and among the general public and patients/ clients</li> <li>• Vague or confusing program guidelines, lack of information about plans and coverage, and how people might lose coverage</li> <li>• Short time-frame for implementation</li> <li>• Potential IT challenges with CBMS and the Exchange</li> <li>• Difficulties in communications with HCPF and Exchange authorities</li> <li>• “Churn” of people between Medicaid, insurance plans, and being insured</li> <li>• Exclusion of certain communities</li> <li>• Difficulties getting on insurance panels and into provider networks</li> <li>• Low reimbursement rates for Medicaid</li> <li>• Difficulties securing reimbursement for mental health care and substance abuse treatment</li> <li>• Lack of reimbursement for care coordinators and wrap-around social services</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of funding and capacity for enrollment assistance</li> <li>• Lack of capacity to handle the influx of new patients in 2014, resulting in longer waiting lists and turning more people away</li> <li>• Large lack of capacity to see new mental health clients, especially severe cases</li> <li>• Shortage of beds in hospital psychiatric units and poor follow-up after discharge</li> <li>• Lack of funding before 2014 to hire providers in all fields</li> <li>• Lack of providers available to hire, even when funding becomes available (see specific shortages below):</li> <li>• Lack of <u>Primary care providers</u> - internal medicine, family medicine, nurse-midwifery</li> <li>• Lack of <u>Behavioral care providers</u> - psychiatrists, psychiatric nurses, psychologists, LCSWs, MSWs, culturally diverse workers at all levels</li> <li>• Lack of <u>Substance abuse treatment providers</u> - Board Certified Addictions Physicians, Certified Addictions Counselors</li> <li>• Lack of funding for care coordinators</li> <li>• Lack of an organized referral system from primary to specialty care</li> <li>• Challenges to organizational missions when patients and clients have coverage in 2014 and beyond</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of knowledge about the ACA, what they will be eligible for, new health insurance vocabulary</li> <li>• Inability to afford insurance even with subsidies</li> <li>• Lack of enthusiasm for enrolling in Medicaid or purchasing insurance on the Exchange</li> <li>• Education needed about how to use new coverage for preventive and primary care, and avoid unnecessary use of emergency rooms and urgent care clinics</li> </ul>

**Best Practices in Expanding Coverage and Coordination**

The Task Force studied best practices in expanding coverage and coordinating health stakeholders in other states and cities. It looked carefully at the experience of Massachusetts, which instituted a health care reform in 2006 that served as a prototype for the nationwide expansion of coverage under the ACA. Although Massachusetts differs from Colorado in having had a low rate of un-insurance even before the 2006 reform, with just over 7% uninsured in 2004, the state was able to drop its uninsured rate to less than half that rate, to 3.1% in 2011.<sup>35</sup> The remaining uninsured in Massachusetts are predominantly young adults, males, Hispanics, and undocumented persons,<sup>36</sup> much like the demographic profile of Colorado’s current uninsured population.

Massachusetts has seen good compliance with the individual insurance mandate among its citizens since instituting the mandate in 2006. Only 1% of residents were assessed a tax penalty in 2010 for lack of insurance. The reform has not crowded out employer-sponsored insurance (ESI),<sup>37</sup> and Massachusetts has had 8% fewer ER visits since implementing its healthcare reform, an important indicator of better access to primary and preventive care. It has also seen gains in the Health Status Index (HSI), relative to other states; the HSI measures BMI, physical activity, and mental health status. It was also able to contain costs on individual premiums, for which there was no net increase between 2006 and 2010.<sup>38</sup>



The Task Force had the opportunity to learn first-hand from the experiences of Seattle and King County in Washington State in coordinating and integrating services among safety-net medical and behavioral health providers, community-based organizations, and the public health and human services departments, through a special session with a visiting senior officer from the Seattle and King County Health Department in May 2013. Seattle and King County have a similar rate of uninsured as Denver, 16%, with a significant variance in health care coverage in different parts of the city, from as low as 3% to as high as 30%. Like Colorado, Washington State has elected to expand Medicaid, and opened its own insurance exchange in October 2013.

Seattle has been involved in multi-stakeholder system integration efforts since early 2011, culminating in a Transformation Plan for King County in July 2013 to create an accountable, integrated system of health, human services, and community-based prevention.<sup>39</sup> The plan was informed by a 30-member panel with a composition very similar to the Denver Access to Care Task Force. It aims to reduce significant inequities in health and well-being across the County through a collective community response, and includes strategies at the individual level for adults with complex health and social needs, and at the community level for high-risk communities with the greatest disparities.



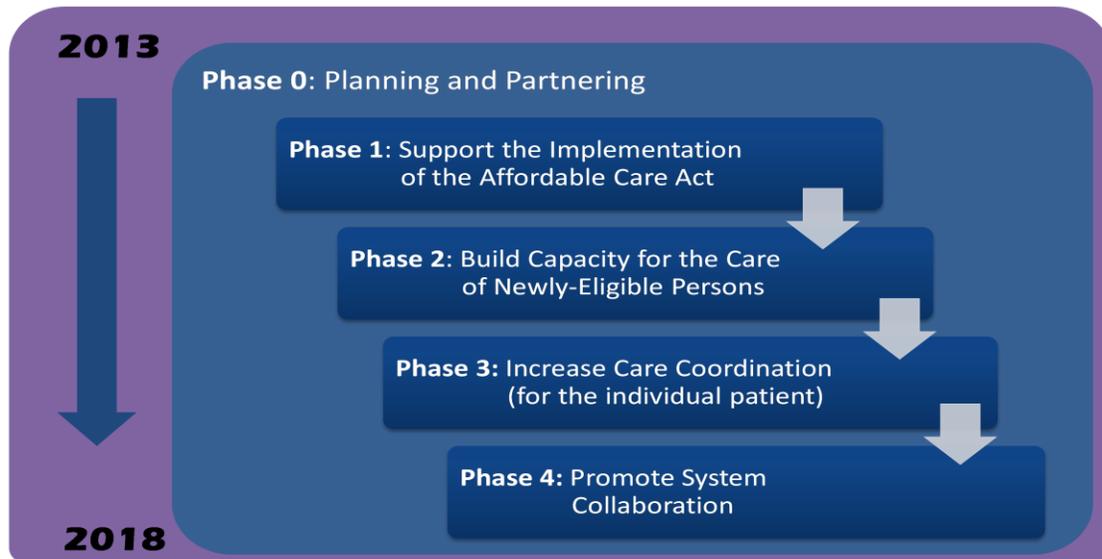
## Phases of Implementing Access to Care Initiatives in Denver

The Task Force envisioned four phases of implementation to increase access to care in Denver, extending over the CHIP implementation period (2013-2018) and beyond (see Figure 9). Given the imminent expansions of coverage under the ACA in 2014, the first phase of work, already underway in 2013, has been to support the implementation of the ACA and facilitate the enrollment of Denver residents in Medicaid and insurance plans at Connect for Health Colorado. Closely connected is the second phase, to assess and build the capacity among health care providers to care for the newly covered persons.

The third phase is to increase care coordination among health care providers in Denver regarding the care of individual patients, and the fourth phase is to promote greater system-level collaboration between public health and human services officials, health care providers, behavioral health care providers, and community-based organizations serving low-income persons in Denver.

These latter efforts will require extensive coordination among a large group of stakeholders over many years, extending beyond the implementation period of the current CHIP. As such, the Task Force concluded that a neutral convener of stakeholders in the form of a health alliance will be needed to carry on the longer-term capacity-building, care coordination, and system integration work.

**Figure 9: Phases of Implementing Access to Care Initiatives**



### **Health Alliance for Overseeing Care Coordination and System Collaboration**

In preparation for phases three and four, the Task Force undertook a study of six health alliances in urban areas of Colorado, to gather information about their formation, how they are structured and funded, their membership, and their roles and responsibilities for coordinating health activities in their communities. The study report is available at [BeHealthyDenver.org](http://BeHealthyDenver.org).<sup>40</sup>

The study was limited to alliances in urban areas of Colorado, given that their experiences would be most comparable to forming a health alliance in Denver to oversee the longer-term care coordination and system-level collaboration needed to improve access to care. Two of the alliances were located in the Denver metropolitan region - one in the city of Aurora and the other in Arapahoe and Douglas Counties in the southern metropolitan area.

Five of the six health alliances were either already established as 501(c)3 non-profit organizations, or in the process of doing so, with Boards of Directors to guide their activities, as well as management and support staff. Their missions focused on improving the general health of their communities, providing greater access to care, improving patient experience and quality of care, and reducing the cost of care.

Alliance members included health care providers, a variety of governmental entities such as local health departments and human services agencies, and a variety of organizations playing a role in the health of the community, such as community-based organizations, insurance companies, and local chambers of commerce. Table 7 illustrates the range of organizations participating in health alliances.

**Table 7: Members in Health Alliances**

Health Care Providers	Governmental Entities	Other Organizations
<ul style="list-style-type: none"> <li>• Safety net clinics and Federally qualified health centers (FQHCs)</li> <li>• Private clinics</li> <li>• Urgent care clinics</li> <li>• Non-profit hospitals</li> <li>• Private hospitals</li> <li>• County behavioral health care organizations</li> <li>• Private behavioral health care organizations</li> <li>• Private physicians</li> <li>• Nurses</li> <li>• Medical societies</li> </ul>	<ul style="list-style-type: none"> <li>• County public health departments</li> <li>• County human services departments</li> <li>• Fire departments</li> <li>• Paramedics groups</li> <li>• Public safety departments</li> <li>• School districts</li> </ul>	<ul style="list-style-type: none"> <li>• Non-profit and community-based organizations</li> <li>• Regional Care Collaborative Organizations (RCCOs)</li> <li>• Behavioral Health Organizations (BHOs)</li> <li>• Health and wellness educators</li> <li>• Health insurance providers</li> <li>• Universities</li> <li>• Chambers of Commerce</li> </ul>

The alliances were engaged in a wide variety of programs to fulfill their missions, as summarized in Table 8. All acted as the central conveners of the relevant stakeholders in health care and public health in their communities, while some also took on the role of coordinating care arrangements for uninsured and underinsured persons among the various providers in the region.

**Table 8: Programs Undertaken by Health Alliances**

Coordination	Access to Care
<ul style="list-style-type: none"> <li>• Convening health stakeholders from hospitals, community health centers, private clinics, public health departments, county human services departments, public safety departments, and community-based organizations</li> <li>• Care coordination among service providers in a region for uninsured and underinsured</li> </ul>	<ul style="list-style-type: none"> <li>• Increasing enrollment in Medicaid and insurance</li> <li>• Acting as Connect for Health Colorado Assistance site and/or Regional Hub</li> <li>• Reducing emergency department visits, readmissions, and expensive imaging by providing alternative primary care destinations</li> <li>• Connecting un- and underinsured to community resources, primary care medical homes, specialty care.</li> <li>• Care management services – for Medicaid holders, high utilizers of emergency departments, chronically ill, special populations - as the RCCO, for the RCCO, and through other programs.</li> <li>• Training primary care providers</li> <li>• Mental health gap analysis</li> <li>• Mental health triage</li> <li>• Emergency crisis service</li> <li>• Direct provision of primary and urgent care for uninsured and underinsured</li> </ul>
Public Health	
<ul style="list-style-type: none"> <li>• Data gathering and analysis on population health, support to local health departments' Community Health Assessments</li> <li>• Community education and mobilization, community health campaigns</li> <li>• Programs to reduce obesity, tobacco use, teen pregnancy (aligned with CHIP priorities)</li> </ul>	
Technology	
<ul style="list-style-type: none"> <li>• Assisting members to establish Electronic Health Records</li> <li>• Coordinating Health Information Exchange for a region</li> </ul>	

The alliances were involved in numerous initiatives to increase access to care in their communities, starting with activities to increase enrollment in benefits and insurance programs. The Denver Access to Care Task Force has already undertaken similar activities in its early implementation of the aspects of the CHIP related to enrollment and coverage. Many helped to connect people to primary care, specialty care,

and non-medical community resources, and some undertook formal care management duties for individual patients and clients - as the Regional Care Collaborative Organization (RCCO)<sup>41</sup> for their area, in coordination with the RCCO, or as part of other care management programs. Some alliances had programs for mental health triage and emergency crisis services in their communities.

Alliances also served public health functions, such as supporting their counties' CHAs, aligning programs around priorities identified in their counties' CHIPs, and conducting education and outreach campaigns on public health issues. Finally, alliances had roles in improving information technology among members, such as assisting members to implement electronic health records and coordinating the exchange of health information among them.

The Access to Care Task Force has a composition very similar to the health alliances surveyed, and has focused on many of the same issues, such as facilitating enrollment in coverage and studying access to care problems for primary care, behavioral health care, and specialty care. However, a more sustainable structure is needed for continued collaboration and to implement the goals and objectives outlined for access to care in this CHIP, as well as other health initiatives that may be proposed. A robust health alliance in the city could take on many similar activities as are currently being undertaken by health alliances in other urban areas, and would be an important stakeholder for achieving many of the access to care and HEAL goals and strategies outlined in the CHIP Action Plan.

There are two health alliances already established in the Denver metropolitan area - the South Metro Health Alliance in Arapahoe and Douglas counties and Aurora Health Access in the city of Aurora. There are also two emergent alliances in Adams and Jefferson Counties. Each of the established alliances focuses on access to care and other health care concerns in their respective areas. Currently there is no alliance focusing on the specific health and health care issues of concern to the core of the metropolitan area, corresponding roughly to the boundaries of the City and County of Denver. Nor is there a metro-wide network of alliances focusing on issues of concern to the entire Denver metropolitan area. As such, the Access to Care Task Force has included among its recommendations a strategic planning process to form a health alliance in the City and County of Denver, which would in time coordinate with like alliances around the metropolitan area.



## Access to Care Action Plan

In order to reach the five-year goal for access to care, the Task Force outlined three objectives to initiate the four-phased approach outlined in Figure 9 above for implementing access to care initiatives: Enrollment and Coverage, Provider Capacity, Care Coordination, and System Collaboration. All of the objectives will be implemented at the community level. They are listed in Table 9 and in the full CHIP Action Plan in Appendix J, which additionally identifies the lead and supporting entities that will contribute to meeting the objectives, potential indicators for measuring progress in meeting the objectives, and best practices to guide implementation.

**Table 9: Access to Care Action Plan**

<b>5-Year Goal: By December 2018, at least 95% of Denver residents will have access to primary medical care, including behavioral health care.</b>
Indicators: 1. Percentage of Denver residents with health care coverage. 2. Percentage of insured/ uninsured residents with a Primary Care Provider (PCP). 3. Percentage of insured/uninsured residents who have had a PCP visit in the last 12 months. Data Sources: American Community Survey, Colorado Health Access Survey
<b>Enrollment and Coverage</b>
<b>Objective A1:</b> Increase the number of Denver residents with health care coverage by supporting implementation of the Affordable Care Act (ACA); 40,000 Denver residents enroll in Medicaid and subsidized insurance by July 1, 2014 and 94% have health care coverage by December 31, 2018.
<b>Provider Capacity</b>
<b>Objective A2:</b> Assess and build the capacity of safety net providers in Denver to deliver primary, specialty, and behavioral health care to persons newly covered starting in 2014, and to those who remain uninsured.
<b>Care Coordination and System Collaboration</b>
<b>Objective A3:</b> Create a health alliance of important stakeholder organizations in Denver, to increase access to care, better coordinate health care services, and decrease health care costs.

The primary data sources for measuring progress in meeting the five-year goal will be the American Community Survey (ACS) and the Colorado Health Access Survey (CHAS). The ACS is conducted annually by the US Census Bureau and will be available every year throughout the CHIP implementation period, from 2013-2018. The CHAS is conducted every two years by the Colorado Health Institute. New CHAS data was released in November 2013 that will provide baseline information for the situation just before the expansion of coverage under the ACA and the CHIP implementation. Two additional CHAS surveys will be conducted during the CHIP Implementation period, in 2015 and 2017.

For each objective, the Task Force outlined a set of strategies, outlined in Tables 10-12 below. For each strategy, a SMART objective was defined that is **Specific, Measurable, Achievable, Realistic, and Time-bound**. The SMART objectives are the specific deliverables that will be tracked and reported against when evaluating the CHIP (see section on Evaluating the CHIP below). They are listed in the full CHIP Action Plan in Appendix J.

A **SMART** objective is:

- **Specific**
- **Measurable**
- **Achievable**
- **Realistic**
- **Time-bound**

The Task Force has also outlined a preliminary set of activities for achieving the SMART objectives. These are also listed in Appendix J, and will continue to be developed and modified as the CHIP is implemented.

Although the new forms of coverage through Medicaid and Connect for Health Colorado were not scheduled to take effect until 2014, enrollment in these new forms of coverage began on October 1, 2013, and months of preparation were needed by many Denver organizations to prepare for the start of enrollment. Given this unprecedented new window of opportunity for increasing access to care in Denver, the Access to Care Task Force took early action on many of the strategies related to enrollment, coverage, assessing provider capacity, and preparing for the formation of a health alliance in Denver, while formulating the five-year Action Plan for Access to Care. This early CHIP implementation is indicated below each strategy in Tables 9-11 below.

## ENROLLMENT AND COVERAGE

**Table 10: Strategies and Implementation of Access to Care Objective A1**

<b>Objective A1: Increase the number of Denver residents with health care coverage by supporting the implementation of the Affordable Care Act (ACA); 40,000 Denver residents enroll in Medicaid and subsidized insurance by July 1, 2014 and 94% of residents have health care coverage by December 31, 2018.</b>	
A. Assess current enrollment practices in Denver and preparations for the forthcoming expansion of coverage under the ACA.	<b>Status:</b> Survey conducted in April 2013 with 50 Medicaid enrollers, safety net providers, community-based organizations, and governmental organizations providing services to low-income Denver residents. Report completed, "Survey Results: Enrollment Practices and ACA Preparations in Denver," available at <a href="http://BeHealthyDenver.org">BeHealthyDenver.org</a> . <sup>42</sup>
B. Develop and conduct Training of Trainers (TOT) courses for health providers and community-based organizations serving low-income Denver residents, to educate staff and community partners about the ACA and enrollment.	<b>Status:</b> The Task Force and the Denver Public Health Prevention Training Center conducted two TOT courses in August and September 2013, for Denver Health frontline staff and staff from other safety net providers and community-based organizations. The training materials are available in English and Spanish at <a href="http://BeHealthyDenver.org">BeHealthyDenver.org</a> for other interested organizations to use in training their own staff. <sup>43</sup>
C. Conduct outreach meetings and provide information about the forthcoming changes under the ACA to various organizations and groups in Denver.	<b>Status:</b> By 1/15/2014, the Task Force Chairs had conducted 45 ACA outreach meetings with organizations, groups, and political leaders. Listed in Appendix D.
D. Produce and distribute brochures and other educational materials for the public on the forthcoming changes under ACA and how people can get enrolled.	<b>Status:</b> By 10/15/2013, the Task Force produced 93,000 bilingual brochures in English and Spanish on the ACA and how to sign up for the new forms of coverage in Denver. By 12/15/2013 it had distributed 90,000 brochures to governmental organizations, health care providers, community-based organizations, and schools. The brochure is available at <a href="http://BeHealthyDenver.org">BeHealthyDenver.org</a> . <sup>44</sup> The September issue of <i>Denver Vital Signs</i> , available at <a href="http://denverhealth.org">denverhealth.org</a> , was devoted to the expansion of coverage under the ACA and highlighted what political leaders, organizations, and individuals can do to encourage enrollment in Denver. <sup>45</sup> It was distributed widely to partners and stakeholders with an interest in health care issues in Denver.

<b>Objective A1: Increase the number of Denver residents with health care coverage by supporting the implementation of the Affordable Care Act (ACA); 40,000 Denver residents enroll in Medicaid and subsidized insurance by July 1, 2014 and 94% of residents have health care coverage by December 31, 2018.</b>
E. Engage with local media to promote enrollment in health care coverage. <b>Status:</b> By 2/4/2014, the Task Force Chairs had conducted eight media interviews with local and national media outlets, and posted two blogs. A list of media events is included in Appendix D.
F. Update and maintain accurate ACA information on the Denver Health website. <b>Status:</b> Denver Health ACA website launched on October 1, 2013.
G. Monitor and report the percentage of Denver residents enrolled in health care coverage. <b>Status:</b> Pending new ACS and CHAS data.
H. Track progress monthly on the number of Denver residents enrolling in Medicaid and subsidized insurance plans at Connect for Health Colorado. <b>Status:</b> The Colorado Department of Health Care Policy and Financing (HCPF) reported that 16,076 Denver residents enrolled newly in Medicaid between October 1 and December 31, 2013. <sup>46</sup> Connect for Health Colorado reported that 6,488 Denver residents purchased new insurance plans during the same period. <sup>47</sup> Thus a total of 22,564 Denver residents gained these new forms of coverage between October 1 and December 31, 2013.

## PROVIDER CAPACITY

**Table 11: Strategies and Implementation of Access to Care Objective A2**

<b>Objective A2: Assess and build the capacity of safety net providers to deliver primary, specialty, and behavioral health care to persons newly covered starting in 2014, and to those who remain uninsured.</b>
A. Conduct an assessment of gaps and challenges in the provision of primary, specialty and behavioral health care in Denver prior to the ACA implementation, and how well safety net providers are prepared to receive persons newly enrolled in Medicaid and subsidized insurance plans in 2014. <b>Status:</b> Assessment conducted in May-June 2013 with 17 safety net providers in Denver. Report completed, "Access to Care in Denver," available at BeHealthyDenver.org. <sup>48</sup>
B. Continue to identify gaps and challenges in primary, secondary and behavioral health care services in Denver as the ACA is implemented.
C. Monitor health care utilization trends in Denver with the implementation of the ACA.
D. Facilitate enrollment of current patients at safety net clinics in Medicaid and insurance plans from Connect for Health Colorado, which will generate income to expand services for additional patients.
E. Provide technical assistance to safety net providers to learn how to effectively bill for Medicaid and commercial insurance.
F. Survey Denver's safety net providers to describe what services they provide and identify their strengths; develop an effective work plan and referral system to make the best use of limited resources and increase collective capacity to serve Denver residents.

## CARE COORDINATION AND SYSTEM COLLABORATION

**Table 12: Strategies and Implementation of Access to Care Objective A2**

<b>Objective A3:</b> Create a health alliance of important stakeholder organizations in Denver, to increase access to care, better coordinate health care services, and decrease health care costs.
A. Conduct an environmental scan of urban health alliances in Colorado. <b>Status:</b> Environmental scan conducted September-October 2013 of six urban health alliances in Colorado, to learn from their experiences and inform the possible creation of a health alliance in Denver. Report completed, "Survey of Urban Health Alliances in Colorado," available at <a href="http://BeHealthyDenver.org">BeHealthyDenver.org</a> . <sup>49</sup>
B. Develop and submit a Convening for Colorado grant application to the Colorado Trust to support the planning process for a potential Denver-based health alliance. <b>Status:</b> A Convening for Colorado Grant was awarded January 2014 to support the planning process.
C. Facilitate a collaborative planning process for creating a health alliance in Denver; prepare and submit a plan and funding proposal to support the creation and early work of the alliance. <b>Status:</b> The first of four health alliance planning meetings will take place on February 24, 2014.



## Healthy Eating and Active Living (HEAL), Including the Built Environment

### HEAL Five-Year Goal

Because of the rapid rate of increase in Denver's childhood obesity rate and the implications for adult obesity rates and future population health, the HEAL Task Force has set a five-year goal to reverse this trend, by increasing the percentage of children in Denver who are at a healthy weight by five percentage points. Since 69% of Denver Public Schools students from pre-school through 9<sup>th</sup> grade were at a healthy weight in 2012/2013,<sup>50</sup> a 5% increase will lead to 74% being at a healthy weight by the end of 2018.

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#### HEAL FIVE-YEAR GOAL:

**BY DECEMBER 2018, THE PERCENTAGE OF CHILDREN AND ADOLESCENTS IN DENVER WHO ARE AT A HEALTHY WEIGHT WILL INCREASE BY FIVE PERCENTAGE POINTS**

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### Childhood Obesity in Denver

Obesity has been identified by CDPHE as one of Colorado's ten winnable battles.<sup>51</sup> Childhood obesity is a major cause for concern because of the strong linkage between childhood and adult obesity, and the correlations between obesity and the risk of chronic diseases such as heart disease, cancer, and stroke. Even very young children are at risk of becoming obese, such that efforts to prevent obesity should start at an early age.

Diet and physical activity play a major role in the US obesity epidemic. The *Dietary Guidelines for Americans, 2010*, published by the US Department of Health and Human Services and the U.S. Department of Agriculture (USDA), emphasized three major goals – (1) to balance calories with physical activity to manage weight, (2) to consume more of certain foods and nutrients such as fruits, vegetables, whole grains, fat-free and low-fat dairy products, and seafood, and (3) to consume fewer foods with sodium, saturated fats, trans-fats, cholesterol, added sugars, and refined grains.<sup>52</sup> Simple changes in a child's diet, such as eating a healthy breakfast, consuming healthy foods like fruits and vegetables, and limiting the consumption of sugar-sweetened beverages, can help the child maintain a healthy weight.



Physical activity is also an essential component of a healthy lifestyle. In combination with healthy eating, it can help a child maintain a healthy weight and prevent many chronic diseases in adulthood. Physical activity helps to control weight, build lean muscle, reduce fat, and promote strong bone, muscle and joint development. Children need 60 minutes of play with moderate to vigorous activity, at least five days a week to maintain a healthy weight.

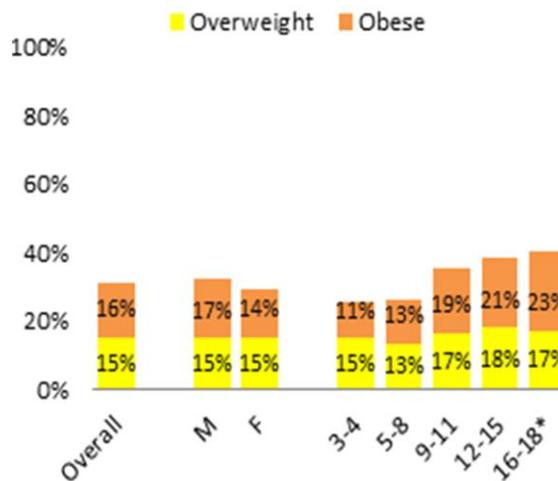
While Denver's adult obesity rate (20% in 2009)<sup>53</sup> and Colorado's adult obesity rate (21% in 2010)<sup>54</sup> are the lowest in the nation and are significantly lower than the national rate (35.7% in 2009-2010),<sup>55</sup> Colorado's childhood obesity rate is ranked 23<sup>rd</sup> in the nation, and is rising faster than in 49 other states.<sup>56</sup> Given the current growth in childhood obesity, Denver's rates of overweight and obese adults will soon catch up with the national rates, unless significant action is taken to reverse the rising trend in childhood obesity.



BMI is a tool for categorizing people as being of normal weight, overweight and obese, based on weight and height measurements. Since 2007, the Denver Public Schools (DPS) Department of Nursing and Student Health Services has recorded height and weight measures of all DPS students from pre-school through the 9<sup>th</sup> grade, from which they are able to calculate students' BMIs and BMI percentiles with which to compare students. Students are deemed to be of normal weight if they have a BMI less than the 85<sup>th</sup> percentile, overweight if they have a BMI from the 85<sup>th</sup>-94<sup>th</sup> percentile, and obese if they have a BMI greater than the 95<sup>th</sup> percentile. These BMI data represents the most accurate measure available of Denver's rates of overweight and obesity in children.

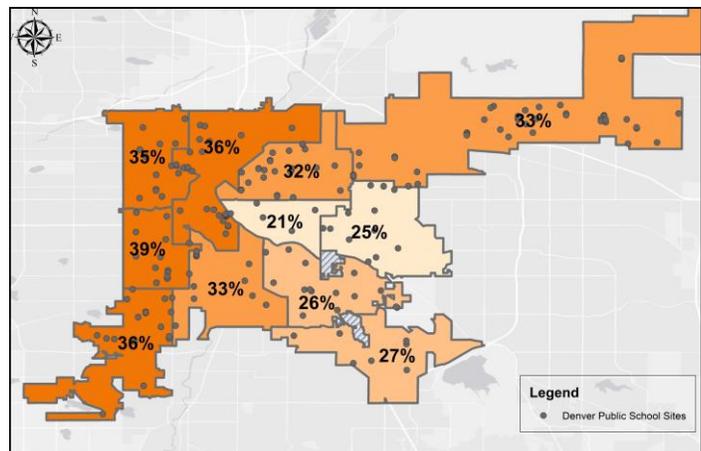
Of 49,550 DPS students with a BMI measurement taken during the 2012-13 school year, 15% were found to be overweight and 16% obese, for a total of 31% of students with an unhealthy weight status.<sup>57</sup> Among DPS students, excessive weight differed based on age, gender, and the neighborhood in which the students lived (Figure 10 and Map 5). Younger children had lower rates of overweight and obesity than older children. Boys and girls were overweight at the same rate (15%), but boys had a higher rate of obesity (17%) than girls (14%). Children attending schools in the western and northern parts of the city were more likely to have excessive weight than those attending schools in other parts of the city (Map 5).

**Figure 10: Percentage of DPS Students at an Unhealthy Weight by Gender and Age**



Source: DPS BMI Dataset, 2013

**Map 5: Percentage of DPS Students at an Unhealthy Weight by Neighborhood\***



\* Unhealthy weight is defined as having a BMI above the 85<sup>th</sup> percentile. A child's school does not always correspond to his or her place of residence. Source: DPS BMI Dataset, 2013

DPS students engaged in several behaviors that lead to excessive weight. In 2009, only 24% of Denver's high school students ate the recommended five servings of fruit and vegetables per day, less than half engaged in 60 minutes of physical activity at least 5 days per week, and a quarter watched television at least three hours per day on school days.<sup>58</sup>

Cumulative DPS BMI data over the last few years indicate that childhood obesity rates in Denver have stabilized, such that efforts can be focused in the coming years on decreasing its prevalence. While some of the strategies outlined below to increase the number of children at a healthy weight are directed at the entire city, others are aimed at reducing disparities among neighborhoods.

## HEAL Strategy Identification Process

The HEAL Task Force examined HEAL literature and initiatives in other cities, especially those that have recently been successful in reducing childhood obesity, such as New York and Philadelphia, to develop a list of best practices. These best practices lists are available at [BeHealthyDenver.org](http://BeHealthyDenver.org). The Task Force was also guided by the Institute of Medicine's (IOM) Early Childhood Obesity Prevention Policies<sup>59</sup> to formulate the community- and policy-level objectives and strategies in the HEAL Action Plan. A list of HEAL best practices for child care centers is included in Appendix E.



The Task Force also reviewed ongoing HEAL activities in Denver, where many organizations have already established healthy weight initiatives for children and youth, such as the Mayor's Cabinet on Childhood Obesity and the DPS Health Agenda 2015. Appendix F lists the key elements of these and other HEAL initiatives in Denver, which *Be Healthy Denver* endorses and fully supports.

Whenever possible, the HEAL Task Force built upon on these ongoing efforts when formulating goals, objectives, and strategies, in order to work with local partners and continue the momentum already established for HEAL in Denver. Strong community partnerships will be essential in reversing the complex health issue of unhealthy weight.

Before defining goals and objectives, the HEAL Task Force developed an initial list of 40 potential strategies, based on the best practices and the experiences of various Task Force members who have implemented these strategies in different environments. Using the same process for reducing priorities as had been used by the Steering Committee and in the community meetings, the Task Force ranked the 40 strategies based on the two criteria of importance and feasibility. A strategy's importance was understood in terms the impact it could have, how many people it could reach, and clear evidence of success in using that strategy. A strategy's feasibility was understood in terms of its cost, the time it would take to implement the strategy, and the likelihood of securing commitment from the partners who would need to implement it. Appendix G lists the 40 initial strategies considered by the HEAL Task Force, and the results of the ranking exercise.

Strategies that ranked high in both importance and feasibility (in the upper right-hand corner of the graph in Appendix G) were included in a prioritized strategy list. Strategies that were high in either importance or feasibility were also retained. A list of prioritized strategies is included in Appendix H.

## HEAL Action Plan

The HEAL Task Force identified four domains, based on where the prioritized strategies are likely to be targeted: the Community as a whole, Child Care Centers, Schools, and City and County Government. Within each domain, one or more objectives were defined, for a total of seven HEAL objectives. These HEAL objectives are outlined in Table 13 and the full CHIP Action Plan in Appendix J, which also identifies the lead and supporting entities that will contribute to meeting the objectives, potential indicators for measuring progress in meeting the objectives, and best practices that can guide implementation.

**Table 13: HEAL Action Plan**

<p><b>5-Year Goal: By December 2018, the percentage of children and adolescents in Denver who are at a healthy weight will have increased by five percentage points.</b></p>
<p><b>Indicators:</b></p> <ol style="list-style-type: none"> <li><b>1. Percentage of children 2-5 years of age using Denver Health and Kaiser Permanente health systems who are at a healthy weight.</b></li> <li><b>2. Percentage of Denver Public Schools (DPS) students, kindergarten through 9<sup>th</sup> grade, who are at a healthy weight.</b></li> <li><b>3. Percentage of DPS students, 6-12<sup>th</sup> grade, who meet the recommended physical activity levels (60 minutes/day, 7 days per week).</b></li> </ol> <p>Data Sources: Denver Health and Kaiser Permanente Electronic Health Records, DPS BMI data, Denver Health Kids Colorado Survey</p>
<p><b>Community</b></p>
<p><b>Objective H1:</b> Increase the number of safe and active environments that support physical activity for Denver communities.</p>
<p><b>Objective H2:</b> Increase access to nutritious foods and beverages in underserved areas of Denver.</p>
<p><b>Child Care Centers</b></p>
<p><b>Objective H3:</b> Increase the number of licensed child care centers with an optimized Healthy Eating and Active Living (HEAL) environment, through strengthened physical activity and nutrition standards and guidelines.</p>
<p><b>Schools</b></p>
<p><b>Objective H4:</b> Increase quality physical education and opportunities for moderate to vigorous physical activity in schools.</p>
<p><b>Objective H5:</b> Increase access to healthy foods and beverages in schools.</p>
<p><b>City and County Government</b></p>
<p><b>Objective H6:</b> Incorporate health considerations and analysis in city policy, processes, and planning.</p>
<p><b>Objective H7:</b> Develop and implement a targeted <i>Be Healthy Denver</i> marketing campaign for Healthy Eating and Active Living (HEAL).</p>

The primary data sources for measuring progress against the five-year HEAL goal will be Electronic Health Records from Denver Health and Kaiser Permanente, the two largest networks of primary care providers in the city, Denver Public Schools BMI data, collected annually for all students in preschool through 9<sup>th</sup> grade, and the Healthy Kids Colorado Survey (HKCS) for Denver, administered each two years.

Although the HEAL five-year goal is intended to promote healthy weight among all Denver children, including those not attending Denver Public Schools and those who have not yet entered preschool and are beyond the 9<sup>th</sup> grade, the DPS BMI data are the most comprehensive and reliable data on weight for children in Denver, and are indicative of trends across the city.

Although these indicators and the HEAL Action Plan do not specifically address underweight children in Denver, many of the HEAL objectives and strategies will benefit both overweight and underweight children. It is estimated that from 2007-2010, only 3.5% of children and adolescents in the U.S. were underweight.<sup>60</sup>

The HEAL Action Plan is intended to be flexible, allowing partners to shift strategies between the different domains and objectives as needed. For example, a strategy of healthy vending may originate in City and County Government, through changes in the city's vending policy when supplying governmental buildings and facilities, but could extend to the Community domain as partners adopt similar healthy vending practices for their own establishments.

A set of strategies was assigned to each of the seven HEAL objectives, listed in Tables 14-20 below. Partners may select strategies and adapt them as needed to improve healthy eating and active living in any environment in which they operate.

The Task Force also outlined a SMART objective to be achieved while implementing each strategy. The SMART objectives are the specific deliverables that will be tracked and reported against when evaluating the CHIP (see section on Evaluating the CHIP below).

The Task Force also outlined a preliminary set of activities for achieving the SMART objectives. These are listed in Appendix J and will be modified and expanded as needed as the CHIP is implemented.

**A SMART objective is:**

- Specific**
- Measurable**
- Achievable**
- Realistic**
- Time-bound**



## COMMUNITY

**Table 14: Strategies for HEAL Objective H1**

<b>Objective H1: Increase the number of safe and active environments that support physical activity for Denver communities.</b>
A. Assess bicycle/walking laws, Safe Routes to School (SRTS) policies and ordinances, and street and sidewalk design and quality; identify opportunities to encourage bicycle use, increase physical activity, and improve safety for pedestrians and cyclists.
B. Improve signage for safe pedestrian/bike use and improve the safety of crosswalks.
C. Allow and encourage community-based organizations to use parks and recreation centers for events and activities.
D. Examine new revenue generation options for bicycle, pedestrian, and multi-modal transportation infrastructure.

**Table 15: Strategies for HEAL Objective H2**

<b>Objective H2: Increase access to nutritious foods and beverages in underserved areas of Denver.</b>
A. Create positive incentives for grocery and convenience stores in low-income areas to offer healthy food and beverage options.
B. Increase the number of convenience stores offering healthy food and beverage options.
C. Increase urban agriculture and gardening in Denver.
D. Protect farmers' markets and improve access to farmers markets by low-income populations.
E. Encourage city partners and other organizations to implement healthy vending policies.

Denver Environmental Health is currently leading several initiatives related to Objective H2, including the policy recommendations of the Sustainable Food Policy Council, ongoing food systems research and policy development, and several programs related to healthy food retail development in underserved areas of Denver. See Appendix F for more information about these initiatives.

### CHILD CARE CENTERS

The national obesity epidemic affects every age group, including young children. For children as young as two years old, obesity is defined as having a BMI at or above the sex- and age- specific 95th percentile on the 2000 CDC Growth Charts.<sup>61</sup> A 2013 CDC report found that one in eight U.S. preschoolers was obese, with the highest rates found in black children (19%) and Hispanic children (16%); Colorado was one of only three states in which the obesity rate of preschoolers is increasing.<sup>62</sup> Strategies aimed at policy and environmental changes within child care centers can have a long-lasting impact on children.<sup>63</sup>

The HEAL Task Force conducted an extensive review of the current literature regarding best practices for managing healthy eating and physical activity in child care centers, the results of which are listed in Appendix E. This review formed the basis for selecting the strategies for Objective H3.

**Table 16: Strategies for HEAL Objective H3**

<b>Objective H3: Increase the number of licensed child care centers with an optimized Healthy Eating and Active Living (HEAL) environment, through strengthened physical activity and nutrition standards and guidelines.</b>
A. Using HEAL best practices, develop a baseline measurement tool for assessing child care center nutrition and physical activity.
B. Conduct a baseline assessment of nutritional and physical activity practices in selected child care centers in Denver.
C. Provide training on selected physical activity and nutrition best practices for licensed child care centers.

**SCHOOLS**

The HEAL Task Force researched best practices for improving nutrition in schools and the results are listed in Appendix I. This research informed the selection of strategies for Objective H5.

**Table 17: Strategies for HEAL Objective H4**

<b>Objective H4: Increase quality physical education and opportunities for moderate to vigorous physical activity in schools.</b>
A. Develop and integrate a “Healthy Schools” designation into Denver Public Schools (DPS) healthy policies, including the DPS Health Agenda.
B. Conduct analyses of student Moderate to Vigorous Physical Activity (MVPA) in DPS, using the System for Observing Fitness Instruction Time (SOFIT) measurement system.
C. Support DPS adherence to state-mandated MVPA in schools; support schools to make free time and physical activity more productive.

**Table 18: Strategies for HEAL Objective H5**

<b>Objective H5: Increase access to healthy foods and beverages in schools.</b>
A. Identify nutritional best practices for providing foods and beverages at schools.
B. Improve Denver Public Schools policies regarding nutritional standards for foods and beverages sold or provided through schools.

Denver Public Schools has several wellness policies related to healthy eating and active living, including its Health Agenda 2015,<sup>64</sup> launched in 2010, the main elements of which are summarized in Appendix F.

The two goals in the Health Agenda related to physical education are as follows:

1. Emphasize the importance of scheduled physical education and recess.
2. Ensure that all students are moderately to vigorously active at least 50 percent of the time in physical education classes.

The two goals in the Health Agenda related to nutrition are as follows:

1. Increase student participation in the free school breakfast program from 30 to 50 percent.
2. Make nutritional changes to school breakfast (see details in Appendix F).

The DPS School Wellness Policy<sup>65</sup> recommends that students have a minimum of 25-30 minutes for lunch, not including time standing in line or serving time, with staff supervision to model proper conduct and healthy eating habits. It also supports a variety of meal delivery strategies, which is compatible with installing hot/cold vending machines to make meals even more accessible to students.

*Be Healthy Denver* fully supports these goals and recommendations, and encourages additional improvements, recognizing that DPS must balance HEAL activities with academic considerations and constraints related to limited school hours, funding, and staffing. The HEAL strategies for schools therefore outline voluntary measures that schools can undertake, including a new “Healthy Schools” designation for schools that adopt a certain number of HEAL or wellness policies. Three tiers of Healthy Schools are envisioned – Gold, Silver, and Bronze. The designation could be used to recognize the school’s efforts and to empower parents to make informed choices of schools for their children. Schools that reach the Gold designation could enter into a lottery for a grand prize at the end of the year.

## CITY AND COUNTY GOVERNMENT

**Table 19: Strategies for HEAL Objective H6**

<b>Objective H6: Incorporate health considerations and analysis in city policy, processes, and planning.</b>
A. Implement healthy vending policies and practices in city buildings and worksites.
B. Promote the inclusion of health considerations in Denver’s 2014 Comprehensive Plan.
C. Promote a city health impact prioritization policy for use in evaluating capital improvement projects.
D. Establish a set of potential criteria, processes, and tools for use in budget processes for determining the health impacts of capital improvement projects.
E. Engage other city departments in developing a plan for expanding the use of health impact assessments to inform neighborhood plans, as adopted by the Denver City Council in its 2014 Priorities.
F. Complete a Health Impact Assessment (HIA) in partnership with other city departments.

Incorporating health considerations and analysis in city processes and planning, such as the Comprehensive Plan, community planning processes, and development and redevelopment review processes, will help city agencies focus attention on health equity issues in the city. Denver Environmental Health and Denver Public Health will assist city agencies by providing personnel, health data, and other resources.

**Table 20: Strategies for HEAL Objective H7**

<b>Objective H7: Develop and implement a targeted <i>Be Healthy Denver</i> marketing campaign for Healthy Eating and Active Living (HEAL).</b>
A. Identify common and comprehensive HEAL messaging to improve physical activity and nutritional behaviors in Denver.
B. Develop a HEAL brand for Denver to align HEAL efforts and activities among obesity prevention partners in Denver.
C. Create a call to action for obesity prevention partners to adopt the HEAL messaging campaign.

Because many organizations and governmental agencies in Denver are already pursuing a variety of HEAL and obesity prevention strategies and initiatives, a unified HEAL campaign will be helpful to unite them and increase their collective impact.



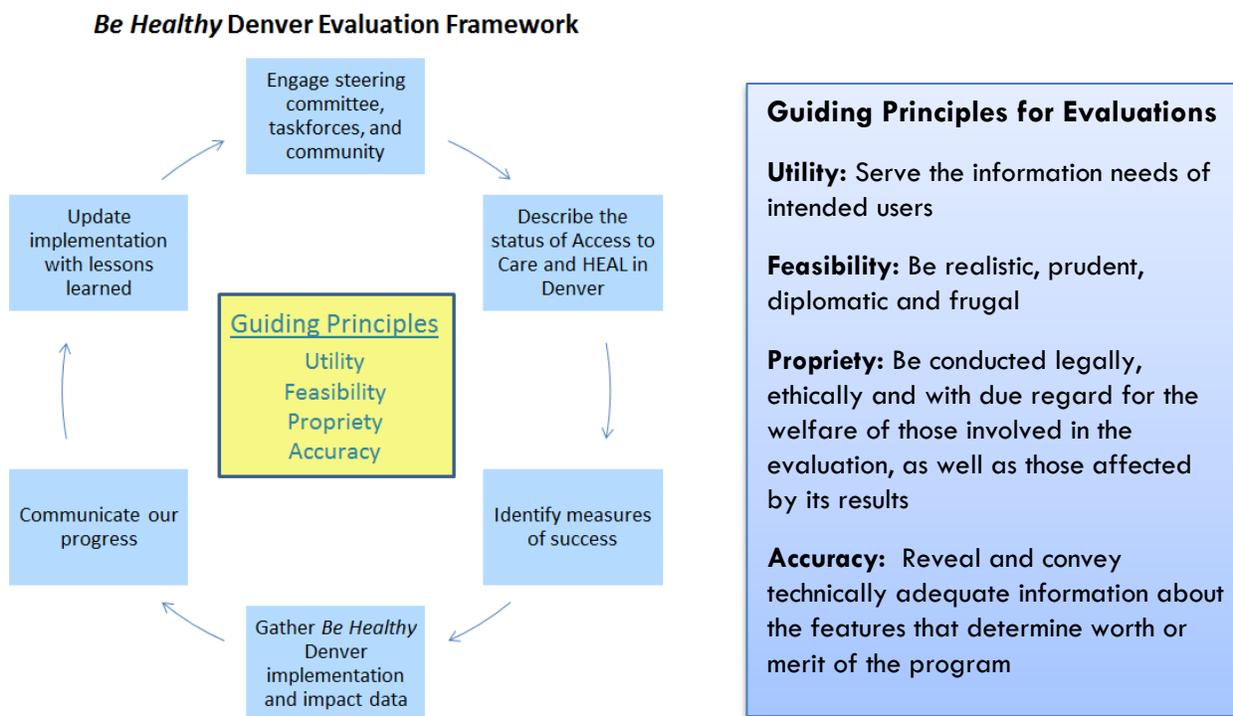
## EVALUATING THE CHIP ACTION PLAN

To demonstrate progress in meeting the CHIP goals and objectives outlined in the Action Plan, a comprehensive evaluation process will be conducted throughout the five-year CHIP implementation period. A *Be Healthy Denver* CHIP evaluation team from Denver Environmental Health and Denver Public Health has been established to oversee these efforts, and will be assisted by community partners and subject-matter experts. This team will periodically assess whether the measurable objectives of the Action Plan are being met, and will share its updates and reports at [BeHealthyDenver.org](http://BeHealthyDenver.org).

Monitoring and evaluation will require ongoing data collection. A mid-term evaluation will be conducted in 2016 and a final evaluation in 2018, to assess whether, and how well, the intended activities have been implemented. The results of the evaluations will be made available at [BeHealthyDenver.org](http://BeHealthyDenver.org).

### Be Healthy Denver Evaluation Framework

The *Be Healthy Denver* core team adapted the CDC Evaluation Framework<sup>66</sup> as the basis for evaluating the CHIP. In this framework, four guiding principles and six steps frame the evaluation effort. Four CDC evaluation standards – utility, feasibility, propriety, and accuracy - will be applied throughout the evaluation, and are defined below.<sup>67</sup>



The six steps of the framework have been applied in sequence from the start of the CHIP planning process, but several cycles of evaluation may take place, with steps repeated as necessary, and important stakeholders engaged at each step. These iterative cycles of evaluation will allow the *Be Healthy Denver* core team to make adjustments and improvements to the CHIP Action Plan, as lessons from implementation are incorporated. Each of these steps is briefly described below.

## Engaging the Steering Committee, Task Forces, and Community

Evaluation stakeholders include all persons who participate in, review results from, have an interest in, and are affected by the CHIP. They include the *Be Healthy Denver* core team from Denver Environmental Health and Denver Public Health, numerous partner organizations that participated in the different stages of developing the CHIP, and community members who are impacted by CHIP activities.

Many stakeholders participated in developing the last CHA, *Health of Denver 2011*, which provided the foundation for the CHIP process, including Denver Environmental Health and Denver Public Health staff members, local leaders, and subject-matter experts on the various health topics. These persons will be invited to participate in evaluating the CHIP, as will the CHIP Steering Committee, members of the Access to Care and HEAL Task Forces, and Denver community members.

## Describe the Status of Access to Care and HEAL Issues in Denver

The Access to Care and HEAL Task Forces have each proposed a five-year goal, and together they have proposed 10 objectives and numerous strategies for meeting these goals, based on their current understanding of the status of Access to Care and HEAL issues in Denver. Evaluation efforts will continue to describe the updated status of these topics as the CHIP is implemented, by reporting the progress made against the goals, objectives, and strategies outlined in the CHIP Action Plan (Appendix J). A key indicator for tracking success in meeting the Access to Care goal will be the percentage of Denver residents with health care coverage. A key indicator for tracking success in meeting the HEAL goal will be the percentage of DPS children at a healthy weight.

## Identify Measures of Success

Each strategy suggested by the task forces is paired with a SMART objective that will be used to monitor progress in implementing that strategy. The task forces have also established a preliminary list of activities that can be undertaken to achieve the SMART objectives, which will be expanded and modified as the CHIP is implemented.

CHIP evaluations will focus on measuring progress towards achieving the SMART objectives. The CHIP evaluation team will create a data collection plan and secure the data needed to report on each SMART objective. It will also assess whether the outlined activities have been completed, and suggest adjustments as needed to SMART objectives and activities.

A comprehensive mid-term evaluation will be completed at the mid-point in the CHIP implementation period in 2016, to report on progress in meeting the goals, objectives, strategies, and SMART objectives. The evaluation will identify strengths, gaps, and areas of improvement for the remaining CHIP implementation.

A final evaluation will be completed at the end of the implementation period in 2018. It will report on the cumulative progress in meeting the goals, objectives, strategies, and SMART objectives, and guide the formulation of the subsequent CHIP and other community health initiatives.



## **Gather *Be Healthy Denver* Implementation and Impact Data**

Each SMART objective has at least one indicator with an identified data source or a basis in credible evidence, by which the CHIP evaluation team can measure progress and whether the SMART objective has been met. The team will develop additional evaluation metrics as necessary during the CHIP implementation period.

## **Communicate Progress**

The *Be Healthy Denver* website, [BeHealthyDenver.org](http://BeHealthyDenver.org), will be the primary means of disseminating information about progress against the CHIP Action Plan. The site will be updated throughout the implementation period, to provide Denver community members and partners with accurate information regarding progress and challenges in implementing the CHIP. The site will track metrics on progress toward meeting the five-year Access to Care and HEAL goals, and house the two evaluation reports. Evaluation findings will be provided in English and Spanish.

## **Update Implementation with Lessons Learned**

Available data and evidence-based best practices will drive the evaluation efforts, and support any suggestions to add objectives, strategies, SMART objectives, activities, or data sources. The CHIP evaluation team will also discuss proposed changes with important stakeholders.

The mid-term evaluation report may suggest modifications to the Action Plan during the remaining implementation period. The two CHAs to be conducted during the implementation period, in 2014 and 2017, will also determine progress towards meeting the CHIP goals and objectives. The final evaluation report will share the cumulative lessons learned over the whole implementation period, and make recommendations for the subsequent CHIP.



## COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP) OVERSIGHT

Denver's CHA and CHIP, with the detailed CHIP Action Plan, help to fulfill the recommendations in Section II – Assessment and Planning - of Colorado's Public Health Improvement Plan of 2009. The CHA, *Health of Denver 2011*, used a collaborative process to identify 14 health topics of concern for Denver residents and provided extensive data to report on the status of each topic. The CHIP planning process engaged the community and a group of important stakeholders to narrow these topics to two – Access to Care and HEAL - on which to focus for improving health in Denver over the next five years. The Access to Care and HEAL Task Forces engaged in a highly collaborative process among numerous stakeholders to outline goals, objectives, and strategies for making progress in each of these two important health areas in Denver. Two additional CHAs will provide updates on the status of important health topics in Denver during the CHIP implementation period.

All of these efforts contribute to the statewide efforts to develop public health indicators, acquire standardized health information across Colorado communities, and develop local planning capacity to inform future statewide public health planning efforts.

Denver's CHIP will also contribute to Colorado's success in winning many of its Ten Winnable Battles.<sup>68</sup> The CHIP Access to Care goal, objectives, and strategies will help Colorado to win battles in Infectious Disease Prevention, Mental Health and Substance Abuse, Obesity, Oral Health, Tobacco, and Unintended Pregnancies. The HEAL goal, objectives and strategies will help Colorado to win battles in Obesity and Safe Food.

The *Be Healthy Denver* core team will coordinate with regional partners in the Denver metropolitan area, including the Tri-County Health Department covering Adams, Arapahoe, and Douglas Counties, Jefferson County Public Health, and Boulder County Public Health, to share experiences in formulating and implementing the respective CHIPs and to align efforts in important areas of mutual concern.

Implementation of the CHIP will be overseen by a *Be Healthy Denver* Advisory Committee appointed by the Mayor of Denver. This Advisory Committee would consist of high-level stakeholders with an interest in health matters in Denver, such as the heads of key governmental agencies and departments, health care organizations, and non-profit and community-based organizations doing work related to Access to Care and HEAL in Denver.

The Advisory Committee will meet quarterly to review the CHIP implementation and progress in meeting the CHIP goals and objectives, with the support of the *Be Healthy Denver* core team. Given that coordinated action by many organizations and individuals will be needed to achieve these goals and objectives by 2018, a key function of the Advisory Committee will be to galvanize efforts by organizations throughout the city to step forward and undertake projects and activities that are in alignment with the CHIP Action Plan, and to help to identify funding sources to support these activities.



## FUNDING

There is no funding specifically earmarked for implementing Denver's CHIP, but a variety of funding sources are likely to become available, given the CHIP's extensive community involvement, comprehensive planning efforts with a wide group of stakeholders, and robust evaluation plans. Existing funding sources for work on HEAL in Denver, such as Denver's Community Transformation Grant, foundation funding for access to healthy foods, funding for the DPS Health Agenda, and a new grant from the U.S. Conference of Mayors to fund healthy child care center initiatives, are likely to align well with the HEAL Action Plan. New proposals for local, state, and federal funding will be more likely to succeed when aligned with the goals, objectives, and strategies outlined in the CHIP Action Plan. Finally, Colorado's health-oriented foundations are likely to fund key parts of the CHIP, given their close involvement throughout the CHIP planning process.

## WHAT LOCAL ORGANIZATIONS AND INDIVIDUALS CAN DO TO HELP

Denver's CHIP has been developed with extensive community involvement, and constitutes a community-wide plan for improving health in the city. This wide community involvement will continue throughout the implementation period, with organizations and individuals coming forward to help realize the goals and objectives outlined in the CHIP Action Plan. Governmental agencies, community-based organizations, and foundations can assist by aligning their programs and activities with these goals and objectives for Access to Care and HEAL in Denver, and by assigning resources accordingly. With such an alignment, organizations can also benefit from the rigorous, ongoing CHIP evaluation that will be carried out in the coming years by the *Be Healthy Denver* evaluation team, to measure progress in their own programs.

**We appreciate your feedback  
and encourage you to get  
involved in Denver's efforts to  
meet the CHIP goals and  
objectives!**

**Contact us at  
[BeHealthyDenver.org](http://BeHealthyDenver.org).**



## APPENDICES

### Appendix A: Outreach Presentations for Health of Denver 2011

No.	Group	Date
1	Denver Medical Society Board of Directors	02/21/2012
2	Denver Health Executive Staff	02/28/2012
3	Staff of Denver Public Health	03/02/2012
4	Denver Public Schools, Health Committee	03/20/2012
5	Staff of Denver Environmental Health	03/20/2012
6	Board of Denver Environmental Health	04/12/2012
7	Denver Community Health Services Board of Directors	04/19/2012
8	Porter Hospital Board of Directors	04/26/2012
9	Medical Staff of St. Joseph's Hospital	05/23/2012
10	Denver Health Board of Directors	05/24/2012
11	Medical staff of Lutheran Hospital	06/19/2012
12	Denver Health Leadership Forum	07/25/2012
13	University of Colorado Family Practice Residency	09/05/2012
14	Medical staff of Good Samaritan Hospital	09/06/2012
15	Health outcomes research staff at Kaiser Permanente	09/10/2012
16	Denver Health Foundation Board of Directors	11/27/2012

## Appendix B: Initial Prioritization Constructs

### 1. Burden/Health Impact

Criterion	Explanation
Health impact	How many people are affected? How serious (deaths, hospitalizations, and disability)?
Trends	Is the problem for health behavior getting better or worse?
Context	How does Denver compare to the state, to other urban areas, to national goals?
Equity	Are there disparities in this health outcome within the population?
Inter-relatedness	Does this health behavior/outcome affect other health outcomes?

### 2. Preventability/Ability to Change

Criterion	Explanation
Best practices	Are there proven/promising strategies for community-based interventions?
Effect size	How much does the intervention(s) affect the problem?
Additional benefits	Does the intervention affect multiple health outcomes?
Population impact	What is the overall effect (effect size x size of the population affected)?
Capacity	Is there community and political support for change in this area?

## Appendix C: CHIP Community Meeting Information

<b>Location</b>	<b>Date</b>	<b>Time</b>	<b>Concurrent Session in Spanish</b>	<b>Child Care Provided</b>
Rachel B. Noel Middle School 5290 Kittredge St.	09/22/2012	3:30 PM	No	No
Skinner Middle School 3435 W. 40th Ave.	09/26/ 2012	5:30 PM	Yes	Yes
Morey Middle School 840 E. 14th Ave.	10/05/ 2012	6:00 PM	No	Yes
Merrill Middle School 551 S. Monroe St.	10/06/ 2012	10:30 AM	No	No
Smiley Middle School 2540 Holly St.	10/11/ 2012	5:30 PM	No	Yes
Abraham Lincoln High School 2285 S. Federal Blvd.	10/13/ 2012	11:30 AM	Yes	No

## Appendix D: Access to Care Outreach Meetings and Media Interviews

ACA Outreach Meetings		
No.	Group	Date
1	Colorado School of Public Health	04/11/13
2	University of Colorado Medical Students	04/20/13
3	Piton Foundation	07/25/13
4	Mayor Michael Hancock	08/08/13
5	Boettcher Foundation Alumni	08/10/13
6	Denver Health Foundation Board	08/20/13
7	Congresswoman Diana DeGette	08/22/13
8	Senator Michael Bennet	08/30/13
9	Club 20	09/07/13
10	National Boards of Pharmacy	09/09/13
11	Senator Mark Udall's Staff	09/09/13
12	Denver Public Libraries	09/09/13
13	Denver Health Medical Staff	09/11/13
14	Archdiocese of Denver	09/12/13
15	Denver City Council Health & Safety Committee	09/17/13
16	Regis University	09/20/13
17	Denver Public Schools	09/23/13
18	Denver Parks & Recreation Department	09/23/13
19	Piton Foundation	09/23/13
20	Denver Hispanic Chamber of Commerce	09/24/13
21	Center for African American Health, African-American Ministerial Alliance	09/24/13
22	Windsor Gardens Retirement Community	09/24/13
23	Chase Small Business Banking and group of small business owners	09/30/13
24	Denver Health Community Health Services, health care providers group	10/02/13
25	Asian Chamber of Commerce	10/02/13
26	Denver Housing Authority Resident Leadership, brief to service coordinators	10/08/13
27	Rocky Mountain Indian Chamber of Commerce	10/08/13
28	Archdiocese of Denver	10/15/13
29	Denver Office of Children's Affairs	10/23/13
30	El Centro San Juan Diego - Hispanic Institute for Family and Pastoral Care for the Archdiocese of Denver	10/23/13
31	Downtown Denver Partnership	10/24/13
32	Denver Health Board of Directors	10/24/13
33	Denver Medical Society	10/24/13

<b>ACA Outreach Meetings</b>		
No	Group	Date
34	Denver Fire Department	10/29/13
35	Community Leaders Breakfast	10/30/13
36	Denver Health Business Leaders	10/30/13
37	Mayor Hancock's Cabinet Meeting	11/06/13
38	Asian Chamber of Commerce	11/08/13
39	Denver Housing Authority and Resident Council Board Health and Safety	11/13/13
40	Small Business Majority and group of small business owners	11/19/13
41	CDPHE Amendment 35 Cancer, Cardiovascular and Pulmonary Disease Program (CCPD) grantees	11/21/13
42	Colorado Restaurant Association	12/04/13
43	Denver Public Schools Nurses	12/12/13
44	Colorado Youth for a Change	01/15/14
45	Women and Girls Lead Advisory Board Meeting	01/22/14

<b>ACA Media Events</b>		
No	News Outlet	Date
1	Community Connections Blog, The Colorado Trust, "The Affordable Care Act and Health Equity"	03/21/13
2	Fox 31 News	09/24/13
3	CBS 4 Denver	09/24/13
4	Entravision	10/01/13
5	NBC National News	10/01/13
6	Fox 31 News	10/01/13
7	CBS 4 Denver	10/02/13
8	Comcast newsmakers spot	11/06/13
9	Community Connections Blog, The Colorado Trust, "Yes, We Can: Progress in Expanding Health Insurance in Denver"	01/21/14
10	Colorado Public Radio	2/4/2014

## Appendix E: Best HEAL Practices for Child Care Centers

### I. Healthy Eating Best Practices

- Serve meals family style (teachers eat same foods as children during meal times).
- Teachers should encourage social interaction and conversation during meals.
- Teachers/caregivers should provide enthusiastic modeling to encourage acceptance of new fruits and vegetables.
- Caregivers/teachers should never force children to try all foods served but encourage with informal modeling.
- Use student rewards that promote health, only with non-food items or activities.
- Increase nutrition education-Promote key HEAL messages to parents and staff in Early Childhood Education (ECE) settings (flyers, handouts, posters, and brochures).
- Formal nutrition information and education programs should be conducted at least twice a year under the guidance of a Nutritionist/RD based on a needs assessment as perceived by families and staff.
- Establish a school garden and serve fruits and vegetable from the garden at school lunch.
- Serve a variety of fruits and vegetables over the course of a 5 day week.
- A nutritious snack should be offered to all children in midmorning and in the middle of the afternoon (snacks should be minimum 2 hrs and maximum 3 hrs apart).
- Fruit rather than fruit juice should be served at most meals (children should be served no more than a total of 4-6 ounces of juice during school day and 12 ounces/day).
- Milk and yogurt should be low-fat for non-fat for children aged 2 years or older.
- Packaged snacks and sweet drinks should be restricted from entering classrooms including all celebrations.
- Provide water bottles free of charge and increase water fountains at all early childhood centers.
- Caregivers/teachers should not bribe children nor use food as a reward or a punishment.
- Establish a school wellness committee that meets monthly consisting of parents, staff, administrators, etc.

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## II. Physical Activity Best Practices

- Caregivers/teachers should lead children in structured physical activities at least 2 times per day.
- Staff should join children in active play.
- Child care sites should have a large variety of portable play equipment in good condition.
- Portable play equipment (balls, hoops, ropes) should be available to preschoolers during both outdoor and indoor time.
- Create more open play space (fields, grassy areas) in outdoor areas.
- Children should be provided 2-3 occasions to play outdoors (60-90 minutes total) for full day child care programs.
- Preschoolers should be allowed 90-120 minutes of unstructured free play time per day for full day child care programs.
- Television or videos should be rarely or never shown.
- Incorporate planned physical activity into the daily preschool schedule that are composed of short activity sessions (15-20 min) with a focus on varied movements such as dancing to music and relay races.
- Increase PA education-Promote key PA messages to parents and staff in ECE settings (flyers, handouts, posters, and brochures).
- Increase size of outdoor play area-It is recommended that play areas are a minimum of 75 square feet at preschools.
- Have adequate provision of covered areas for shade and shelter on playgrounds.
- Children should not be sedentary for more than 30-60 minutes at one time except when sleeping.
- Provide physical activity training and education for ECE staff throughout the school year – at least 2 times/year, e.g., “I am Moving, I am Learning” (IMIL), SPARK Physical Education, Animal Trackers).
- Do not withhold physical activity as punishment.

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## Appendix F: Ongoing HEAL Initiatives

### I. Denver Children's Cabinet, Childhood Obesity Working Group

The Denver Children's Cabinet is responsible for coordinating and integrating services across city agencies and key partners, developing and providing policy guidance, and developing strategies to remove the barriers that stand in the way of Denver Children and youth.

**Goal:** Reduce the number overweight and obese children in Denver by 5 percent in 5 years.

#### Three main focus areas:

1. Increase access to healthy foods;
2. Increase access to physical activity; and
3. Align city programs and services.

#### Possible Strategies:

- Assess retail food environments to ensure access to healthy foods;
- Incentivize farmers' markets to establish businesses in low-income areas;
- Expand programs that bring local fruits and vegetables to schools;
- Support nutrition education in early care and education facilities;
- Increase access to free drinking water;
- Limit the sale of drinks with added sugars in schools;
- Support breastfeeding in hospitals and workplaces;
- Create and maintain safe neighborhoods for physical activity and improve access to parks; and
- Support physical education in schools and daily physical activity in child care facilities.

### II. Denver Public Schools Health Agenda 2015

The DPS Health Agenda 2015<sup>69</sup> was developed by the Denver School Health Advisory Council through the work of committees and with input from more than 1,200 stakeholders who completed a survey.

Priority was given to:

1. Health issues with the strongest correlation to learning and/or readiness to learn
2. Strategies that are evidence-based and best practices
3. Health indicators that are measurable and ones that schools can directly affect
4. Goals that are ambitious yet feasible within five years
5. Objectives that build on existing programs and strategies proven successful in DPS

#### Goals:

##### 1. Nutrition:

- 1a. Increase student participation in the free school breakfast program from 30 to 50 percent.
- 1b. Make nutritional changes to school breakfast, including:
  - Serve only unflavored milk (skim and 1%).
  - Offer oatmeal daily.

- Limit sugar in cereals to less than 6g of sugar per serving, and include at least 2g of fiber per serving (excluding rice cereals).
- Increase the weekly protein options available from six to 10.
- Increase organic produce offerings as variables allow.

**2. Physical Education:**

- 2a. Emphasize the importance of scheduled physical education and recess.
- 2b. Ensure that all students are moderately to vigorously active at least 50 percent of the time in physical education classes.

**3. Health Education:**

Develop and implement a quality assurance system for health education.

**4. Social-Emotional Wellness:**

- 4a. Increase the level of social work and psychological service to schools.
- 4b. Provide the Signs of Suicide curriculum to every 6th and 9th grader.

**5. Health Services:**

- 5a. Increase the level of nursing service to schools.
- 5b. Increase the number of students who have health insurance by 7,000.
- 5c. Increase the number of students who are served by school-based health centers and other physical health services on school grounds.

**6. Healthy and Safe School Environment:**

Implement Positive Behavior Interventions and Supports in all schools.

**7. Health Promotion to Staff:**

Implement a voluntary, comprehensive employee health promotion program.

**8. Family and Community Involvement :**

Implement a culturally-responsive, health promotion campaign to families.

**9. The Denver School Health Advisory Council identified strategies to integrate health-related activities with other school efforts in order to improve efficiencies and effectiveness across multiple areas of health. Those recommendations are listed below.**

- 9a. Include school nurses, social workers and/or psychologists on school leadership teams to incorporate measures of health in the school population.
- 9b. Conduct a biennial (every other year) survey of students, such as the Youth Risk and Behavior Survey, to assess health needs, risks and behaviors in DPS.
- 9c. Develop and publish a DPS-approved list of health-related programs and partnerships
- Encourage staff to input appropriate student health data into Infinite Campus — the student information system — so the data may be used to inform health strategies.
- 9e. Solicit and promote ongoing research on the relationship between health and learning.
- 9f. Support school wellness teams in completing the DPS School Wellness Assessment to identify priorities for nutrition and physical activity (Policy ADF-School Wellness, 2006).

### **III. Denver Sustainable Food Policy Council**

The Sustainable Food Policy Council is a Denver citizen advisory council appointed by the Mayor to advance policies that foster food security for all community members and promote a healthy, equitable, and sustainable local food system, with consideration to economic vitality and environmental impact. The SFPC has outlined four current policy priorities:

#### **Policy #1 – Promote Residential Food Sales**

The SFPC supports an amendment to the Denver Zoning Code to allow the sale of raw agricultural goods and homemade food products on residential properties. This will help to promote the cultivation of backyard and community gardens for personal use while also increasing the availability of fresh produce for sale in all Denver neighborhoods. The amendment would only apply to fruits, vegetables and herbs and any food products made from plants grown on the same site. All raw food and products must be tied directly to the person selling it, and must be sold directly to the consumer.

#### **Policy #2 – Local Purchasing Ordinance**

The SFPC supports the development of a local purchasing ordinance that gives preference of all City of Denver contracts to local farms and ranches and/or vendors of food from local farms and ranches. Such a policy would increase local, sustainable food access and support the City and County of Denver's Economic Development Plan and the health of the regional economy. Our hope is that this ordinance would help to ensure that at least 10% of the City's food-related products come from local sources by 2020.

#### **Policy #3 – Increase SNAP Redemption Opportunities**

The SFPC supports the expansion of accepting Supplemental Nutrition Assistance Program (SNAP) benefits at all Denver farmers' markets through the following tactics:

- Seeking new and/or allocating existing funding, resources, and support to market managers to ensure that all farmers' markets in Denver have the means to acquire current and supporting technology, such as Electronic Benefits Transfer (EBT) machines, by the start of the 2013 market season.
- Seeking new and/or allocating existing funding, resources, and support for community outreach to SNAP recipients about the opportunities to redeem SNAP benefits at Denver farmers' markets.

#### **Policy #4 – Encourage a Broad Range of Fresh Food Outlets**

The SFPC supports a broad range of food outlets from traditional grocery store models to alternative methods such as food hubs, mobile produce markets, and food co-operatives. This effort will require employing diverse strategies suited to the specific needs and interests of each community. Potential outcomes include increased access to affordable, healthy food, lower rates of diet-related illnesses such as diabetes and obesity, and job creation at local businesses in Denver neighborhoods.

#### **IV. Food Systems Research and Policy Development**

The Park Hill Thriving Communities Program at Denver Environmental Health is currently completing an in-depth research analysis to identify a set of possible Denver food systems policies for improving the health of Denver residents. The results of this research will provide the foundation for forming new partnerships and launching new healthy food policy initiatives.

#### **V. Healthy Food Retail Development Initiatives**

Denver Environmental Health convened the Denver Food Access Task Force to identify ways to improve the quality and amount of affordable and nutritious food in areas of Denver with the greatest need, by stimulating grocery store development. The Task Force's final report and recommendations are available at [denvergov.org](http://denvergov.org).<sup>70</sup> To achieve its recommendations, the Task Force facilitated the creation of the Colorado Fresh Food Financing Fund (CO4F), a Colorado Housing and Financing Authority fund that provides low-cost loans and grants for healthy food retail development.

Denver Environmental Health also partnered with Denver's Office of Economic Development to launch the Denver FRESH initiative - Food Retail Expansion to Support Health - to support city systems to incentivize healthy food retail through grocery and corner store retailers. It recently received a grant to implement a corner store healthy food conversion pilot project, to be launched in 2014.

#### **VI. Denver Moves**

Denver Moves is a physical and action-oriented plan that builds upon Denver's Bicycle Master Plan Update, Denver Parks and Recreation Game Plan, Pedestrian Master Plan, and transit-oriented development (TOD) plans.<sup>71</sup> It integrates the off-street and on-street networks identified in these past planning efforts to create safe, comfortable corridors that link neighborhoods, parks, employment centers, business districts, transit hubs, and other destinations in all parts of the city. It recommends improvements for Denver's bicycle corridors and presents a plan for phased implementation.

##### **Goals:**

1. A biking and walking network where every household is within a quarter mile (5-minute walk or 2-minute bicycle ride) of a high ease-of-use facility.
2. Achieve a 15% bicycling and walking commute mode share by 2020.

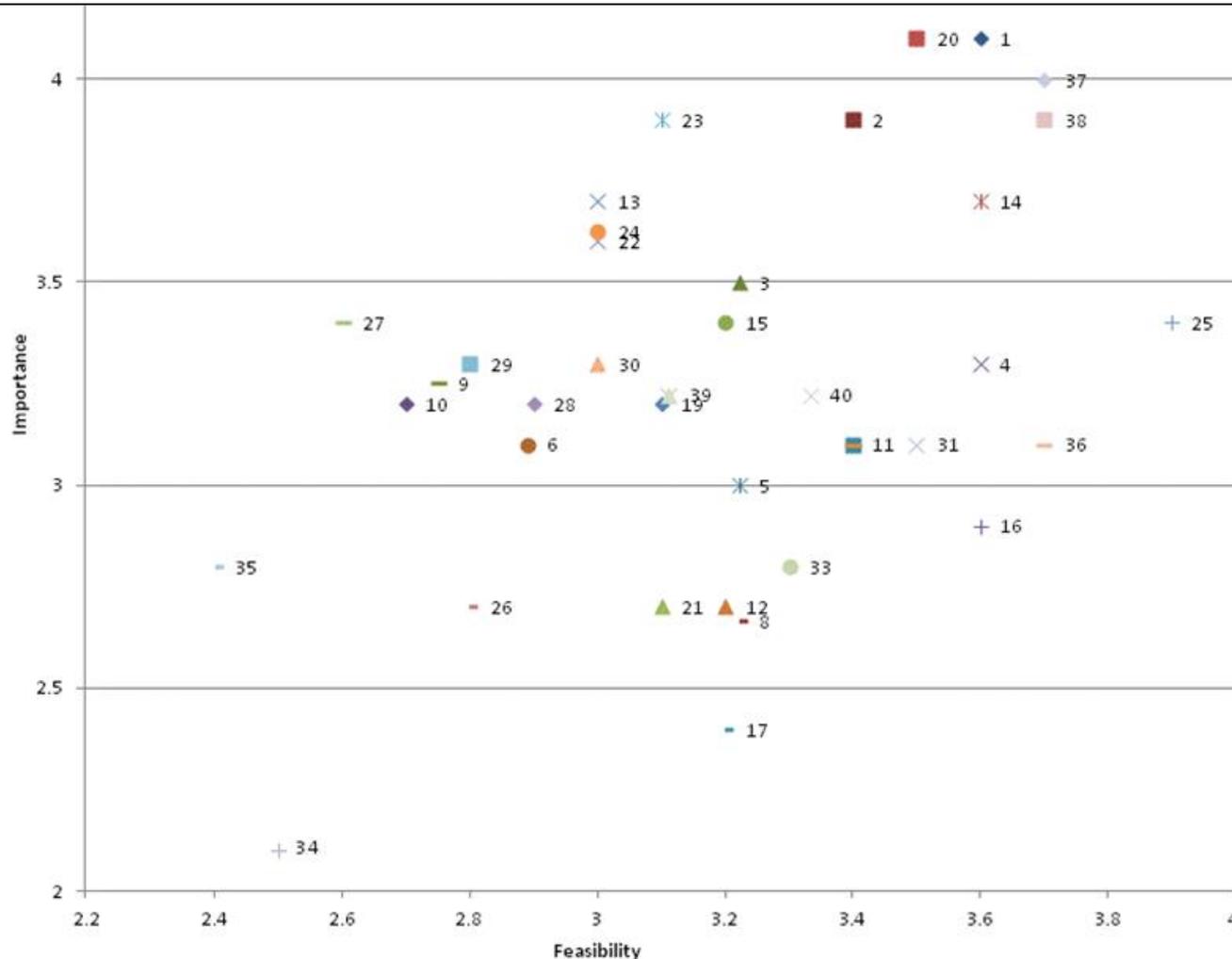
By building a simpler and more comfortable system, Denver Moves contributes to an increase in non-motorized person trips. While this can be for all trips, the second goal focuses on the commute, or to-work trip, given the available data for measuring progress.

##### **Objectives:**

1. Create a New Identity
2. Build a Simpler System
3. Embrace Innovative, Practical Ideas
4. Include All Users

The Denver Moves objectives guided the outreach process, technical planning and design, and selection of recommendations. They reflect active living, transportation, recreation, and community needs.

## Appendix G: HEAL Strategy Ratings



1	Enhance nutritional standards/ guidelines for child care centers
2	Exercise standards/ guidelines for child care centers
3	DPS Early Childhood Ed. access to healthy food and salad bars
4	Create city government vending standards
5	Require secure bike parking in existing lots/garages and in new facilities. Allow bikes in buildings with freight elevators

6	Block closures/play streets/ bike boulevards
7	Improved/Increased signage for safe pedestrian/bike for improved crosswalks, information on routes & distances
8	City sports program healthy snacks
9	Health bucks
10	Encourage farmer's markets in low income neighborhoods

11	Facilitate active stair design in buildings –City Codes / Choice Architecture
12	Allow and encourage healthy food kiosks in city and parks
13	Sugar sales tax or excise tax on sugar sweetened beverages
14	10 miles of sharrows or bike lanes near school
15	Umbrella campaign for all strategies and overall health
16	Encourage bike rack/corral policies
17	Actively encourage community organizations to use recreation centers for events
18	Increase bicycle parking throughout the city
19	Allow cyclists different traffic law provisions
20	Scale back on junk food
21	Restrict advertising at/near schools
22	Adopt standard nutrition education
23	State mandated physical education
24	Restricting competitive foods
25	Policy to eliminate use of recess or P/E as punishment
26	Water jet installations
27	Encourage DPS policies of mandated free time to be more productive for exercise
28	Feedback mechanism for student's BMI
29	Menu labeling
30	Ban artificial trans fats
31	Reduced permitting fee for healthy food mobile vendors
32	Corner store initiatives
33	Restrict mobile vendors around schools
34	Healthier toy giveaway
35	Require a vegetable or fruit in a child's meal at restaurants
36	Meal/snack standards purchased by city agencies
37	Policy for Health Impact Assessments in all planning
38	Policy for assessing health impact in capital improvement projects
39	Healthy hospitals initiative standards ( <a href="http://healthierhospitals.org/nhi-challenges/healthier-food">http://healthierhospitals.org/nhi-challenges/healthier-food</a> )
40	Encourage Denver hospitals to achieve "Baby-Friendly" designation (UNICEF/WHO initiative)( <a href="http://www.babyfriendlyusa.org/Why">http://www.babyfriendlyusa.org/Why</a> )

## Appendix H: Prioritized HEAL Strategies

No.	Orig. No.	Strategy	High in Importance (≥3.5)	High in Feasibility (≥3.5)
1	1	<b>Enhance nutritional standards/guidelines for child care centers</b>	✓	✓
2	2	Exercise standards/guidelines for child care centers	✓	
3	3	DPS Early Childhood Education access to healthy food and salad bars	✓	
4	4	Create city government vending standards		✓
5	13	Sugar sales tax of excise tax on sugar sweetened beverages	✓	
6	14	<b>10 miles of sharrows or bike lanes near school</b>	✓	✓
7	20	<b>Scale back on junk food</b>	✓	✓
8	22	Adopt standard nutritional education	✓	
9	23	State mandated physical education	✓	
10	24	Restricting competitive foods	✓	
11	25	Policy to eliminate use of recess or P/E as punishment		✓
12	36	Meal/snack standards purchased by city agencies		✓
13	37	<b>Policy for Health Impact Assessments in all planning</b>	✓	✓
14	38	<b>Policy for assessing health impacts in capital improvement projects</b>	✓	✓

## Appendix I: Best Practices for Nutrition in Schools

- Lunch after recess.
- At least 20 minutes in the chair to eat lunch with staff supervision.
- Breakfast in the classroom.
- Restrict unhealthy vending near schools. The after the bell vending undermines the nutritional efforts in school. A strategy may be to allow healthy carts/trucks or DPS carts/trucks right on DPS property and then create an ordinance that keeps other unsanctioned trucks further from schools. This may require creating a “healthy cart” rating by the City for carts allowed on/near schools.
- Create “Junk Free Zones” in schools. Kids bringing in outside foods (e.g. bags of chips, candy etc. for themselves and others) is a problem. Creating junk free zones would reduce the amount of unhealthy foods brought into schools.
- Water jet installations in or near cafeterias. This will encourage more water consumption and decrease dehydration.
- Install /cold vending machines where possible to dispense reimbursable meals during breakfast/lunch times and healthy snacks at other times.

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Appendix J: Denver CHIP Action Plan

Access to Care	Healthy Eating and Active Living (HEAL)
<p><b>5-Year Goal: By December 2018, at least 95% of Denver residents will have access to primary medical care, including behavioral health care.</b></p>	<p><b>5-Year Goal: By December 2018, the percentage of children and adolescents in Denver who are at a healthy weight will have increased by five percentage points.</b></p>
<p><b>Indicators:</b></p> <ol style="list-style-type: none"> <li>1. Percentage of Denver residents with health care coverage.</li> <li>2. Percentage of insured/ uninsured residents with a Primary Care Provider (PCP).</li> <li>3. Percentage of insured/uninsured residents who have had a PCP visit in the last 12 months.</li> </ol> <p>Data Sources: American Community Survey, Colorado Health Access Survey</p>	<p><b>Indicators:</b></p> <ol style="list-style-type: none"> <li>1. Percentage of children 2-5 years of age using Denver Health and Kaiser Permanente health systems who are at a healthy weight.</li> <li>2. Percentage of Denver Public Schools (DPS) students, kindergarten through 9<sup>th</sup> grade, who are at a healthy weight.</li> <li>3. Percentage of DPS students, 6-12<sup>th</sup> grade, who meet the recommended physical activity levels (60 minutes/day, 7 days per week).</li> </ol> <p>Data Sources: Denver Health and Kaiser Permanente Electronic Health Records, DPS Body Mass Index (BMI) data, Denver Health Kids Colorado Survey</p>
Enrollment and Coverage	Community
<p><b>Objective A1:</b> Increase the number of Denver residents with health care coverage by supporting implementation of the Affordable Care Act (ACA); 40,000 Denver residents enroll in Medicaid and subsidized insurance by July 1, 2014 and 94% have health care coverage by December 31, 2018.</p>	<p><b>Objective H1:</b> Increase the number of safe and active environments that support physical activity for Denver communities.</p> <p><b>Objective H2:</b> Increase access to nutritious foods and beverages in underserved areas of Denver.</p>
Provider Capacity	Child Care Centers
<p><b>Objective A2:</b> Assess and build the capacity of safety net providers in Denver to deliver primary, specialty, and behavioral health care to persons newly covered starting in 2014, and to those who remain uninsured.</p>	<p><b>Objective H3:</b> Increase the number of licensed child care centers with an optimized Healthy Eating and Active Living (HEAL) environment, through strengthened physical activity and nutrition standards and guidelines.</p>
Care Coordination and System Collaboration	Schools
<p><b>Objective A3:</b> Create a health alliance of important stakeholder organizations in Denver, to increase access to care, better coordinate health care services, and decrease health care costs.</p>	<p><b>Objective H4:</b> Increase quality physical education and opportunities for moderate to vigorous physical activity in schools.</p>
	<p><b>Objective H5:</b> Increase access to healthy foods and beverages in schools.</p>
	City and County Government
<p><b>Objective H6:</b> Incorporate health considerations and analysis in city policy, processes, and planning.</p>	<p><b>Objective H7:</b> Develop and implement a targeted <i>Be Healthy Denver</i> marketing campaign for Healthy Eating and Active Living (HEAL).</p>

## Access to Care Action Plan

### ENROLLMENT AND COVERAGE

<b>Objective A1: Increase the number of Denver residents with health care coverage by supporting the implementation of the Affordable Care Act (ACA); 40,000 Denver residents enroll in Medicaid and subsidized insurance by July 1, 2014 and 94% of residents have health care coverage by December 31, 2018.</b>		
<p><b>Lead Entities:</b> Denver Public Health, new Denver-based health alliance (see Objective A3).</p> <p><b>Supporting Entities:</b> Denver Environmental Health, Denver Department of Human Services, Certified Application Assistance Sites (CAAS) in Denver, Connect for Health Colorado and its Regional Hub and Assistance Sites in Denver, Department of Health Care Policy and Financing (HCPF), safety net health care providers, community-based organizations.</p> <p><b>Potential Indicator(s):</b> Increase in number of Denver residents enrolled in Medicaid, CHP+, and insurance plans through Connect for Health Colorado; increase in number of enrollment/medical assistance sites; number of training sessions provided to health care organizations and community-based organizations; number of individuals/groups trained; reach of Training of Trainers events; number of brochures and educational materials distributed; number of media interviews conducted; number of visits to Denver Health ACA website.</p>		
Strategies	SMART Objectives	Data Sources/Results
A. Assess current enrollment practices in Denver and preparations for the forthcoming expansion of coverage under the ACA.	By 7/1/2013, survey 50 safety net providers, community-based organizations, and governmental organizations providing services to low-income Denver residents about their current enrollment practices and preparations for the ACA expansions.	<ul style="list-style-type: none"> <li>• Survey conducted</li> <li>• Organizations surveyed</li> <li>• Organizations responded</li> <li>• Response rates</li> <li>• Report completed</li> </ul>
B. Develop and conduct Training of Trainers (TOT) courses for health providers and community-based organizations serving low-income Denver residents, to educate staff and community partners about the ACA and enrollment.	By 10/1/2013, conduct two TOT courses with (1) Denver Health frontline staff and (2) staff from other safety net providers and community-based organizations. By 11/1/2013, translate training materials from the TOT courses into Spanish and make available at BeHealthyDenver.org for use by interested organizations.	<ul style="list-style-type: none"> <li>• TOT courses conducted</li> <li>• Organizations and individuals attended</li> <li>• Trainings conducted by attendees with colleagues in their own organizations</li> <li>• TOT materials available at BeHealthyDenver.org</li> </ul>
C. Conduct outreach meetings and provide information about the forthcoming changes under the ACA to various organizations and groups in Denver.	By 3/14/2014, conduct 40 outreach meetings and distribute information about the expansion of coverage under the ACA.	<ul style="list-style-type: none"> <li>• Outreach meetings conducted</li> <li>• Organizations and individuals attended</li> <li>• Materials distributed</li> </ul>

**Objective A1: Increase the number of Denver residents with health care coverage by supporting the implementation of the Affordable Care Act (ACA); 40,000 Denver residents enroll in Medicaid and subsidized insurance by July 1, 2014 and 94% of residents have health care coverage by December 31, 2018.**

Strategies	SMART Objectives	Data Sources/Results
D. Produce and distribute brochures and other educational materials for the public on the forthcoming changes under ACA and how people can get enrolled.	By 10/1/2013, produce a special edition of <i>Denver Vital Signs</i> on the ACA and enrollment, and distribute to partners. By 11/1/2013, develop, design, and print 93,000 bilingual brochures on the ACA and how to enroll in Denver. By 3/1/2014, disseminate the brochures and ACA training slides to governmental organizations, health care providers, and community-based organizations.	<ul style="list-style-type: none"> <li>• <i>Denver Vital Signs</i> ACA edition published and distributed to partners</li> <li>• 93,000 ACA brochures printed and distributed to partner organizations</li> <li>• TOT slides produced in English and Spanish, shared with partners, and posted on BeHealthyDenver.org</li> </ul>
E. Engage with local media to promote enrollment in health care coverage.	By 4/1/2014, the Director of Denver Public Health will participate in eight media interviews regarding the implementation of the ACA, with four different media outlets.	<ul style="list-style-type: none"> <li>• Interviews conducted</li> <li>• Media outputs (broadcasts, articles)</li> </ul>
F. Update and maintain accurate ACA information on the Denver Health website.	By 10/1/2013, develop an ACA page on the Denver Health website. Update the website monthly.	<ul style="list-style-type: none"> <li>• Denver Health ACA website created</li> <li>• Website updates</li> </ul>
G. Monitor and report the percentage of Denver residents enrolled in health care coverage.	From 1/1/2013-12/31/2018, note and report on Denver's rate of health care coverage, as determined by the American Community Survey and the Colorado Health Access Survey.	<ul style="list-style-type: none"> <li>• American Community Survey (ACS)</li> <li>• Colorado Health Access Survey (CHAS)</li> <li>• Reports posted on BeHealthyDenver.org</li> </ul>
H. Track progress monthly on the number of Denver residents enrolling in Medicaid and subsidized insurance plans at Connect for Health Colorado.	By 1/1/2014, develop a reporting framework and collect Denver enrollment data from HCPF and Connect for Health Colorado. From 1/1/2014-12/31/2018, report monthly or quarterly on the number of Denver residents who enrolled in Medicaid and purchased health insurance through Connect for Health Colorado.	<ul style="list-style-type: none"> <li>• Reporting format agreed with HCPF and Connect for Health Colorado</li> <li>• Monthly Medicaid enrollment data acquired from HCPF and monthly insurance enrollment data acquired from Connect for Health Colorado</li> <li>• Colorado Benefits Management System (CBMS) data</li> <li>• Medicaid Management Information System (MMIS) data</li> </ul>

**Objective A1: Increase the number of Denver residents with health care coverage by supporting the implementation of the Affordable Care Act (ACA); 40,000 Denver residents enroll in Medicaid and subsidized insurance by July 1, 2014 and 94% of residents have health care coverage by December 31, 2018.**

**Best practices that may inform strategies:** Colorado’s experience with the early expansion of Medicaid for Adults without Dependent Children (AwDC), best practices from other cities in enrolling Eligible but not Enrolled (EBNE) populations, Massachusetts’ experience in implementing health care reform and the individual coverage mandate starting in 2006, other states’ and the federal government’s experience in setting up insurance exchanges, other cities’ experiences in expanding Medicaid enrollment and encouraging people to purchase insurance on the state and federal exchanges starting in October 2013.

Action Steps	Organization Responsible	Target Date	Status	Anticipated Result
Prepare questionnaire for Enrollment and ACA Survey, identify stakeholder organizations to survey, send out surveys, collect responses, analyze data, complete report.	Access to Care Task Force	July 1, 2013	Completed	Report completed, “Summary of Enrollment and ACA Survey Results,” available at <a href="http://BeHealthyDenver.org">BeHealthyDenver.org</a> .
Develop Training of Trainers (TOT) training material, conduct trainings, provide follow-up information to attendees, note trainings that attendees conduct with colleagues, translate materials into Spanish, make available to partners.	Access to Care Task Force, Denver Public Health Prevention Training Center	November 1, 2013	Completed	Two TOTs conducted, slide sets produced and translated into Spanish, made available at <a href="http://BeHealthyDenver.org">BeHealthyDenver.org</a> .
Prepare slides and handouts for ACA outreach and education meetings, schedule and conduct meetings.	Access to Care Task Force Chairs	April 1, 2014	39 meetings completed by December 15, 2013	Reliable, accurate and consistent messaging regarding the ACA, informed community leaders.
Design, print and distribute brochures to educate people about the forthcoming changes under the ACA and how to enroll in Denver, distribute brochures to partner organizations.	Access to Care Task Force	April 1, 2014	93,000 brochures printed, 89,000 distributed by December 15, 2013	Reliable, accurate and consistent messaging regarding ACA, brochures printed and distributed, electronic copy of brochure available at <a href="http://BeHealthyDenver.org">BeHealthyDenver.org</a> .
Write and produce <i>Denver Vital Signs</i> issue on the ACA, distribute to partners and community leaders.	Access to Care Task Force	October 1, 2013	Completed	“Expanding Access to Health Care in Denver Under the ACA,” <i>Denver Vital Signs</i> , September 2013, available <a href="http://denverhealth.org">denverhealth.org</a> .
Approach media outlets, participate in interviews, and submit articles for publication on the beneficial aspects of the expansion of coverage under the ACA; respond to media queries.	Director of Denver Public Health, Denver Health Public Relations and Communications Department	April 1, 2014	7 interviews completed by December 1, 2013	Reliable, accurate and consistent messaging regarding ACA Interviews conducted, articles published.

Create an ACA sub-page on the Denver Health website.	Denver Health Public Relations and Communications Department	October 1, 2013	Completed	Reliable, accurate and consistent messaging regarding ACA, webpage created.
Obtain new releases of data from the ACS and CHAS, analyze data, extract Denver-specific data on health coverage.	Denver Public Health, Colorado Health Institute	Ongoing through December 31, 2018	Ongoing	Survey data available, evidence of an increase in the coverage rate of Denver residents from 2013 through 2018.
Develop reporting format with HCPF and Connect for Health Colorado to collect monthly data on enrollment in Medicaid and insurance plans; collect data monthly, analyze data, report results.	Denver Public Health, HCPF, Connect for Health Colorado	Ongoing through December 31, 2018	Ongoing	Monthly data on enrollment in Medicaid and insurance plans, increase in the coverage rate of Denver residents from 2013 through 2018.

**PROVIDER CAPACITY**

<b>Objective A2: Assess and build the capacity of safety net providers to deliver primary, specialty, and behavioral health care to persons newly covered starting in 2014, and to those who remain uninsured.</b>		
<p><b>Lead Entities:</b> Denver Public Health, new Denver-based health alliance.  <b>Supporting Entities:</b> Denver Environmental Health, primary, specialty care, and behavioral health care providers, community-based organizations.  <b>Potential Indicator(s):</b> Number of patients seen monthly and annually by safety net providers in Denver; number of patients turned away and referred elsewhere; number of patients insured and uninsured; percent of revenue for safety net providers coming from patient fees, Medicaid and insurance reimbursement, and other funding sources; qualitative data from key informant interviews with safety net providers about access and capacity challenges; patient confidence in knowledge of needed services and in accessing needed services; emergency department utilization and hospitalization patterns in Denver.</p>		
Strategies	SMART Objectives	Data Sources/Results
A. Conduct an assessment of gaps and challenges in the provision of primary, specialty and behavioral health care in Denver prior to the ACA implementation, and how well safety net providers are prepared to receive persons newly enrolled in Medicaid and subsidized insurance plans in 2014.	By 9/1/2013, the Access to Care Task Force will conduct key informant interviews with the leaders of 15 safety net providers in Denver and produce a report of the findings.	<ul style="list-style-type: none"> <li>• Interviews conducted</li> <li>• Report completed and made available at BeHealthyDenver.org</li> </ul>
B. Continue to identify gaps and challenges in primary, secondary and behavioral health care services in Denver as the ACA is implemented.	On an ongoing basis between 1/1/2014 and 12/31/2018, Denver Public Health will analyze data from the CHAS, HCPF, and Denver Health to identify gaps and challenges in primary, secondary, and behavioral health care.	<ul style="list-style-type: none"> <li>• CHAS</li> <li>• HCPF data on Medicaid enrollment</li> <li>• Denver Health data</li> </ul>
C. Monitor health care utilization trends in Denver with the implementation of the ACA.	On an ongoing basis between 1/1/2014 and 12/31/2018, Denver Public Health will analyze data from the Colorado Hospital Association and the CHORDS Registry to identify trends in how patients access health care through safety net providers.	<ul style="list-style-type: none"> <li>• Colorado Hospital Association</li> <li>• Denver CHORDS Registry (combined electronic health records from Denver Health, Kaiser Permanente, and other safety net providers)</li> </ul>

**Objective A2: Assess and build the capacity of safety net providers to deliver primary, specialty, and behavioral health care to persons newly covered starting in 2014, and to those who remain uninsured.**

Strategies	SMART Objectives	Data Sources/Results
<p>D. Facilitate enrollment of current patients at safety net clinics in Medicaid and insurance plans from Connect for Health Colorado, which will generate income to expand services for additional patients.</p>	<p>On an ongoing basis from 10/1/2013 through 12/31/2014, Denver Health and other safety net providers in Denver will reach out to current patients and assist them to enroll in Medicaid and subsidized insurance plans on Connect for Health Colorado.</p>	<ul style="list-style-type: none"> <li>• Number and percentages of patients at Denver’s safety net clinics who are uninsured, enrolled in Medicaid and CHP+ , and enrolled in private insurance</li> <li>• New revenues for safety net clinics from Medicaid and insurance payments</li> <li>• Investments in improving facilities and hiring new staff</li> </ul>
<p>E. Provide technical assistance to safety net providers to learn how to effectively bill for Medicaid and commercial insurance.</p>	<p>A new Denver-based Health alliance may elect to coordinate the provision of technical assistance for Medicaid and insurance billing for its members as an early priority. Dates to be determined by the alliance.</p>	<ul style="list-style-type: none"> <li>• Technical assistance provided</li> <li>• Increased revenues to safety net clinics through Medicaid and insurance payments</li> <li>• Investments in improving facilities and hiring new staff</li> </ul>
<p>F. Survey Denver’s safety net providers to describe what services they provide and identify their strengths; develop an effective work plan and referral system to make the best use of limited resources and increase collective capacity to serve Denver residents.</p>	<p>A new Denver Health alliance may decide to survey its members regarding their respective capacities and specializations, and to develop a division of labor and referral system for the care of low-income Denver residents. Dates to be determined by the alliance.</p>	<ul style="list-style-type: none"> <li>• Survey conducted of safety net organizational capacity and specializations in Denver</li> <li>• Division of labor agreed on</li> <li>• Referral system established and operational</li> <li>• Number of referrals</li> </ul>
<p><b>Best practices that may inform strategies:</b> Successful practices in other cities for managing primary, specialty, and behavioral health care for low-income residents, Denver Health’s experience with its Center for Medicare and Medicaid Innovation (CMMI) grant, experience of other CMMI grant holders, Camden, NJ model for high users of emergency departments.</p>		

**Objective A2: Assess and build the capacity of safety net providers to deliver primary, specialty, and behavioral health care to persons newly covered starting in 2014, and to those who remain uninsured.**

Action Steps	Organization Responsible	Target Date	Status	Anticipated Result
Identify organizations and contact persons for key informant interviews on gaps and challenges in the provision of primary, specialty and behavioral health care, conduct interviews, analyze interview data, write capacity assessment report.	Access to Care Task Force	September 1 , 2013	Completed	Report completed, "Access to Care in Denver: Progress Report of the Denver Access to Care Task Force", available at BeHealthyDenver.org.
Analyze data from the CHAS, HCPF, and Denver Health to identify continued gaps and challenges in primary, secondary, and behavioral health care, report findings.	Denver Public Health	Ongoing through 12/31/2018	Ongoing	Data analyzed, periodic reports completed.
Analyze data from the Colorado Hospital Association and the CHORDS Registry to identify trends in how patients access health care through safety net providers.	Denver Public Health	Ongoing through 12/31/2018	Ongoing	Data analyzed, periodic reports completed.
Individual safety net providers increase their enrollment capacity or refer patients out to enrollment sites, to ensure that current patients get enrolled.	Safety net providers, Enrollment sites	December 31, 2014	Ongoing	Patients who are already connected to safety net clinics now have a reliable payer source for their care. The revenues generated by current patients help to generate the revenues for clinics to expand capacity and offer services to more patients.
Identify clinics that need technical assistance to bill for Medicaid and private insurance, who can provide this assistance, and how the provision of technical assistance can be funded, e.g. through lending expertise between member organizations in a new health alliance.	New Denver-based health alliance Safety net providers	To be determined	To be determined	Safety net clinics have the skills and expertise to bill Medicaid and insurance companies. They derive revenues that can be reinvested to expand capacity and offer services to more patients.
Create a survey instrument and research plan, identify safety net clinics to be surveyed, conduct survey, coordinate meetings of safety net providers, agree on and implement division of labor and referral system.	New Denver-based health alliance Safety net providers	To be determined	To be determined	Safety net clinics realize efficiencies and maximize limited resources, thereby increasing the overall capacity in Denver to care for the health needs of low-income residents.

**CARE COORDINATION AND SYSTEM COLLABORATION**

<p><b>Objective A3: Create a health alliance of important stakeholder organizations in Denver, to increase access to care, better coordinate health care services, and decrease health care costs.</b></p>		
<p><b>Lead Entities:</b> Denver Public Health, in conjunction with Denver Health Community Health Services, Mental Health Center of Denver (MHCD), Inner City Health Center, Clínica Tepeyac, and Colorado Alliance for Health Equity and Practice (CAHEP).</p> <p><b>Supporting Entities:</b> Denver Environmental Health, Denver Health and Hospital Authority (multiple units), Children’s Hospital, Exempla St. Joseph Hospital, Kaiser Permanente, Denver Department of Human Services, safety net providers of primary care, specialty care, behavioral health care, and substance abuse treatment, community-based organizations.</p> <p><b>Potential Indicator(s):</b> Number of health care agencies participating in the formation of the alliance; number of meetings held, attendance at meetings, meeting minutes recorded; key issues identified for the alliance to address; plan produced for the formation of the alliance; vision and mission for the alliance; funding proposal for supporting the alliance in its early years and plan for sustainable funding in to the future; alliance created and operating.</p>		
Strategies	SMART Objectives	Data Sources/Results
A. Conduct an environmental scan of urban health alliances in Colorado.	By 11/1/2013, the Access to Care Task Force will interview the leaders of six urban alliances on key aspects of their operations, and produce a report of the findings.	<ul style="list-style-type: none"> <li>• Interviews conducted</li> <li>• Report completed</li> </ul>
B. Develop and submit a Convening for Colorado grant application to the Colorado Trust to support the planning process for a potential Denver-based health alliance.	By 11/25/2013, the Access to Care Task Force will submit a Convening for Colorado grant application to the Colorado Trust to support a planning process to form a health alliance in Denver.	<ul style="list-style-type: none"> <li>• Grant application developed</li> <li>• Grant submitted</li> <li>• Grant awarded</li> </ul>
C. Facilitate a collaborative planning process for creating a health alliance in Denver; prepare and submit a plan and funding proposal to support the creation and early work of the alliance.	Between 1/1/2014 and 5/31/2014, Denver Public Health and a hired facilitator will facilitate four meetings with 30 stakeholders. By 6/28/2014, Denver Public Health and a core group of group of safety net providers in Denver, with the help of a technical writer, will prepare a plan and funding proposal for creating a health alliance.	<ul style="list-style-type: none"> <li>• Meetings held, agendas prepared and minutes taken</li> <li>• Organizations and individuals attended</li> <li>• Plan and funding proposal written and submitted</li> <li>• Funding granted</li> <li>• Health alliance formed</li> </ul>
<p><b>Best practices that may inform strategies:</b> Institute for Healthcare Improvement’s (IHI) Triple Aim, experiences of other health alliances in Colorado, notably the North Colorado Health Alliance, guidance from networks of health alliances in Colorado (Colorado Network of Health Alliances) and the United States (Communities Joined in Action), best practices in care coordination among health care providers in other cities, best practices in using patient care navigators and patient-centered medical homes, and in reducing emergency room visits and readmissions.</p>		

**Objective A3: Create a health alliance of important stakeholder organizations in Denver, to increase access to care, better coordinate health care services, and decrease health care costs.**

Action Steps	Organization Responsible	Target Date	Status	Anticipated Result
Identify urban health alliances in Colorado and their leaders, conduct interviews, analyze data, write report.	Access to Care Task Force	November 1, 2013	Completed	Report completed, "Survey of Health Alliances in Colorado," available at BeHealthyDenver.org.
Write and submit Convening for Colorado grant application.	Access to Care Task Force	November 25, 2013	Completed, Grant Awarded	Funding awarded to support a planning process to create a health alliance in Denver.
Convene four planning meetings for creating a health alliance, write and submit a plan and funding proposal for creating the alliance.	Denver Public Health, hired facilitator and technical writer	June 28, 2014	Ongoing	Planning process completed to establish a health alliance in Denver, plan and funding proposal submitted.

## Healthy Eating and Active Living (HEAL) Action Plan

### COMMUNITY

<b>Objective H1: Increase the number of safe and active environments that support physical activity for Denver communities.</b>		
<p><b>Lead Entity:</b> Denver Environmental Health</p> <p><b>Supporting Entities:</b> Denver Public Health, Denver Public Schools, Denver Community Planning and Development (CPD), Denver Public Works Department, Denver Parks and Recreation, Denver City Council, Denver Safe Routes to School Coalition, Walk Denver, Bike Denver, neighborhood associations</p> <p><b>Potential Indicator(s):</b> Percentage of adults commuting to work by bike; Number of bike lanes and sharrows create;, percentage of adults engaging in leisure time physical activity; percentage of adults meeting physical activity recommendations; number of pedestrian/bicycle improvements made; number of pedestrian/bicycle accidents with motor vehicles per year; amount of new revenue dollars for bicycle, pedestrian, and multi-modal transportation; percentage of DPS students living within one mile of school who walk or bike to school</p>		
<b>Strategies</b>	<b>SMART Objectives</b>	<b>Data Sources/Results</b>
A. Assess bicycle/walking laws, Safe Routes to School (SRTS) policies and ordinances, and street and sidewalk design and quality; identify opportunities to encourage bicycle use, increase physical activity, and improve safety for pedestrians and cyclists.	By 12/31/2015, (1) review city and DPS policies that could be improved to enhance walking/bicycle use and safety, and (2) complete Denver Bike Policy Assessment. By 12/31/2016, conduct a complete streets assessment.	<ul style="list-style-type: none"> <li>• Walking/biking policy reviewed</li> <li>• Denver Bike Policy Assessment completed</li> <li>• Denver Safe Routes to School and Denver Public School Policy matrix created</li> </ul>
B. Improve signage for safe pedestrian/bike use and improve the safety of crosswalks.	By 12/30/2014, convene a stakeholder group to analyze traffic, road safety level (spatial and temporal design, day and night visibility, and accessibility) pedestrian, and bike accident data. By 6/30/2015, complete data assessment and provide recommendations to make crosswalks safer. By 12/31/2015, create a Master Signage Plan defining priority areas and standards for signage.	<ul style="list-style-type: none"> <li>• Report summarizing traffic, road safety conditions, pedestrian, and bike accident data</li> <li>• High-fatality crosswalks mapped</li> <li>• Master signage plan created</li> <li>• Signs added and replaced</li> </ul>
C. Allow and encourage community-based organizations to use parks and recreation centers for events and activities.	By 12/31/2014, partner with Denver Parks and Recreation to produce a baseline report about how, and with what frequency, community organizations use parks and recreation centers for events and activities, and how this usage can be increased to create more play and exercise opportunities for children.	<ul style="list-style-type: none"> <li>• Baseline report completed using Denver Parks and Recreation data</li> </ul>

<b>Objective H1: Increase the number of safe and active environments that support physical activity for Denver communities.</b>				
D. Examine new revenue generation options for bicycle, pedestrian, and multi-modal transportation infrastructure.	By 7/31/2014, complete a revenue generation analysis for bicycle, pedestrian and multi-modal transportation.	• Revenue generation analysis completed		
<b>Best practices that may inform strategies:</b> Safe Routes to School (SRTS), Denver's previous experiences and best practices in other cities for enhancing safe walking and cycling, improving signage, and facilitating multi-modal transportation.				
<b>Action Steps</b>	<b>Organization Responsible</b>	<b>Target Date</b>	<b>Status</b>	<b>Anticipated Output</b>
Convene stakeholders, political leaders, businesses, and community partners related to each strategy.	Denver Environmental Health, Denver Public Works, Denver Public Health For Signage: Denver SRTS Coalition, Denver Public Works, Trust for Public Land. For Parks and Recreation: Denver Parks and Recreation, Trust for Public Land	3/1/2014	Ongoing	Commitment and support from stakeholders.
Meet with stakeholder to determine/finalize SMART objectives for strategies.	Denver Environmental Health, Denver Public Works, Denver Public Health	7/1/2014	Ongoing	SMART objectives further defined.
Create work plan for each strategy.	Denver Environmental Health, Denver Public Works, Denver Public Health	6/1/2014	Ongoing	Work plans created.

**Objective H2: Increase access to nutritious foods and beverages in underserved areas of Denver.**

**Lead Entity:** Denver Environmental Health.

**Supporting Entities:** Denver Public Health, Office of Economic Development (OED), Denver Parks and Recreation, Denver Public Schools, Office of Children’s Affairs, Denver Human Services, Denver Urban Gardens, Trust for Public Land.

**Potential Indicator(s):** Relative price of milk in Denver compared to sugar sweetened beverages (SSB); number of vending machines in City and County of Denver offices that meet good nutrition standards; average proximity of residences to grocery stores; availability of healthy options at convenience stores.

Strategies	SMART Objectives	Data Sources/Results
A. Create positive incentives for grocery and convenience stores in low-income areas to offer healthy food and beverage options.	By 12/31/2018, identify one new source of funding to support grocery and convenience stores that offer healthy food and beverage options.	<ul style="list-style-type: none"> <li>• Colorado Fresh Food Financing Fund (CO4F)</li> <li>• Denver FRESH data</li> </ul>
B. Increase the number of convenience stores offering healthy food and beverage options.	By 12/31/2018, increase healthy food offerings in convenience stores in two low-income Denver areas.	<ul style="list-style-type: none"> <li>• CO4F</li> <li>• Denver FRESH data</li> <li>• Healthy convenience stores established</li> </ul>
C. Increase urban agriculture and gardening in Denver.	By 12/31/2016, convene urban agriculture and gardening partners to conduct a scan of best policies and practices and draft policy recommendations for increasing access to urban agriculture and gardens in underserved areas of Denver.	<ul style="list-style-type: none"> <li>• Denver Environmental Health data</li> <li>• Denver Community Planning and Development (CPD) Department data</li> <li>• Colorado Farmers Market Association (CFMA) data</li> <li>• Policy recommendations drafted on urban agriculture</li> </ul>
D. Protect farmers’ markets and improve access to farmers markets by low-income populations.	By 12/31/2018, increase the number of farmer’s markets that accept EBT cards for SNAP benefits. By 12/31/2018, increase the number of farmer’s markets in two low- income areas of Denver.	<ul style="list-style-type: none"> <li>• Denver Environmental Health data</li> <li>• Denver Urban Gardens data</li> <li>• Office of Economic Development data</li> <li>• New farmers markets opened</li> </ul>
E. Encourage city partners and other organizations to implement healthy vending policies.	By 12/31/2015, include strategy in the Denver Healthy Vending Policy implementation plan for encouraging partners and organizations to adopt healthy vending.	<ul style="list-style-type: none"> <li>• Denver Healthy City Vending Policy adopted by partner organizations</li> </ul>

**Best practices that may inform strategies:** Aligning vending standards with good nutritional standards, healthy vending standards developed by advocacy organizations, and healthy vending policies adopted in other cities.

**Objective H2: Increase access to nutritious foods and beverages in underserved areas of Denver.**

Action Steps	Organization Responsible	Target Date	Status	Anticipated Output
Convene stakeholders, political leaders, businesses, and community partners related to each strategy.	Denver Environmental Health, Denver Public Health	3/1/2014	Ongoing	Commitment of support from stakeholders.
Meet with stakeholders to further refine SMART objectives for each strategy.	Denver Environmental Health, Denver Public Health	7/1/2014	Ongoing	SMART Objectives refined.
Create work plan for each strategy.	Denver Environmental Health, Denver Public Health	5/1/2014	Ongoing	Work plans completed.
Identify funding to support strategies.	Denver Environmental Health, Denver Public Health	12/31/2018	Open	Funding identified.

**CHILD CARE CENTERS**

**Objective H3:** Increase the number of licensed child care centers with an optimized Healthy Eating and Active Living (HEAL) environment, through strengthened physical activity and nutrition standards and guidelines.

**Lead Entity:** Denver Environmental Health.  
**Supporting Entities:** Denver Public Health, Rocky Mountain Prevention Research Center, Denver Office of Children’s Affairs, Denver Early Childhood Council, American Heart Association (AHA).  
**Potential Indicator(s):** Number of child care centers recruited and trained; number of child care centers HEAL-certified; number of HEAL best practices implemented by child care centers.

Strategies	SMART Objectives	Data Sources/Results
A. Using HEAL best practices, develop a baseline measurement tool for assessing child care center nutrition and physical activity.	By 6/30/2014, identify 1-3 best practices related to nutrition and physical activity to assess in child care centers.	<ul style="list-style-type: none"> <li>• Nutritional and physical activity assessment tool developed</li> </ul>
B. Conduct a baseline assessment of nutritional and physical activity practices in selected child care centers in Denver.	By 12/31/2014, conduct baseline assessment of child care centers in at least two low-income areas in Denver.	<ul style="list-style-type: none"> <li>• Child care center baseline assessments conducted</li> </ul>
C. Provide training on selected physical activity and nutrition best practices for licensed child care centers.	By 6/30/2015, conduct trainings on nutritional and physical activity best practices in at least two child care centers in Denver.	<ul style="list-style-type: none"> <li>• Training materials developed</li> <li>• Child care centers trained</li> </ul>

**Best practices that may inform strategies:** Best practices for managing nutrition and exercise for children attending child care centers.  
 For nutrition: Serve a variety of fruits and vegetables, offer nutritious snacks at midmorning and midafternoon, offer safe drinking water available on demand, limit juice, serve skim milk to children over 2 years of age, encourage social interaction and conversation during meals, do not force children to try all foods, and use student rewards that promote health.  
 For exercise: Limit sedentary time to 30-60 minutes at one time except when sleeping, train staff about physical activity, do not use physical activity as a punishment, lead children in structured physical activities at least 2 times per day, join children in active play, have a variety of portable play equipment and make available during outdoor and indoor time, create open play space, and provide for outdoor play 60-120 minutes daily.

**Objective H3: Increase the number of licensed child care centers with an optimized Healthy Eating and Active Living (HEAL) environment, through strengthened physical activity and nutrition standards and guidelines.**

Action Steps	Organization Responsible	Target Date	Status	Anticipated Outputs
Organize working group of Early Childhood Education experts.	Denver Environmental Health, AHA	4/1/2014	Ongoing	Ideas and commitment of support from stakeholders. Work plan created.
Conduct and evaluate pilot program.	AHA	11/1/2014	Ongoing	Agreement reached about what data will be tracked, evaluation shared with appropriate stakeholder groups.
Based on evaluation results, make revisions to work plans with the help of facilitating organization(s) and stakeholder groups.	Denver Environmental Health, CHIP evaluation team, AHA	12/1/2015	Ongoing	Adjustments made to programs based on evaluation results.
Identify 1-3 best practices in reducing obesity, on which child care centers can focus.	Denver Environmental Health, AHA	1/1/2016	Ongoing	High priority best practices identified.
Create sustainability plan to expand program to more child care centers in Denver.	Denver Environmental Health, AHA	1/1/2016-1/1/2017	Ongoing	Sustainability plan created.

**SCHOOLS**

<b>Objective H4: Increase quality physical education and opportunities for moderate to vigorous physical activity in schools.</b>		
<p><b>Lead Entity:</b> Denver Public Schools (DPS).  <b>Supporting Entities:</b> Denver Environmental Health, Denver Public Health, Denver Office of Children’s Affairs.  <b>Potential Indicator(s):</b> Number of 6-12<sup>th</sup> grade DPS students meeting Moderate to Vigorous Physical Activity (MVPA) recommendations (60 minutes, 7 days per week); integration of ‘Healthy Schools’ designation to DPS healthy policies, including the DPS Health Agenda.</p>		
<b>Strategies</b>	<b>SMART Objectives</b>	<b>Data Sources/Results</b>
A. Develop and integrate a “Healthy Schools” designation into Denver Public Schools (DPS) healthy policies, including the DPS Health Agenda.	By 12/31/2014, incorporate sustainable program for “Healthy Schools” designation into DPS Health Agenda.	<ul style="list-style-type: none"> <li>• “Healthy Schools” designation integrated into DPS Health Agenda</li> </ul>
B. Conduct analyses of student Moderate to Vigorous Physical Activity (MVPA) in DPS, using the System for Observing Fitness Instruction Time (SOFIT) measurement system.	By 8/1/2014, complete MVPA analysis of DPS elementary, middle and high school students, using SOFIT.	<ul style="list-style-type: none"> <li>• SOFIT Data collected in DPS elementary, middle, and high schools</li> <li>• MVPA analysis completed using SOFIT data</li> </ul>
C. Support DPS adherence to state-mandated MVPA in schools; support schools to make free time and physical activity more productive.	By 6/1/ 2014, align five DPS policies with state-mandated MVPA.	<ul style="list-style-type: none"> <li>• DPS policy review related to MVPA completed</li> </ul>
<p><b>Best practices that may inform strategies:</b> Best practices for increasing quality and quantity of physical activities in schools, e.g. lunch after recess, improving recess equipment, involving the private sector to donate equipment, optimal scheduling of physical education and recess, ensuring that all students are active at least 50% of the time in physical education classes.</p>		

**Objective H4: Increase quality physical education and opportunities for moderate to vigorous physical activity in schools.**

Action Steps	Organization Responsible	Target Date	Status	Anticipated Outputs
Meet with stakeholder, businesses, and community partners to gain commitment to improving access to free time/recess equipment.	Denver Public Schools, Denver Environmental Health, Denver Public Health	3/1/2014	Ongoing	Ideas and commitment of support from stakeholders.
Evaluation team will meet with stakeholders to refine SMART objectives for strategies and make an evaluation plan.	Denver Environmental Health, Denver Public Health, various stakeholders	3/1/2014	Ongoing	SMART objectives refined for each strategy, evaluation plan made.
Review DPS wellness policies to plan for “Healthy School” designation.	Denver Public Schools, Denver Environmental Health, Denver Public Health	6/1/2014	Ongoing	DPS wellness policies evaluated.
Meet with DPS wellness groups and champions to gather input.	Denver Public Schools, Denver Environmental Health	8/1/2014	Ongoing	Input gathered from advocacy groups.
Launch “Healthy School” program and encourage and assist individual schools to implement the options that best fit their needs.	Denver Public Schools, Denver Environmental Health	9/1/2014	Ongoing	“Healthy School” program launched, schools choose options.
Award “Healthy School” designation that can be displayed on website, in newsletters, etc.	Denver Public Schools	9/1/2014-ongoing	Ongoing	Schools receive “Healthy School” designation and provide an example for other schools to do the same.

**Objective H5: Increase access to healthy foods and beverages in schools.**

**Lead Entity:** Denver Public Schools (DPS).

**Supporting Entities:** Denver Environmental Health, Denver Public Health, Denver Office of Children's Affairs.

**Potential Indicator(s):** Number of schools that implement Healthy School recommendations; number of recommendations implemented per school; number of schools that achieve the Healthy School designation.

Strategies	SMART Objectives	Data Sources/Results
A. Identify nutritional best practices for providing foods and beverages at schools.	By 6/1/2014, select 1-2 nutritional best practices for DPS prioritization and implementation.	<ul style="list-style-type: none"> <li>• Review of nutritional standards</li> <li>• Best practices prioritized</li> </ul>
B. Improve Denver Public Schools policies regarding nutritional standards for foods and beverages sold or provided through schools.	By 6/1/2014, identify DPS policies for foods and beverages where best practices could be incorporated and nutritional standards improved.	<ul style="list-style-type: none"> <li>• DPS policy review conducted</li> <li>• Policies identified for improvement</li> </ul>

**Best practices that may inform strategies:** Best practices for increasing healthy foods and beverages in schools, e.g. 20 minutes in the chair for lunch with staff supervision, breakfast in the classroom, breakfast before the bell, restricting unhealthy vending, creating “Junk Free Zones”, water jet installations near cafeterias to encourage water consumption, farm to school programs.

Action Steps	Organization Responsible	Target Date	Status	Anticipated Outputs
Meet with stakeholders, political leaders, businesses, and community partners to gain commitment.	Denver Public Schools, Denver Environmental Health, Denver Public Health	3/1/2014	Ongoing	Commitment of support from stakeholders. Create work plan. Create evaluation plan.
Evaluation team will meet with stakeholders to refine SMART objectives for strategies.	Denver Environmental Health, Denver Public Health, various stakeholders	3/1/2014	Ongoing	SMART objectives refined for each strategy.
Identify resources to develop and implement nutritional standard policies.	Denver Public Schools, Denver Environmental Health, Denver Public Health	6/1/2014-12/1/2018	Ongoing	Nutritional standards identified.

**CITY GOVERNMENT**

**Objective H6: Incorporate health considerations and analysis in city policy, processes, and planning.**

**Lead Entity:** Denver Environmental Health.  
**Supporting Entities:** Denver Public Health, Denver Community Planning and Development (CPD), Denver Public Works Department, Denver Budget Management Office.  
**Potential Indicator(s):** Number of Health Impact Assessments (HIA) conducted to support neighborhood plans and major developments; adoption and utilization of a health tool by the Budget Management Office to determine health impact for capital improvement projects; inclusion of health in Denver’s 2014 Comprehensive Plan.

Strategies	SMART Objectives	Data Sources/Results
A. Implement healthy vending policies and practices in city buildings and worksites.	By 12/31/2015, develop Denver Healthy City Vending Policy and implementation plan for city buildings and worksites.	<ul style="list-style-type: none"> <li>• Healthy vending standards</li> <li>• Healthy vending plans from other cities</li> <li>• Denver Healthy City Vending Policy and implementation plan</li> </ul>
B. Promote the inclusion of health considerations in Denver’s 2014 Comprehensive Plan.	By 12/31/2014, provide input to CPD about incorporating health considerations in the 2014 Comprehensive Plan.	<ul style="list-style-type: none"> <li>• 2014 Comprehensive Plan includes health considerations</li> </ul>
C. Promote a city health impact prioritization policy for use in evaluating capital improvement projects.	By 12/31/2014, complete a scan of other municipalities and identify best practices for establishing health policies for capital improvement planning and budgets.	<ul style="list-style-type: none"> <li>• Scan and best practices completed</li> </ul>
D. Establish a set of potential criteria, processes, and tools for use in budget processes for determining the health impacts of capital improvement projects.	By 12/31/2015, develop and submit a proposed health assessment process to the Budget Management Office for use in a budget package for all capital improvement projects.	<ul style="list-style-type: none"> <li>• Health assessment process developed and submitted to the Budget Management Office</li> </ul>
E. Engage other city departments in developing a plan for expanding the use of health impact assessments to inform neighborhood plans, as adopted by the Denver City Council in its 2014 Priorities.	By 12/31/2014, in conjunction with other city agencies, develop a plan for expanding the use of health impact assessment in neighborhood plans.	<ul style="list-style-type: none"> <li>• Plan developed and shared with other city agencies</li> <li>• Minimum standards and best practices guides for HIAs</li> </ul>
F. Complete a Health Impact Assessment (HIA) in partnership with other city departments.	By 12/31/2014, complete one HIA to inform a neighborhood plan.	<ul style="list-style-type: none"> <li>• HIA completed</li> </ul>

**Objective H6: Incorporate health considerations and analysis in city policy, processes, and planning.**

**Best practices that may inform strategies:** Best practices in other cities for incorporating health in comprehensive plans, Health In All Policies (HIAP) recommendations, established Health Impact Assessment (HIA) standards and best practices, Healthy Places Assessment Tool (H-PAT).

Action Steps	Organization Responsible	Target Date	Status	Anticipated Result
Meet with stakeholders, political leaders, businesses, and community partners to gain commitment.	Denver Environmental Health, Denver Public Health	12/31/2014	Open	Commitment of support from stakeholders.
Draft a timeline, work plan and recommendations for the City & County of Denver to incorporate health into city policies.	Denver Environmental Health, Denver Public Health	12/31/2014	Open	Timeline, work plan, and recommendations made.

**Objective H7: Develop and implement a targeted Be Healthy Denver marketing campaign for Healthy Eating and Active Living (HEAL).**

**Lead Entities:** Denver Environmental Health, Denver Public Health.

**Supporting Entities:** Denver Mayor’s Office, State of Colorado, media organization(s), other local public health agencies.

**Potential Indicator(s):** HEAL branding schemes reviewed and selected; number of hits to BeHealthyDenver.org or HEAL brand website.

Strategies	SMART Objectives	Data Sources/Results
A. Identify common and comprehensive HEAL messaging to improve physical activity and nutritional behaviors in Denver.	By 12/31/2013, identify HEAL stakeholders and partners. By 4/1/2014, convene Messaging Committee.	<ul style="list-style-type: none"> <li>• HEAL stakeholders identified</li> <li>• Messaging Committee convened</li> <li>• Messaging Committee meetings held</li> </ul>
B. Develop a HEAL brand for Denver to align HEAL efforts and activities among obesity prevention partners in Denver.	By 4/1/2014, identify resources to support HEAL branding for Denver.	<ul style="list-style-type: none"> <li>• Resources identified for HEAL branding</li> </ul>
C. Create a call to action for obesity prevention partners to adopt the HEAL messaging campaign.	By 3/1/2014, complete a draft call to action to adopt HEAL messaging campaign.	<ul style="list-style-type: none"> <li>• Call to action draft completed</li> </ul>

**Best practices that may inform strategies:** Best practices in other cities for successful HEAL messaging.

Action Steps	Organization Responsible	Target Date	Status	Anticipated Output
Meet with stakeholders, political leaders, and community partners to brainstorm ideas and gain commitment and develop work plan.	Denver Environmental Health, Denver Public Health, various stakeholders	4/1/2014	Ongoing	Commitment and support from stakeholders, work plan developed.
Identify resources to champion HEAL messaging.	Denver Environmental Health, Denver Public Health	2/1/2014	Ongoing	Resource plan developed.

## ACRONYMS

Acronym	Full Name
ACA	Patient Protection and Affordable Care Act (2010)
ACC	Accountable Care Collaborative
ACS	American Community Survey
AwDC	Adults without Dependent Children
BHO	Behavioral Health Organization
BMI	Body Mass Index
BRFSS	Behavioral Risk Factor Surveillance System
CAAS	Certified Application Assistance Site (for Medicaid benefits in Colorado)
CAHEP	Colorado Alliance for Health Equity and Practice
CALPHO	Colorado Association of Local Public Health Officials
CBMS	Colorado Benefits Management System
CCDP	Cancer, Cardiovascular Disease and Chronic Pulmonary Disease Prevention, Early Detection, and Treatment Grant Program, CDPHE
CDC	Centers for Disease Control and Prevention
CDPHE	Colorado Department of Public Health and Environment
CFMA	Colorado Farmers Market Association
CHA	Community Health Assessment
CHAS	Colorado Health Access Survey
CHIP	Community Health Improvement Plan
CHP+	Child Health Plan Plus Program
CICP	Colorado Indigent Care Program
CIVHC	Center for Improving Value in Health Care
CMMI	Center for Medicare and Medicaid Innovation
CPD	Community Planning and Development, City and County of Denver
CO4F	Colorado Fresh Food Financing Fund
COHID	Colorado Health Information Dataset
CORHIO	Colorado Regional Health Information Organization
DEH	Denver Environmental Health
DHHA	Denver Health and Hospital Authority (Denver Health)
DHHS	U.S. Department of Health and Human Services
DPH	Denver Public Health
DPS	Denver Public Schools
EBNE	Eligible But Not Enrolled
EBT	Electronic Benefit Transfer
ECE	Early Childhood Education
ESI	Employer Sponsored Insurance
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
HCPF	Health Care Policy and Financing, State of Colorado
HEAL	Healthy Eating and Active Living
HIA	Health Impact Assessment
HIAP	Health in All Policies
HKCS	Healthy Kids Colorado Survey
H-PAT	Healthy Places Assessment Tool
HSI	Health Status Index
IHI	Institute for Healthcare Improvement

Acronym	Full Name
IOM	Institute of Medicine
MHCD	Mental Health Center of Denver
MVPA	Moderate to Vigorous Physical Activity
NACCHO	National Association of County and City Health Officials
NCHS	National Center for Health Statistics
NPHPS	National Public Health Performance Standards
OED	Office of Economic Development, City and County of Denver
PCP	Primary Care Provider
PEAK	Colorado Program Eligibility and Application Kit
RCCO	Regional Care Collaborative Organization
SBIRT	Screening, Intervention, and Referral to Treatment
SOFIT	System for Observing Fitness Instruction Time
SFPC	Denver Sustainable Food Policy Council
SNAP	Supplementary Nutrition Assistance Program
SRTS	Safe Routes to School
SSB	Sugar Sweetened Beverage
TOD	Transit Oriented Development
TOT	Training of Trainers
UNICEF	United Nations Children's Fund
USDA	United States Department of Agriculture
WHO	World Health Organization

## ENDNOTES

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