



**DENVER
HEALTH™**

— est. 1860 —

FOR LIFE'S JOURNEY

Community Health Needs Assessment 2026



TABLE OF CONTENTS

LETTER FROM THE CHIEF EXECUTIVE OFFICER	1
EXECUTIVE SUMMARY	2
Purpose	
Methods	
Priority Health Needs	
Next Steps	
INTRODUCTION AND BACKGROUND OF DENVER HEALTH	3
METHODS AND PROCESS	4
Defining Our Community	
Community Health Needs Assessment Data Collection	
Primary Data Collection	
Secondary Data Collection	
Identification and Prioritization of Denver Community Health Needs	
SUMMARY FINDINGS	7
Community Served: City and County of Denver	
Population Profile	
Age Distribution and Demographics	
Race, Ethnicity, Language, and Country of Birth	
Education, Employment, and Income	
Healthcare Implications	
Secondary Data	
Denver County Healthy Rankings	
Leading Causes of Death	
Life Expectancy	
Disability	
Key Chronic and Mental Health Conditions	
Health Risk Behaviors	
Maternal Health	
Behavioral Health: Mental Health and Substance Misuse	
Violence and Injury	
Healthcare Insurance and Access	

TABLE OF CONTENTS CONT'D

Telehealth
Preventative Care
Health Related Social Needs
Leading Causes of Death
Community Connectedness/Social Support
Homelessness
Food Insecurity

COMMUNITY ENGAGEMENT: MOVING TOWARDS PRIORITIES 20

Results: Identified Health Priorities
Public Survey
Public Forum: Community Health Needs Assessment Feedback
Limitations and Areas Not Addressed

CONCLUSIONS 24

ACKNOWLEDGEMENTS 25

REFERENCES 26

APPENDICES 28

Appendix A: Denver Health Community Benefit Annual Public Meeting
Appendix B: Denver Health Community Benefit Public Survey
Appendix C: Facilitated Denver Health Community Benefit Public Survey Conversation
Appendix D: Members of the Denver Health Community Benefit Steering Committee

LETTER FROM THE CHIEF EXECUTIVE OFFICER

DEAR DENVER COMMUNITY,

It is my pleasure to share our 2026 Community Health Needs Assessment.

Denver Health has served a vital role in the community since 1860. It is our longstanding mission to care for all in the community regardless of the ability to pay, including patients from more than 190 countries speaking over 136 languages. Between our level one trauma hospital, 11 federally qualified health centers, 19 school-based clinics, mobile vans, behavioral health, public health and numerous other specialty services and institutes, Denver Health provides unparalleled lifesaving and life-sustaining support.

We appreciate the thoughtful feedback and insights shared by community members and local organizations that went into this 2026 Community Health Needs Assessment. Through this process, we identified four priority areas that address the diverse social and economic barriers to healthcare faced by our patients:

- Access to Care
- Cost of Care and Insurance
- Behavioral Health (Mental Health and Substance Use)
- Housing and Homelessness

These priorities will help guide the objectives, projects, and metrics in our next Community Health Implementation Plan.

With new provisions of H.R.1 set to take effect January 2027, it will take continued collaboration to address the ongoing needs of our community. These provisions threaten healthcare and will likely lead to thousands of patients losing their Medicaid coverage over the next several years. Denver Health will continue to do all it can to serve our community and keep patients on Medicaid, but we can't do it alone.

Thank you for your continued partnership. We are stronger together.

With gratitude,



Donna Lynne, DrPH Chief Executive Officer

PURPOSE

In 2019 Colorado passed House Bill 19-1320 that aimed to increase community benefit transparency and accountability among Colorado hospitals^{18,20}. This legislation expanded the requirements of a Community Health Needs Assessment (CHNA) and implementation plan every three years to include the Denver Health and Hospital Authority (DH) and the University of Colorado Hospital, in addition to non-profit hospitals already mandated to do Community Health Needs Assessments. Under this legislation, hospitals are also required to provide annual financial and activity reports and hold an annual public meeting to gain input on implementation of planned activities.

In accordance with House Bill 19-1320, Denver Health produced its first CHNA in 2020 and has been reporting progress on addressing prioritized needs annually. This latest 2026 Denver Health CHNA provides an updated portrait of the Denver community, and the needs as stated by community members that will be used to organize and focus Denver Health's community benefit efforts for the next three years (2026-2029).

METHODS

This CHNA is informed by data, opinions and perspectives collected directly from individual community members and individuals who represent various Denver-area constituencies, as well as secondary data from local, state, and national sources. The collection of community data included surveys, focus groups and public conversations. The internal Denver Health Community Benefit Steering Committee considered factors of health condition burden, health disparities, community priorities, evidence-based strategies for addressing needs, and staff and financial resources to identify the top three priorities for the current CHNA. The group ultimately gained approval from the community through the public meeting process.

PRIORITY HEALTH NEEDS

Via the inputs listed above, community members prioritized four areas to be considered as priorities. After review by the Denver Health Community Benefit Steering Committee and approval during the public forum, the four priority areas of focus for the current CHNA are:

- Access to Care
- Cost of Healthcare and Insurance
- Behavioral Health (Mental Health and Substance Use)
- Housing and Homelessness

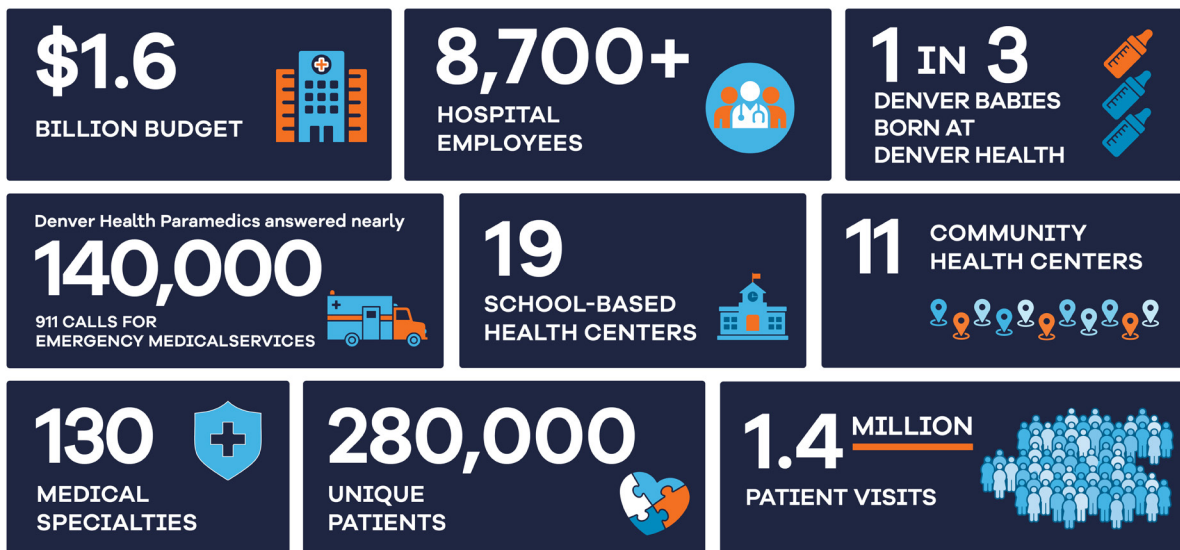
NEXT STEPS

Over the next year, the Denver Health Community Benefit Steering Committee will work with internal and external partners and community stakeholders to develop our Community Benefit Implementation Plan that will address these prioritized needs, including key metrics for measurement.

INTRODUCTION AND BACKGROUND OF DENVER HEALTH

Denver Health is a fully integrated academic safety-net healthcare system serving the city and county of Denver. Denver Health is a Level 1 trauma center with a 525-bed hospital, 11 federally qualified health centers (FQHCs) in neighborhoods throughout Denver, three mobile units, three urgent care centers, 19 Denver school-based health clinics, and many other specialized services. Those services include our LGBTQ+ Health Services and the Center for Addiction Medicine that contains both an outpatient behavioral health services arm and an emergency and residential detoxification facility. In addition, DH provides care for persons in the Denver correctional and jail facilities. DH uses an integrated electronic health record (EHR), Epic, to support performance improvement for patient care as a Learning Health System. In addition, DH manages a non-profit insurance plan, the 911 medical response system for the City and County of Denver, the Rocky Mountain Poison and Drug Center, and a Public Health Institute.

Denver Health at-a-glance



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The Denver Health system is nationally recognized for our mission to deliver high-quality care to all, regardless of their ability to pay. Denver Health's integrated system provides opportunities to influence community well-being coupled with community engagement, a core organizational competency as a Learning Health System. To do this well, Denver Health works with a broad range of community partners: Denver Public Schools (DPS), neighborhood associations, social service agencies, other government agencies, and community-based organizations that serve vulnerable populations.

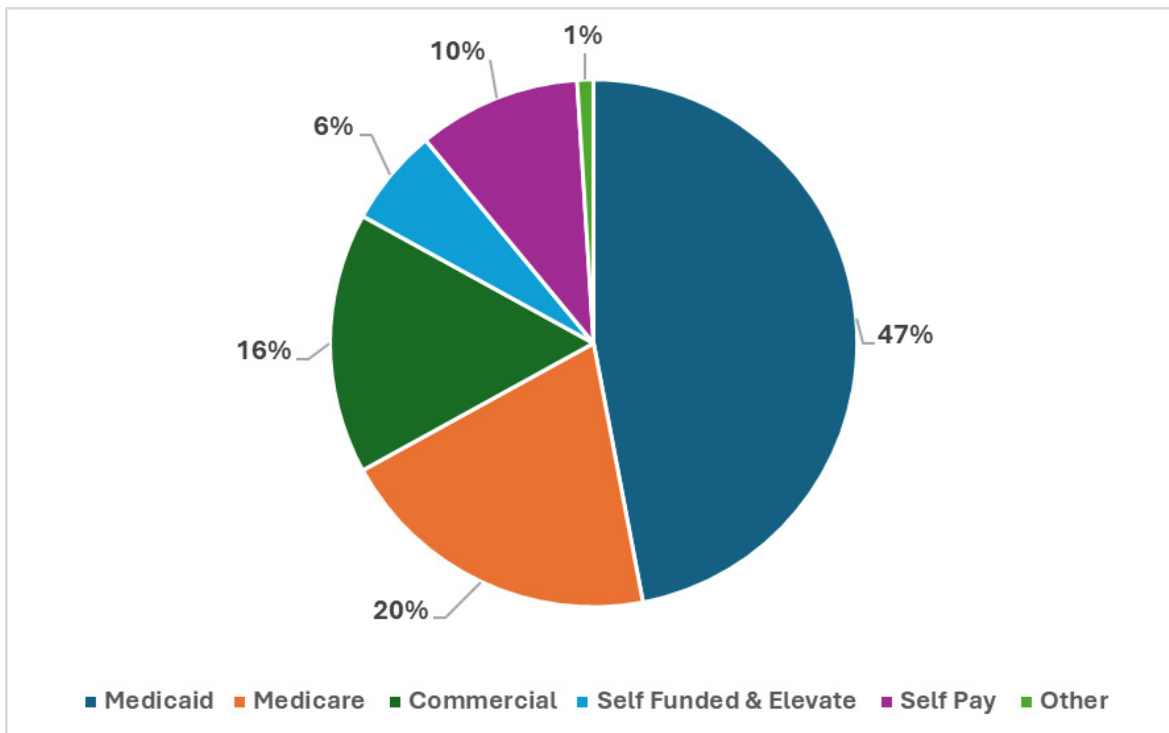
DEFINING OUR COMMUNITY

In 2025, Denver Health served close to 280,000 unique individuals across more than 1.4 million visits, reinforcing its role as the safety-net provider and health care backbone of the Denver community. Consistent with our longstanding mission to provide high-quality care to all who walk through our doors, regardless of ability to pay, Denver Health serves one of the most diverse and vulnerable patient populations in the region.

The depth of need within our community is reflected in the complexity of the population we serve. In 2025, Denver Health identified approximately 14,000 patients experiencing homelessness and 14,500 patients facing food insecurity, two of the most significant social determinants of health driving poor health outcomes. Nearly 70,000 patients in our total population were uninsured, collectively accounting for 193,000 clinical encounters throughout the year. The emergency department alone recorded 117,000 unique visits in 2025, underscoring the critical role Denver Health plays as a point of access for individuals who may have no other option for care.

The financial landscape of Denver Health's patient population further illustrates the scope of community need. As highlighted in the payer mix below, many of Denver Health's patients are covered through Medicaid and Medicare; both public payer programs typically reimburse below the true cost of care. Combined with the significant volume of uninsured patients served, this reliance on public payer sources resulted in approximately \$145 million in uncompensated care provided to the community in 2025. This figure is not simply a financial data point; it is a tangible measure of Denver Health's unwavering commitment to healthcare access for all residents of Denver, regardless of their socio-economic circumstances.

2025 PAYER MIX



COMMUNITY HEALTH NEEDS ASSESSMENT DATA COLLECTION

PRIMARY DATA COLLECTION

Primary data collection was conducted by hearing community perspectives on top health concerns in Denver. Three different strategies were employed, including a publicly advertised meeting, a survey distributed to hundreds of community contacts, and through facilitated conversations with community members at several forums. More specifically:

- Denver Health’s annual community benefit public meeting was shared and advertised at the facilitated conversations (described below), posted on Denver Health’s public website, published in LaVoz, and sent via email to community contacts.
- Surveys for community members and community organizational leaders were distributed via email, QR codes on TV screens across campus, and delivered through physical copies to the Access Transformative Outreach Program (ATOP). Additionally, 1:1 interactions were focused in the OB/GYN clinics and Primary Care settings.
- Participants in the meetings and surveys were asked to identify the top health concerns of their community, as well as what areas they believe Denver Health could impact.
- A facilitated conversation, based on the above survey, was also conducted within the DH Center for Addiction Medicine Community Advisory Meeting (CAM CAM), Community Advisory Panel (CAP), and the four Affinity Groups listed below:
 - LGBTQ+ Leaders
 - Black Leaders
 - Asian and Pacific Islander Leaders
 - Latino Leaders

Community Input

In-Person Discussion - 197 People

Survey Respondents - 230 People

Community members and partners included representatives from local and state government, community and service organizations, health and mental health services, advocacy groups, small businesses, the education sector, patients of Denver Health, and members of the community across the city and county of Denver. Comprehensive data on community forums, survey respondents, and results are available in Appendices A-C.

SECONDARY DATA COLLECTION

This report aims to provide detailed sociodemographic and health statistics for the Denver County population that are relevant to identifying top needs for marginalized populations. When possible, the Denver data is compared to data for the state of Colorado and the United States.

IDENTIFICATION AND PRIORITIZATION OF DENVER COMMUNITY HEALTH NEEDS

Identification and prioritization of needs were determined through a systematic process that considered primary and secondary data, organizational expertise, and review by a dedicated Denver Health Community Benefit Steering Committee with final confirmation from the community through the public meetings. The DH Steering Committee is made up of executive and clinical leaders across the Denver Health system, representing in-patient and ambulatory care, specialty care, government affairs, community impact, patient experience, quality improvement, behavioral health, and research (Appendix D). The Committee is responsible for assessing priority areas and developing a 3-year Community Benefit Implementation Plan and supporting annual reporting. The Steering Committee reviewed the input from all primary data streams and analyzed based on what trends were seen, if Denver Health could impact that priority area, and the changing healthcare landscape. This information was also reviewed during the public meeting for final approval. The Implementation Plan will include more detailed processes and outcome metrics.



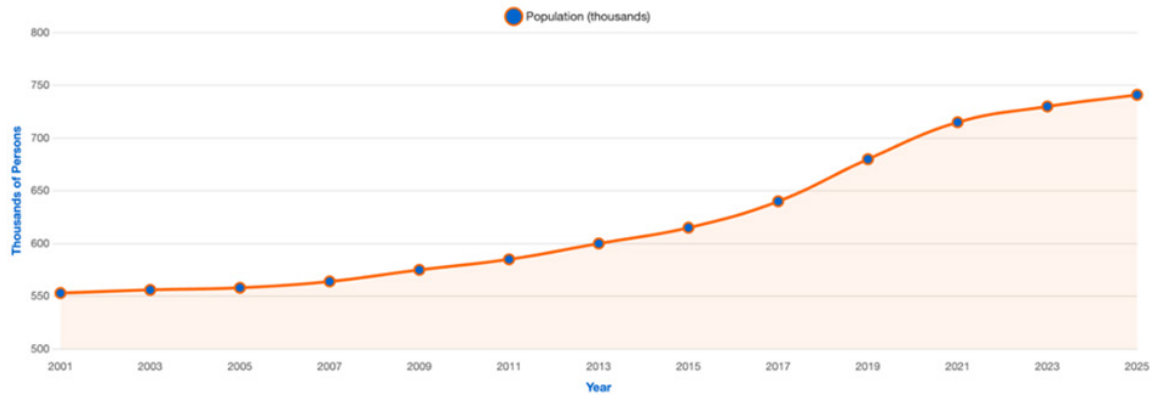
SUMMARY FINDINGS

COMMUNITY SERVED: CITY AND COUNTY OF DENVER

Population Profile

The current population for the City and County of Denver is an estimated 740,613 individuals. This represents a 3.5% increase over the last five years, indicating steady growth and demographic vitality in the region³⁰.

Growth Trend Resident Population in Denver County/City, CO (2001-2026)

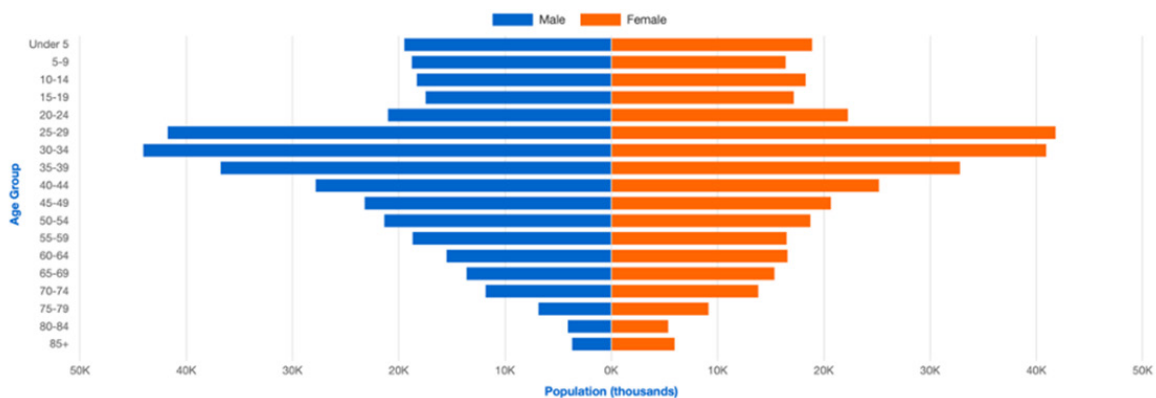


Age Distribution and Demographics

The median age in Denver County is 35.6 years, which is lower than the Colorado state average of 38 years³⁷. Most individuals are between 25 and 34 years of age, reflecting Denver's appeal as a destination for young professionals and families. The population is relatively evenly distributed between males and females, with 365,977 (50.7%) males and 355,900 (49.3%) females.

Although the demographic data shows that Denver has a young population, projection data shows that the population over 65 is the only population that is growing in Denver in the next 10 years. This age demographic data has important implications for healthcare delivery, employment patterns, and community services planning.

Age Distribution Population Pyramid: Population by Age and Sex in Denver County



United States Census Bureau. (2024). American community survey 5-year estimates, 2024. <https://data.census.gov/>

Race, Ethnicity, Language, and Country of Birth

Race/Ethnicity	Percentage
Non-Hispanic White	54.6%
Hispanic or Latino	28.3%
Black or African American	10.2%
Asian	4.6%
Two or More Races	3.7%
American Indian	1.8%

United States Census Bureau. (2024). American community survey 5-year estimates, 2024. <https://data.census.gov/>

Many Denver residents speak English only at home while many speak Spanish, Indo-European, Asian and Pacific Islander, and other languages. This linguistic diversity reflects Denver's position as a welcoming community for immigrants and diverse populations.

Languages spoken at home	Percentage
English only	75.5%
Spanish	17.6%
Other Indo-European languages	3.0%
Asian and Pacific Islander languages	2.1%
Other languages	1.8%

United States Census Bureau. (2024). American community survey 5-year estimates, 2024. <https://data.census.gov/>

Education, Employment, and Income

Denver has a notably well-educated population. Among residents aged 25 and older, a majority hold a bachelor's degree or higher, well above the Colorado state average. Meanwhile, others have a high school diploma or equivalent, some have attended college without earning a degree, and a portion hold an associate's degree, reflecting a strong overall emphasis on higher education within the city³⁷. Colorado is known for the education paradox, where a large percentage of degrees are people that migrate into the state.

Education Attainment (Population 25 Years and Older)	Percentage
High school or equivalent degree	14.3%
Some college, no degree	13.4%
Associate's degree	5.1%
Bachelor's degree	34.3%
Graduate or professional degree	24.3%

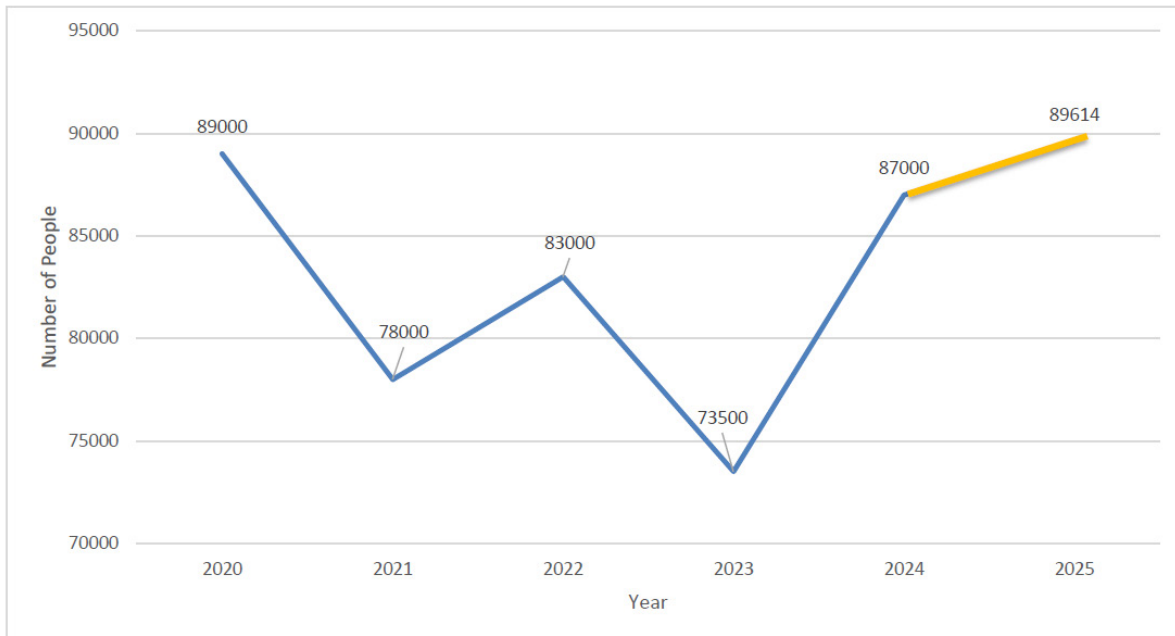
United States Census Bureau. (2024). American community survey 5-year estimates, 2024. <https://data.census.gov/>

SUMMARY FINDINGS CONT'D

Of Denver's residents ages 16 and older, 70.6% are employed and 29.4% are not in the labor force³⁷. An estimated 12.1% of Denver residents are living at or below the poverty line. This rate has increased over the past years, while Denver County's population has also increased, leading to a significant rise in the number of residents in poverty³⁰. The median household income in Denver is \$92,504, which is slightly lower than the state median of \$97,113. However, the cost of living in Denver tends to be higher than in other areas of Colorado.

Estimate of People Living Below the Poverty Line in Denver County

The yellow line on the graph below highlights the projection for 2025.



Federal Reserve Bank of St. Louis. (n.d.) FRED Population Data. <https://fred.stlouisfed.org/>

The median rent in Denver County is \$1,870, which is slightly higher than the state average of \$1,822. However, homeownership is significantly less in Denver County compared to the rest of the state, at 48.1% and 65.9%, respectively. This shows that it is more difficult for Denver residents to own their own home and build equity towards a more stable future. Over the last 5 years, Denver has become far more expensive. The Consumer Price Index has risen from 272.207 in 2020 to 335.070 in 2025, which is a 23% increase.

Healthcare Implications

Employment status, income, race, ethnicity, and education are all social determinants that affect the health of individuals and communities. Healthcare access is a critical issue for Denver Health's service population. About 27% of Denver County residents are enrolled in Medicaid; nearly half of Denver Health's patients rely on it, 47% of the system's revenue comes from Medicaid³⁷. Additionally, the current uninsured rate in Denver County stands at 9.3%³⁸.

Medicaid

IN DENVER:

27%

AT DENVER HEALTH:

47%

Uninsured

IN DENVER:

9.3%

AT DENVER HEALTH:

17%

With anticipated reductions in Medicaid enrollment due to federal policy changes, Denver Health is likely to face serious financial and operational challenges. A decline in coverage will likely increase the uninsured population, placing additional strain on safety-net services while reducing a major source of revenue, ultimately impacting the system's ability to provide care to vulnerable communities.

SECONDARY DATA

Data comparing health behaviors and health conditions among residents in Denver County to other counties in Colorado⁴¹ and the United States^{8,41} were used to identify areas with greatest opportunity for improvement. In general, Colorado is known as a healthy state, but disparities exist. Specific metrics of greater concern (i.e., greater burden or lower positive health behavior) in Denver compared to other Colorado counties and/or national statistics were identified, and included:

- Access to Care and Health Insurance
- Behavioral Health (Mental Health and Substance Misuse)
- Firearm Fatalities, Suicide, Homicides
- Food Insecurity
- Housing Instability/Homelessness
- Low Birthweight Babies
- Life Expectancy
- Social Connectedness and Social Support

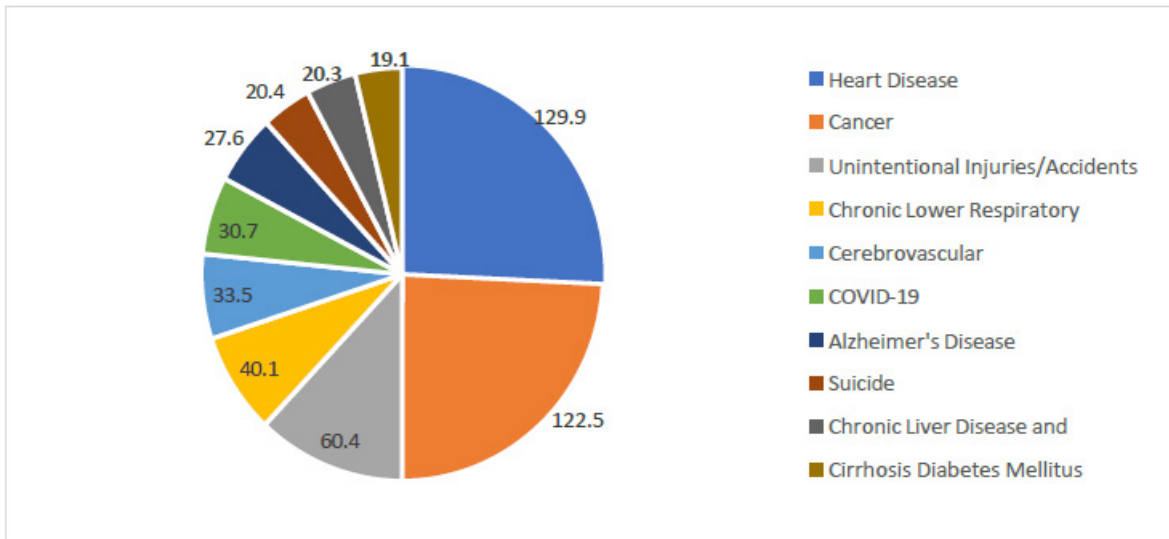
Denver County Health Rankings

County Health Rankings measures health outcomes and health factors, including health behaviors, clinical care, social and economic factors, and physical environment. The most recent annual County Health Rankings available for Denver County remains the 2025 release, which places Denver in the middle tier of Colorado counties on health outcomes and the lower-middle tier on health factors²⁵. The county's largest challenges are associated with social and economic conditions, including income inequality, child poverty, and housing cost burden.

Leading Causes of Death

The most recent county-level leading causes of death were released in 2022; the lag is due to the verification of death certificates. The data from 2022 showed heart disease (129.9/100,000 persons) and cancer (122.5/100,000 persons) as the top two leading causes of death in Denver County, followed by unintentional injuries (60.4/100,000 persons), chronic lower respiratory diseases (40.1/100,000), and cerebrovascular diseases/stroke (33.5/100,000)¹⁷. At the statewide level there is more recent mortality data from 2023 showing cancer surpassed heart disease as Colorado's leading cause of death for the first time in several years, reflecting a longer-term trend that may be emerging at the county level as well¹⁷. Non-health-related leading causes of death in Denver include drug overdoses, suicide, motor vehicle accidents and homicide.

Leading Causes of Death, Denver County, 2022.



Numbers represent rates per 100,000 population.

Colorado Department of Public Health and Environment. (2023). Colorado health information dataset (CoHID): Mortality data, Denver County, 2022. <https://cdphe.colorado.gov/cohid>

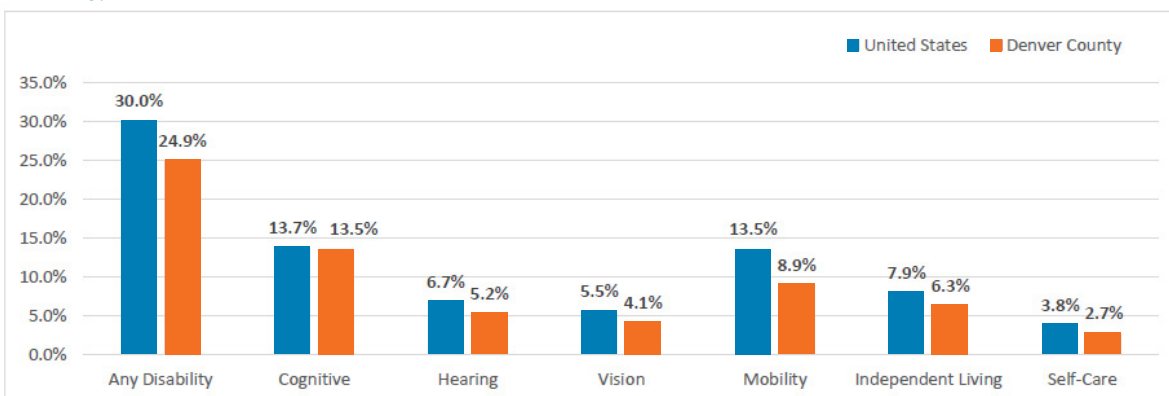
Life Expectancy

According to the CDC’s most recent report, Colorado ranked approximately 11th in the United States for life expectancy at birth²⁴. Colorado’s life expectancy has improved in recent reporting, reaching 80.4 years in 2024, up from 79.9 in 2023²⁵. In Denver County, life expectancy still varies sharply by neighborhood, reflecting longstanding inequities tied to structural racism, the built environment, air pollution, access to healthy food, housing conditions, and access to healthcare resources.

Disability

An estimated 24.9% of Denver County residents have one or more disabilities, which is lower than national estimates across all types of disabilities⁸. Disabilities can include challenges with cognition, hearing, vision, physical mobility, independent living, and self-care.

Proportion of the population ≥18 years with a disability, United States and Denver County, 2023

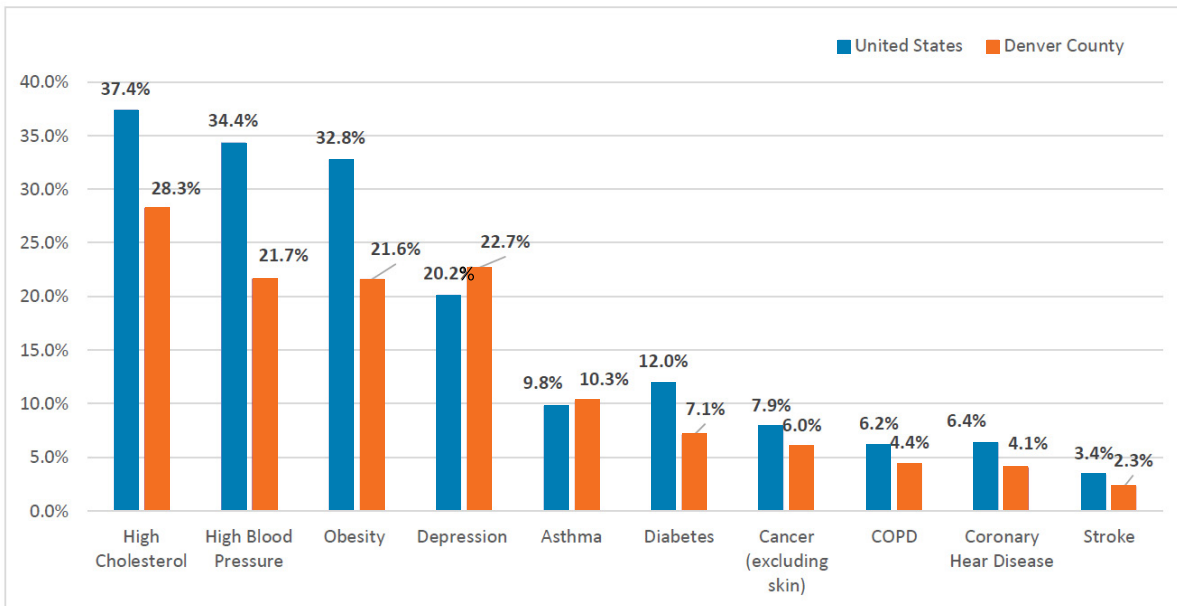


Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. (2025). PLACES data. <https://www.cdc.gov/PLACES>

Key Chronic and Mental Health Conditions

Generally, adult Denver County residents have lower rates of most key chronic health conditions than the overall U.S. population, including lower rates of high blood pressure, obesity, diabetes, heart disease, and stroke (2023)⁸. However, Denver residents report higher rates of depression, affecting approximately 22.7% of adults; this is above the national estimate of 20.2%. Asthma rates (10.8%) are slightly higher in Denver County as compared to trends seen across the nation.

Prevalence (%) of adults ≥18 years of age with key chronic conditions, United States and Denver County, 2023



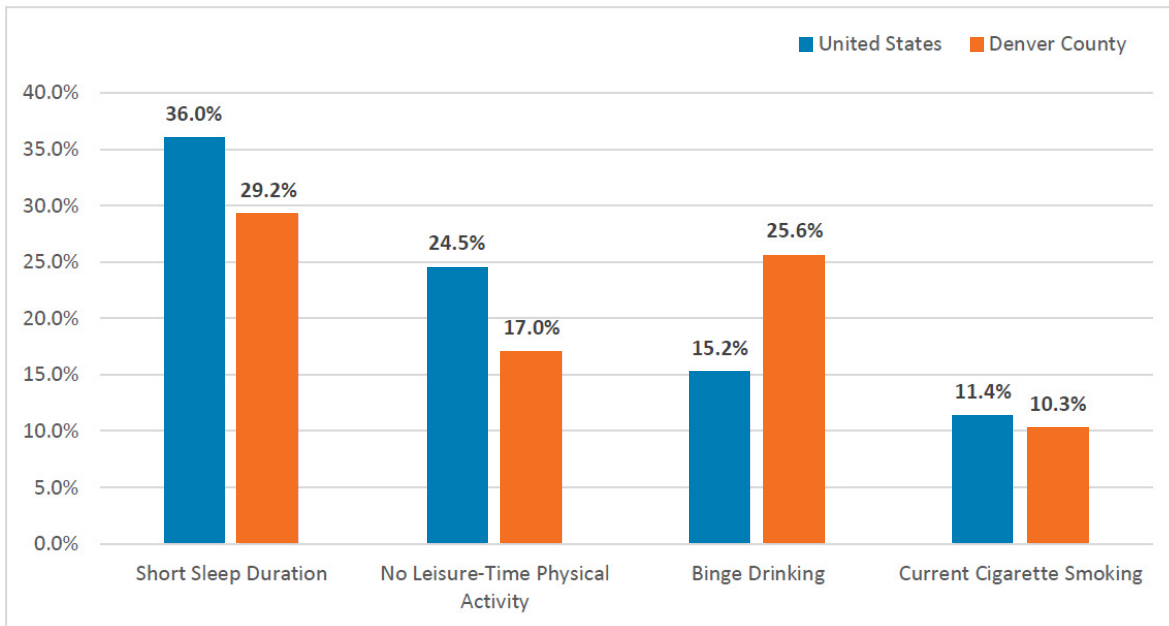
Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. (2025). PLACES data. <https://www.cdc.gov/PLACES>

Health Risk Behaviors

Compared to the United States, Denver residents engage in more physical activity and sleep more but have substantially higher rates of binge drinking. This is a persistent and significant gap that warrants targeted intervention⁸.



Prevalence (%) of health risk behaviors among adults ≥18 years of age, United States and Denver County, 2023



Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. (2025). PLACES data. <https://www.cdc.gov/PLACES>

Maternal Health

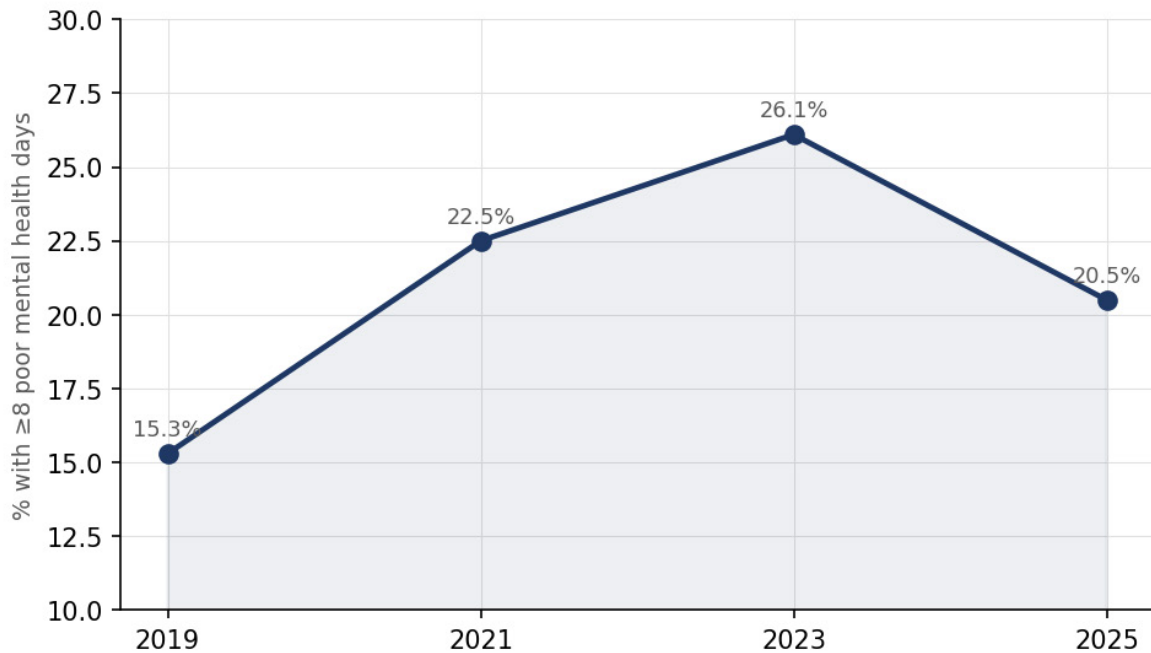
Colorado’s maternal mortality rate was 17 per 100,000 births (2019–2023 average), ranking among the best states nationally. However, maternal morbidity stands at 108.7 per 10,000 delivery hospitalizations, worse than the national rate of 93.1³³. The leading causes of pregnancy-related deaths statewide remain suicide, accidental drug overdose, and obstetric complications¹⁵.

Colorado’s preterm birth rate was 10.0% in 2024, which garnered a grade of C from the March of Dimes; Denver County’s rate (10.3%) is slightly above the state average³². Teen birth rates continue to exceed state and national averages in Denver County, and the low birthweight rate in Colorado (9.74% in 2023) remains among the higher rates nationally⁹.

Behavioral Health: Mental Health and Substance Misuse

The 2025 Colorado Health Access Survey found that 20.5% of Coloradans statewide reported ≥8 days of poor mental health in the previous 30 days, down from a peak of 26.1% in 2023²³. While there are improvements, the Colorado Health Access Survey still revealed that almost 13% of people who needed mental health services could not obtain care. Colorado ranked 41st among states for overall mental health and 14th in the country for access to mental health care³.

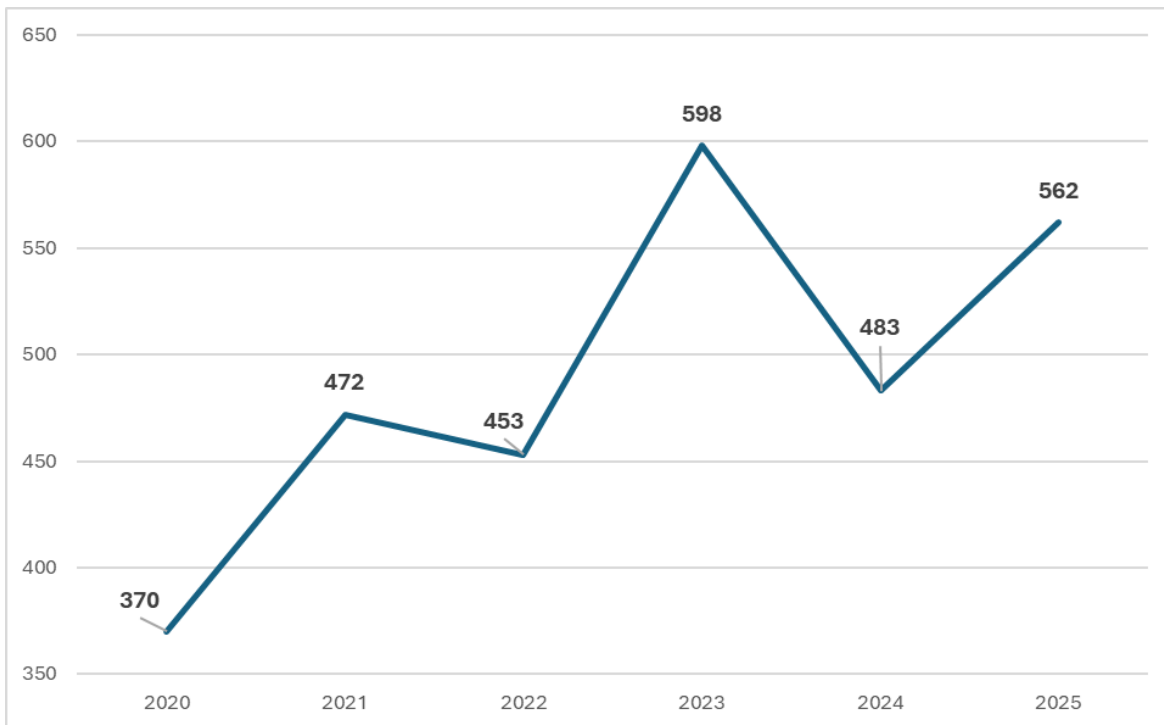
Proportion of Coloradans Reporting ≥ 8 Poor Mental Health Days in Past 30 Days, 2019-2025



Colorado Health Institute. Colorado Health Access Survey, 2019-2025.
<https://www.coloradohealthinstitute.org/research/colorado-health-access-survey-2025>

Drug overdose deaths in Denver reached a century-high level in 2023 before declining modestly in 2024. Preliminary 2025 data show fatal fentanyl overdoses rising again, with approximately 346 fentanyl-involved deaths. This is an increase from 2024, which showed 277 fentanyl-involved deaths²⁸. While on the national stage, U.S. drug overdose deaths fell by 26.2% between 2023 and 2024, the largest single-year decline during the 2014-2024 tracking period¹⁰.

Drug Overdose Deaths, Denver County, 2019-2025 (2025 preliminary)



Denver Department of Public Health and Environment. (2026). Drug overdose data overview. City and County of Denver. <https://www.denvergov.org/files/assets/public/v/2/public-health-and-environment/documents/bphe/drug-overdose-data-overview-presentation.pdf>

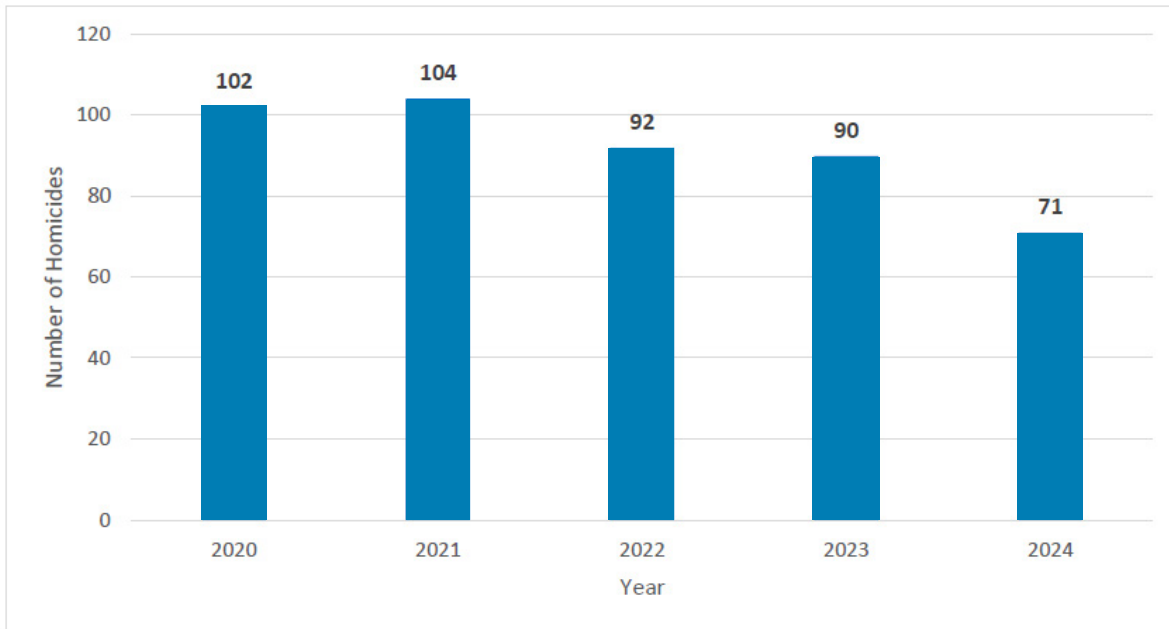
Violence and Injury

Injuries are classified into 3 key categories: preventable (accidental), intentional, and undetermined intent. Most injury-related deaths are preventable. Poisoning is the leading cause of preventable injury-related deaths in the United States, followed by motor vehicle crashes and falls³⁵. In 2024, preventable injuries were responsible for 3,827 deaths in Colorado. The death rates were 25/100,000 for poisoning, 16.9/100,000 for falls, and 13.0/100,000 for motor vehicle crashes.

Suicide rates in Colorado remain among the highest in the nation, estimated at 21.93 per 100,000 (2024)¹⁴. Firearms are involved in approximately 54% of Colorado suicides¹⁴. The statewide firearm injury death rate was 16.6 per 100,000 in 2023¹⁴.

Published data for homicides is only through 2024 and are shown in the figure below. However, despite this progress, domestic violence fatalities across Colorado rose 24% in 2024, with firearms involved in 75% of cases¹².

Homicide Victims, Denver County, 2020-2024



Denver Department of Public Health and Environment, Office of the Medical Examiner. (n.d.). Medical examiner data, City and County of Denver [Data set]. <https://www.denvergov.org/Government/Agencies-Departments-Offices/Agencies-Departments-Offices-Directory/Public-Health-Environment/Medical-Examiner/Medical-Examiner-Data>

Healthcare Insurance and Access

The 2025 Colorado Health Access Survey found Colorado’s overall uninsured rate at 5.9%, a pre-federal-cuts baseline that will likely worsen as 2026 federal subsidy changes take effect²³. Medicaid enrollment fell from 30.0% in 2023 to 21.0% in 2025 following the end of pandemic-era continuous coverage, but Medicaid coverage is predicted to drop in 2027 and beyond due to new federal regulations also causing an increase in uninsured. Denver County’s uninsured rate is estimated at approximately 9.3% in 2024³⁸.

Denver County has substantially better healthcare provider supply than the Colorado state median: Primary Care Provider Ratio 1:767 vs. 1:1,200 statewide; Mental Health Provider Ratio 1:140 vs. 1:230 statewide^{26,41}. Although this is positive data, there are still issues with access to necessary health care, particularly with specialties. Also, despite strong provider supply, racial and ethnic disparities in access persist. Coloradans identifying as Black, Indigenous, or persons of color are 15–26% more likely than non-Hispanic White residents to be unable to make a primary care appointment when needed, and Black and Hispanic Coloradans report avoiding care due to unfair treatment at approximately twice the rate of White non-Hispanic residents²³.

Dentists are slightly scarcer in Denver than statewide, with a Dental Provider Ratio of 1:1,180 compared to 1:1,130 for Colorado, both are better statistics than are seen nationwide (1:1,340)⁴¹. Just under two-thirds of Denver residents (61.0%) and Americans (63.4%) visit their dental provider annually⁶. Finally, regarding mental health, there is a greater concentration of mental health providers in Denver (1:120) than in the state (1:190) and the nation (1:290)⁴¹.

Telehealth

Telehealth use has stabilized at substantially elevated post-pandemic levels, with approximately one-third of Coloradans using telehealth in the past year (2025 CHAS)²³. Racial and digital-equity disparities persist: Black and Hispanic Coloradans and lower-income residents are more likely to rely on audio-only telehealth rather than video. Mental health remains the most common reason for telehealth use across all racial and ethnic groups.

Preventive Care

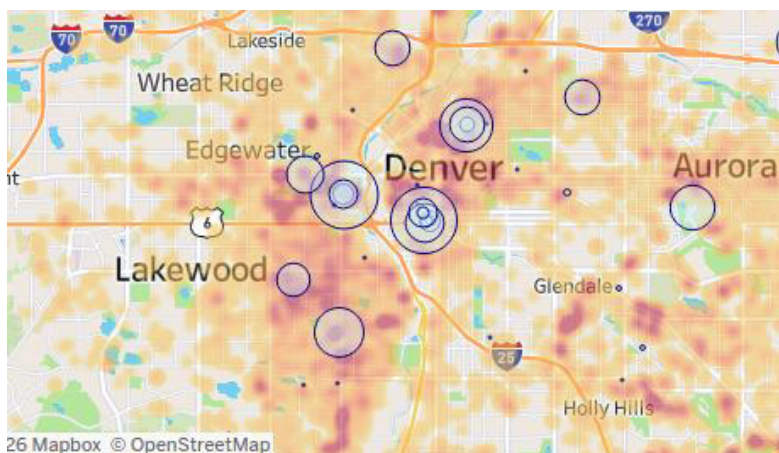
In Denver, rates of annual primary care visits among working-age adults remain below the national average (2022), continuing a persistent access gap⁸. However, older adult Denver residents (≥ 65 years) are more likely than the national average to be up to date on core preventive services including flu vaccination, pneumococcal vaccination, colorectal cancer screening, and mammography⁸.

Health Related Social Needs

In addition to healthcare insurance, the circumstances in which people live, work, and play, often referred to as social determinants of health, or health-related social needs, have a profound impact on healthcare access and overall health outcomes.

Denver Health screens for health-related social needs (HRSN) and has mapped where our patients with the most HRSN are living. The map below is data from our patients that were screened for health-related social needs (HRSN) in 2025. The darker color areas represent areas where there is a higher concentration of Denver Health patients with HRSN. The circles represent the locations of Denver Health clinics.

Denver Health Heat Map for Patients with Health-Related Social Needs



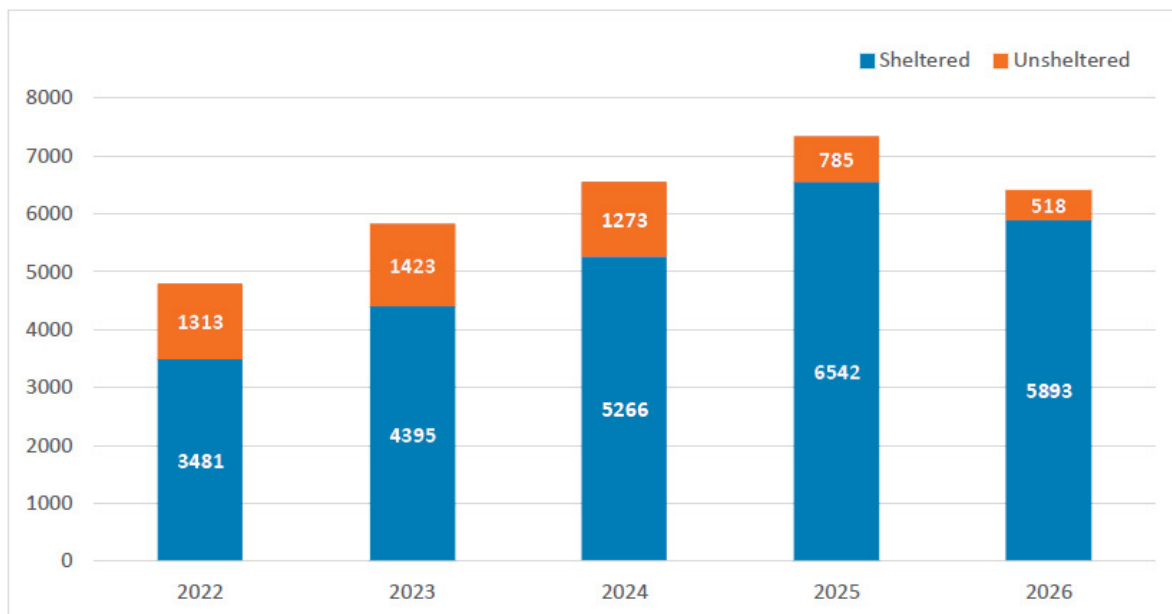
Community Connectedness/Social Support

The Centers for Disease Control and Prevention (CDC) recognize social connectedness as a sense of belonging among individuals or groups and a recognized social determinant of health⁷. The 2025 Colorado Health Access Survey measured loneliness for the first time: 21.7% of Coloradans statewide screened as lonely, with Denver tracking at or slightly above the statewide rate²³. Loneliness was highest among gender-diverse Coloradans (approximately two-thirds), young adults ages 18–29, people with disabilities, and American Indian/Alaska Native Coloradans. Additionally, Denver residents reported being the loneliest (29.7%). Lonely Coloradans were more than twice as likely as non-lonely peers to report fair or poor overall health.

Homelessness

The 2026 Point-in-Time Count identified 9,950 people experiencing homelessness across the seven-county Metro Denver region, with 6,411 in Denver County³³. The number of unsheltered individuals in Denver dropped to 518, a 64% drop since 2023. Homelessness continues to disproportionately impact persons who identify as Black, Indigenous, and persons of color. Approximately 21% of those counted identified as Black (vs. ~10% of the general Denver population) and 28% identified as Hispanic^{4,33}.

Point-in-Time Homelessness Count by Shelter Status, Denver County, 2022- 2025



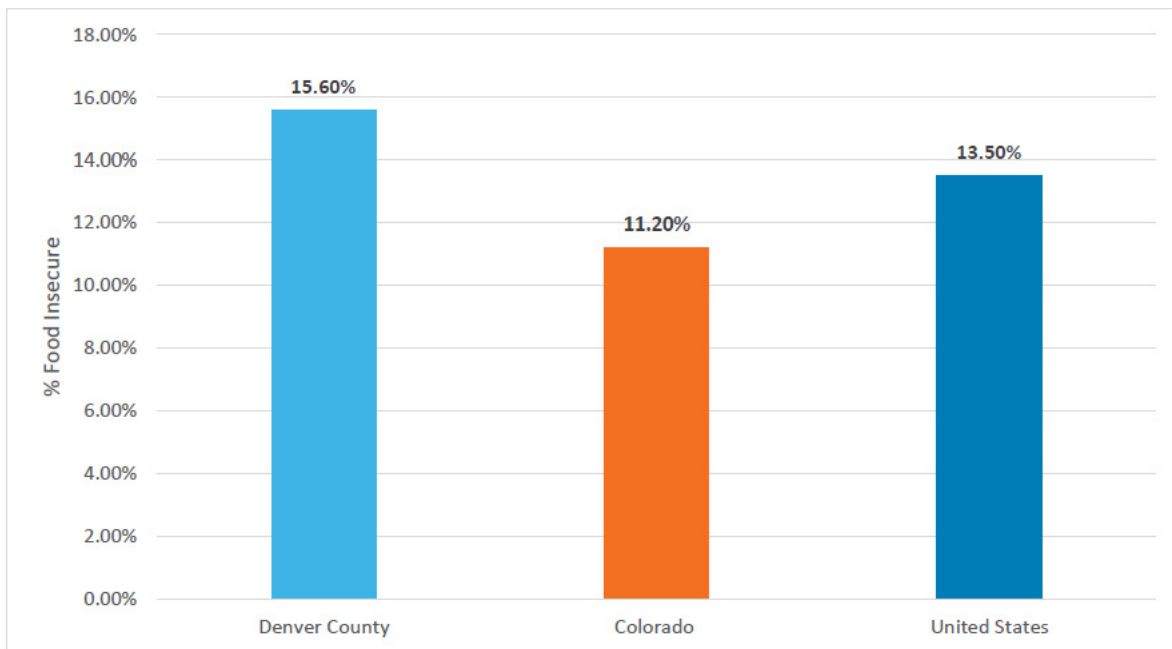
Metro Denver Homeless Initiative. (2026). 2026 point-in-time count. <https://www.mdhi.org/pit>

Food Insecurity

Food insecurity remains a major barrier for Denver residents. The 2023 Denver Food Insecurity Survey found that 15.6% of Denver adults are food insecure, exceeding both the Colorado statewide rate (11.2% in 2023) and the national household rate (13.5% in 2023)^{22,27,39}. Below is a chart comparing 2023 food insecurity between Denver, Colorado, and the United States. We used 2023 to create a fair comparison.

Among Denver adults who rely on food pantries, 45% had cut or skipped meals, and approximately one in five parents reported a child went a full day without eating²⁷. Subgroup rates are significantly higher than the citywide average among unemployed individuals, low-income households, Hispanic and multiracial residents, LGBTQ+ Denverites, individuals with mobility disabilities, young adults ages 18–24, and parents of children under 18.

Food Insecurity Rates



Colorado Health Institute. (2023). 2023 CHAS: Food security. <https://www.coloradohealthinstitute.org/research/2023-chas-food-security>

RESULTS: IDENTIFIED HEALTH PRIORITIES

The following health concerns, based on primary and secondary data, were reviewed by the Denver Health Community Benefit Steering Committee: access to care, healthcare cost/insurance, mental health, homelessness, healthy aging, substance/drug use, adolescent health, air quality/environment, community connections, healthcare equity, domestic/sexual violence, economic stability, gun violence, immunizations, maternal health, nutrition/not enough food, social support, and transportation. Based on the list of questions in the brief survey, community members indicated that all needs were present in Denver, but some rose to the top as priorities. The results also made it clear that Denver Health was positioned to address them. After review by the Denver Health Community Benefit Steering Committee, and discussion at the Public Forum meeting, the four priority areas of focus for the current CHNA and three-year Community Benefit Implementation Plan were identified as:



ACCESS TO CARE



HEALTHCARE COST AND INSURANCE



BEHAVIORAL HEALTH (MENTAL HEALTH AND SUBSTANCE MISUSE)



HOUSING AND HOMELESSNESS

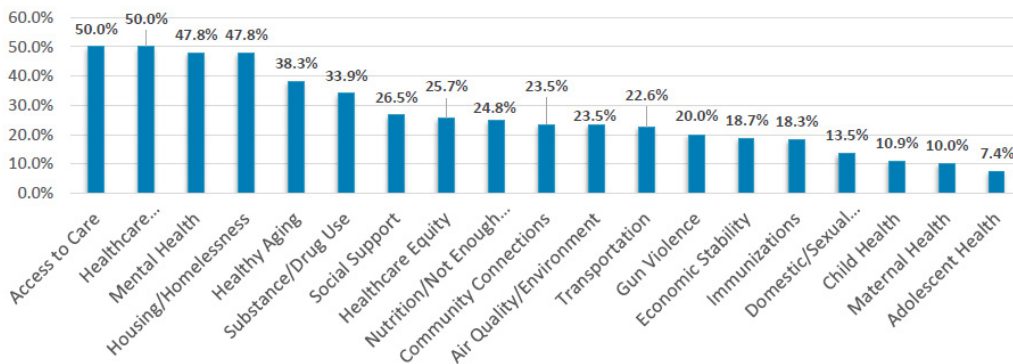
Public Survey

From January to May of 2026, Denver Health’s public survey was available to members of the community to complete. It was sent to community partners and patient populations, with a targeted approach for at-risk populations seen in programs and clinics such as the Access Transformative Outreach Program (ATOP), OB/GYN, and Primary Care clinics. Two questions were asked in the survey, along with demographic data. For the two main questions in the survey, participants were able to select all answers that they thought applied. The two questions, as well as the results, are listed below. For more specific survey participant information please see Appendix B.

Question 1: What are the top health concerns in your community? (n=230)

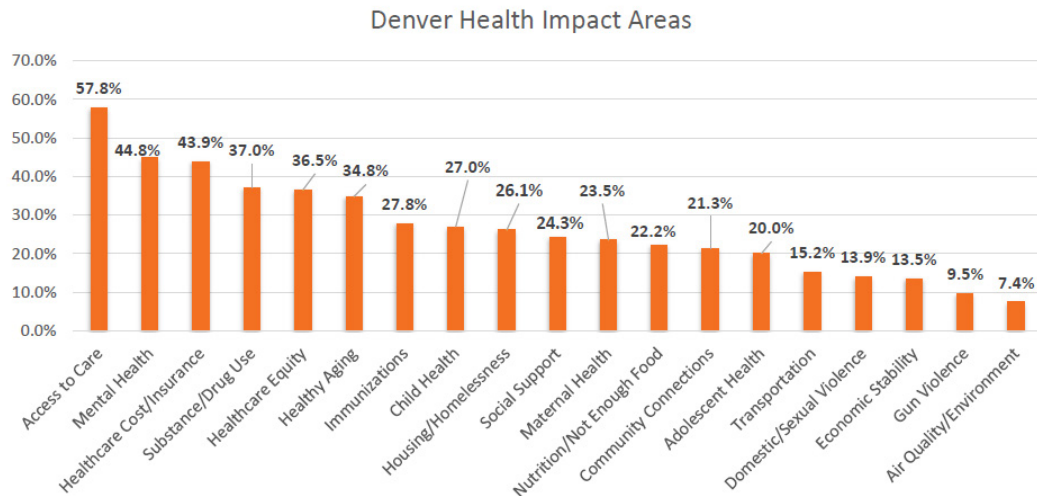
Percentages show how many of the total respondents selected each answer. For example, 50% of 230 community members believe that access to care is a top health concern in their community.

Top Health Concerns in the Community



Question 2: What areas do you think Denver Health can impact the most? (n=230)







Percentages show how many of the total respondents selected each answer. For example, 57.8% of 230 community members believe that Denver Health can impact Access to Care.



PUBLIC FORUM: COMMUNITY HEALTH NEEDS ASSESSMENT FEEDBACK

On May 14 Denver Health hosted two public meetings that gave space for a report-out to the community on the previous Community Health Implementation Plan (2024 - 2026) and to receive feedback on the upcoming priorities for the 2026 Community Health Needs Assessment. The results from the public survey above were shared with the group, with many agreeing that their own CHNA priorities aligned with our top four, and community members continued to give feedback on how to improve those priorities in the 2027 - 2030 CHIP (more specific information on the Public Forum can be found in Appendix C). There was a goal of narrowing the focus of the conversation to understand what “Access to Care” meant to community. This narrowed lens was created because the preliminary results and secondary data research showed Access to Care as a major priority. To fully address that priority, we wanted to understand what people were seeing and feeling as a barrier, as well as what progress looks like moving forward. The two questions below were asked on a virtual platform called Mentimeter. Through those responses the themes below were derived.

QUESTION 1: WHAT DOES “ACCESS TO CARE” MEAN TO YOU?

<p>Appointment Access</p> <p>“Easier to book appointments” “Timely appointments” “Wait list options if appointments aren’t available”</p> 	<p>Transportation</p> <p>“More patient navigators to call Medicare/Medicaid transit options” “RTD passes or Uber Gift Cards” “Easier way for Medicaid members to get transportation to specialty appointments”</p> 
<p>Cost & Coverage</p> <p>“Access to enrollment services without financial burden” “More enrollment team members to keep people on Medicaid” “Being able to receive care regardless of ability to pay”</p> 	<p>Provider Relationships</p> <p>“Ability to find a provider who is available and willing to listen” “Access to a PCP where you can build a relationship” “Ability to see an actual doctor”</p> 
<p>Geographic Access</p> <p>“Getting care when you need it, where you need it” “Access to appointments closer to your neighborhood” “A continuum of care at the neighborhood, local, and regional level”</p> 	<p>Education & Outreach</p> <p>“Education about preventative care” “Teaching community how to access care” “Outreach to populations who may not normally seek medical care”</p> 

WHAT MILESTONES WOULD SHOW THAT DENVER HEALTH IS IMPROVING “ACCESS TO CARE”?

CATEGORY	SUGGESTED METRIC OR MILESTONE
<p>Patient Experience</p>	<ul style="list-style-type: none"> • Patient satisfaction surveys and data; % of requests for care met within 2 weeks • Patient transit time and cancellations due to transit (self-reported); time to schedule appointments
<p>Capacity & Access</p>	<ul style="list-style-type: none"> • Number of empaneled patients increased year over year • Doctor availability relative to patient wait times; visit wait times • New facilities throughout the area; more mobile units (e.g., dental unit)
<p>Geography</p>	<ul style="list-style-type: none"> • Heat map of appointments scheduled overlaid with where patients live • Heat map of mobile units serving areas, overlaid with community and school-based health centers • RTD grant utilization and transportation access data
<p>Utilization</p>	<ul style="list-style-type: none"> • Percent of targeted patients seen within 7 days of discharge • More upstream service use and decreased acute/ED care utilization
<p>Community</p>	<ul style="list-style-type: none"> • Provider data: CBO providers reporting clients successfully received care

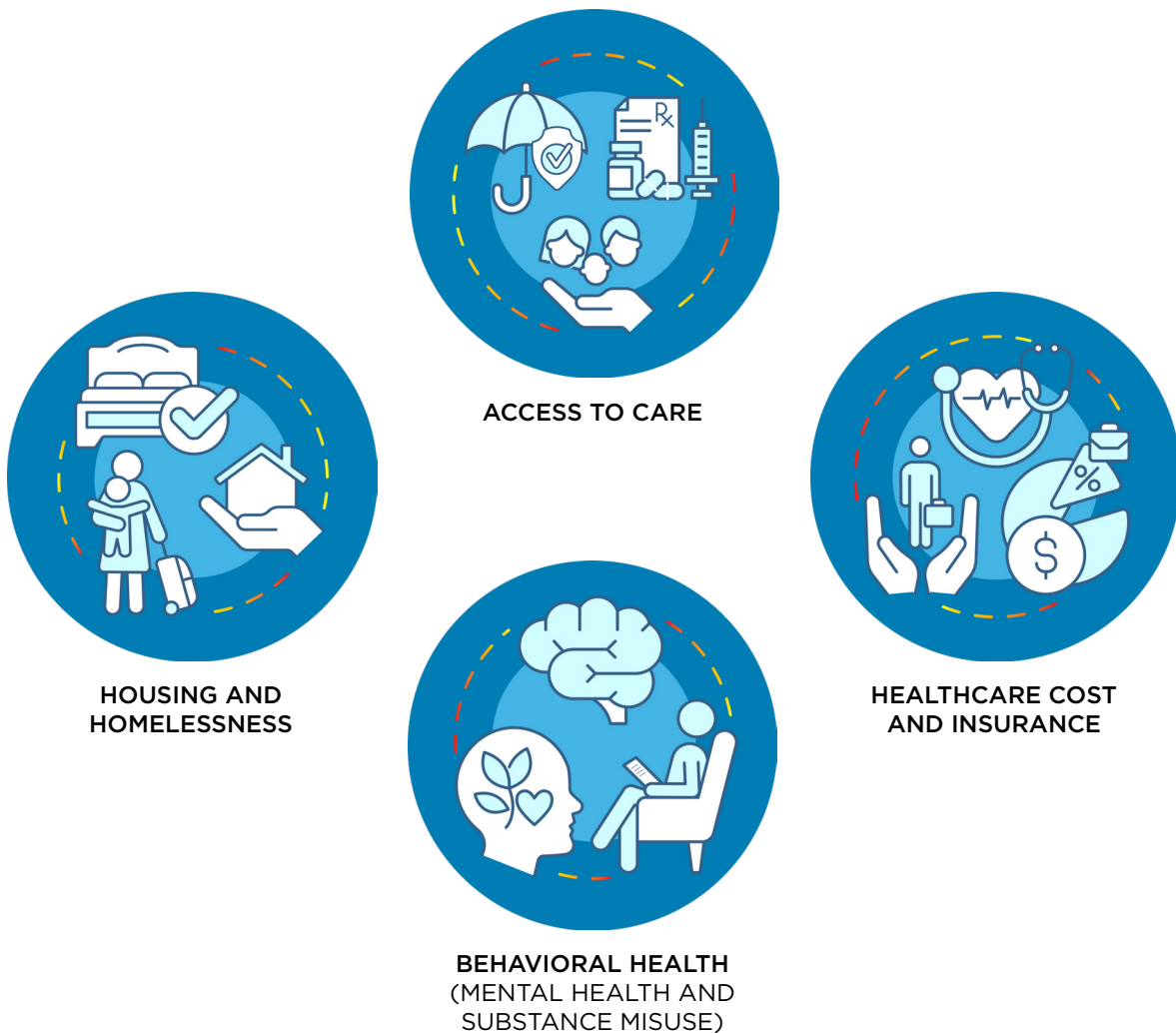
LIMITATIONS AND AREAS NOT ADDRESSED

While the Committee did not include all of the needs that were identified or asked of the community, there is significant intersection between many of the issues and those that were selected as priorities for the 2026 - 2029 Community Health Needs Assessment. For example, transportation and healthcare equity intersect with access to care, while economic stability significantly overlaps with the cost of healthcare and insurance. In addition, the Community Benefit Implementation Plan will include review of current efforts and evidence-based strategies such as peer support in facilitating improved health. Adolescent health was also not included in the final priorities due to the nature of the priority areas including individuals across the lifespan, which includes adolescents. The Committee also recognized diabetes as the only singular disease condition included in topics identified by community members and intends to consider the impact of efforts focused on improving healthcare access particularly by race and ethnicity due to present disparities and facilitating resources for health-related social needs (including housing stability and food) for individuals with chronic disease conditions.



CONCLUSIONS

The 4 health priorities identified in the current CHNA include:



These priorities were identified based on input from community partners, individuals in the community, and secondary data; prioritization considered burden, the presence of health disparities, existing evidence-based strategies, and the ability of Denver Health to address the issue. These priorities align with local and state strategic health areas of focus, and the key considerations in addressing priorities including community engagement and equity.

Fortunately for the community and Denver Health, these priorities are consistent with existing work, work we have planned, and new ventures with community partners. Working to address these priorities is meaningful work that we believe will improve the health of our Denver community and increase trust in Denver Health as an organization committed to excellence in care for Denver.

ACKNOWLEDGEMENTS

We would like to thank our community partners and community members who have voiced their perspectives and engaged with Denver Health over the years for aiding in our continuous reflection and improvement upon our approaches and strategies to support and optimize the health of our greater Denver community. We are appreciative of the organizational leaders and individuals who took time to complete our survey or engage in discussions to identify top health concerns in Denver. The written content and input through facilitated dialogue will be used to inform details of our Community Benefit Implementation Plan. We appreciate the time and investment of our internal Denver Health Community Benefit Steering Committee (see Appendix D for members). Finally, we would like to express our gratitude to the many additional staff members across Denver Health who have provided support and guidance through this effort, including navigating data sources, connecting with community groups, and aligning with organizational efforts.



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APPENDICES

APPENDIX A: DENVER HEALTH COMMUNITY BENEFIT ANNUAL
PUBLIC MEETING

APPENDIX B: DENVER HEALTH COMMUNITY BENEFIT PUBLIC SURVEY

APPENDIX C: FACILITATE DENVER HEALTH COMMUNITY BENEFIT PUBLIC
SURVEY CONVERSATION

APPENDIX D: MEMBERS OF THE DENVER HEALTH COMMUNITY BENEFIT
STEERING COMMITTEE

APPENDIX A: DENVER HEALTH COMMUNITY BENEFIT ANNUAL PUBLIC MEETING

Methods

Denver Health and Hospital Authority held two forums on May 14, 2026. The first was hosted online during business hours, the second was hosted in-person on Denver Health’s main campus after business hours. Both meetings offered simultaneous Spanish Language interpretation. These forums were advertised through an e-mail invitations that were sent to community members and leaders, social media posts, as well as public notices in the April 8th and May 6th editions of LaVoz.

The meeting followed an agenda including review and feedback regarding Community Benefit Implementation Plan Activities in 2025, and recommended Community Benefit priorities for the 2026 CHNA. Feedback was requested verbally, through the Webex chat feature, and through the online platform Mentimeter. The questions prompting participant Community Benefit engagement included:

- What feedback do you have for Denver Health regarding their community benefit work?
- Based on the results from the Public Survey, do you agree with the priority areas?
- What does “Access to Care” mean to you?
- What milestones or data points would show you that Denver Health is increasing “Access to Care”?
- Do you have any feedback for the Hospital Transformation Program?

Results

We recorded the following 18 participants from organizations outside Denver Health. The participants included representatives of health alliances, advocacy organizations, state departments, and health care.

NAME	ORGANIZATION
Ron Thomas	Denver Police Department
Kate Johnston	Project Angel Heart
Charlene Barrientos	Community Member
Deena Duwaik	City of Denver
Bianca Melancon	Colorado Office of eHealth Innovation
Donald Ku	Lower Downtown Neighborhood Association
Dr. Geneene Duran	Ducks in a Row Human Services Inc
David Roberts	Lower Downtown Neighborhood Association
Ashlee Grace	HCPF
Bryan Trujilio	AdventHealth

NAME	ORGANIZATION
Barbara Ingram	Community Member
Michaela Hennig	DHS
Nathan Keffer	DDPHE
Thomas Worthy	Community Member
Madilyn Lowry	Community Member
Emma Lookner	Community Member
Shayla Perkins	Kaiser Permanente
Ann White	Montbello 2020 & Beyond

The questions and responses below were discussed amongst the group:

- One participant had the question, “How full is the PES (Psychiatric Emergency Services) unit typically? Do you need more capacity?”**

A. Monica Lintz (Behavioral Health Admin): The PES unit is approximately 80% full most of the time. The challenge is not intake capacity but flow — getting patients to the right level of care afterward. The real capacity need is in residential and inpatient spaces so patients don’t get stuck in emergency-level care.
- One participant had the question, “How can Denver Health effectively reduce the number of people with substance use disorder or mental health issues on the streets of downtown? What is the best course of action for individuals who refuse care?”**

A. Thomas Gray Answered: STAR (Support Team Assisted Response) is the primary resource — a team that can be dispatched for someone in a street-based crisis. Monica Lintz added: 988 (mental health crisis line) dispatches a mobile crisis team. The ATOP outreach team (nurses, psychiatrists, case managers) goes into the community. Peer support services and Caring for Denver funding are also available to wrap around patients with complex needs.
- One participant commented, “Substance use and drug use need to be a higher priority than current rankings suggest.”**

A. Answer: This was noted by Lorena Zimmer. The comment was acknowledged and recorded as part of community input into the 2026 -2029 CHNA priorities.
- One participant had the question, “Our community (Montbello and far northeast Denver) has been trying to get a larger health care center since 2002 and keeps being passed over. We continue to grow, the health issues are evident, and seniors especially cannot travel far for care. What does the community or elected officials need to do to make this happen?”**

A. Answer: Lorena Zimmer acknowledged the far northeast as one of Denver’s fastest-growing areas and conceded that healthcare access has not kept up with that growth. She noted that mobile units have been deployed as a temporary measure but are not sufficient. The need was affirmed and flagged as a priority for the ongoing CHNA process.

- **One participant had the question and response, “How do you define healthcare access? For seniors and ethnic communities in our area, access is very specific – it includes transportation to and from appointments, ability to make appointments, and technology access. We just opened a senior technology center in Montbello (already at capacity). For people with disabilities, veterans, and seniors, how they get around shapes everything about how they can access care.”**
 - A. Answer: Lorena Zimmer affirmed the community-specific nature of access and highlighted that this input – along with Mentimeter responses – was informing Denver Health’s definition of access to care. David Roberts also noted in comments that communities are very different and needs must be tailored.
- **One participant commented, “Denver Health is over capacity – residents from the far northeast have tried to get in and cannot. We need more.”**
 - A. Answer: Lorena Zimmer acknowledged the concern and reiterated the importance of the community’s continued advocacy voice. She mentioned connecting with an events coordinator regarding the 10th Annual Health & Wellness Back to School event in August.
- **One participant commented and asked the following question, “The definition of ‘community’ matters here. I conducted an independent Black Community Health Assessment from January 2025 to March 2026 with over 500 Black Denver community respondents – and my results differed significantly from both Denver Health’s and DDPHE’s findings. There is a racial/ethnic data gap in how these assessments are conducted. Will Denver Health engage with those findings? Northeastern communities – not just Montbello, but Green Valley Ranch, Avondale, Parkfield, Gateway – are consistently overlooked.”**
 - A. Answer: Lorena Zimmer expressed strong interest in the Black Community Health Assessment results and committed to collaboration. Dr. Duran noted that findings will be published in July and a Black Community Health Improvement Plan will be launched, with elected officials and Black community health leaders involved. She left her email in the chat for follow-up.
- **One participant had the question, “What is the age breakdown of your survey respondents? Age significantly shapes what health priorities look like and could skew results. Also, surveys and focus groups often don’t reach the most underserved patients, the people who most need care are not always the ones who get identified as ‘community leaders’ or participate in these processes. Who identifies leaders? What does reach actually look like?”**
 - A. Answer: Lorena Zimmer confirmed that demographic data on survey respondents is available and offered to share it. She also acknowledged the legitimate concern about representativeness and invited further direct engagement with Denver Health’s team.
- **One participant commented, “Kaiser Permanente’s CHNA results align with Denver Health’s top four priorities. I’d add that health literacy is a significant component of access – Colorado has a high insurance rate but not a high access rate, partly because people don’t know how to navigate the system. Transportation barriers are also a factor, including things as specific as unsheltered bus stops discouraging transit use.”**
 - A. Answer: Lorena Zimmer agreed and noted that health literacy and enrollment support (Medicaid, Health First Colorado) are roles that healthcare systems can and should play. She noted the opportunity to reconnect with Kaiser to collaborate on shared priorities.

APPENDIX B: DENVER HEALTH COMMUNITY BENEFIT PUBLIC SURVEY

Methods

A brief survey was created to further solicit input from community-based organizations, community members, and patients.

This survey was distributed to contacts including:

- A list of more than 200 community organizations and local government leaders who were invited to the annual DH community benefit presentation, and people they passed the survey to via direct email distribution lists, newsletters, and social media
- The Denver Health Office of Research Community Advisory Panel
- The Center for Addiction Medicine Community Advisory Panel

The survey solicited responses to two primary questions with response options based on priorities identified in previous Community Health Needs Assessments, through discussion with the Community Benefit Steering Committee, and known community health domains.

The primary questions were:

- What are the health concerns in your community?
- What areas do you think Denver Health can impact the most?

The survey also included an open-ended response section for community members to specify why the issues selected are important, how Denver Health could best impact the issue or concern, and for additional thoughts and concerns we should be aware of.

Participants were also asked to describe themselves based on various demographic questions and type of organizational affiliation for respondents from community-based organizations.

Results

Participants: Community Members

Characteristics of Individual Community Members who Responded to the Community Benefit Public Survey (n=230).

AGE	N (%)
18-34	32 (13.9)
35-49	64 (27.8)
50 - 64	70 (30.4)
65 or older	61 (26.5)

APPENDIX B

GENDER	N (%)
Female	128 (55.7)
Male	94 (40.9)
Non-Binary	2 (0.9)
Prefer Not to Answer	5 (2.2)

ETHNICITY	N (%)
Hispanic, Latino, Spanish, or Mexican	54 (23.5)
Non-Hispanic	156 (67.8)
Prefer Not to Answer	14 (6.1)

RACE	N (%)
White	141 (61.3)
Black or African American	20 (8.7)
American Indian or Alaska Native	8 (3.5)
Asian	9 (3.9)
Native Hawaiian or Pacific Islander	4 (1.7)
Other/Multiple Races	34 (14.7)
Prefer Not to Answer	11 (4.8)

Respondents were allowed to not enter their demographic information

APPENDIX C: FACILITATED DENVER HEALTH COMMUNITY BENEFIT PUBLIC SURVEY CONVERSATION

Methods for Office of Research Community Advisory Panel (CAP)

On February 18, 2026 a focus group was conducted among participants attending the Denver Health Center for Addiction Medicine monthly Community Advisory Meeting to discuss community health priorities. The purpose of this group is to engage patients and other community members with lived experience with substance use and recovery in shaping programs, patient care initiatives, and research related to mental health and substance use care at Denver Health. The monthly meetings are an open roster of individuals who express interest in participation without a requirement for continued engagement; however, many of the participants are regular monthly attendees. The number of attendees monthly ranges from 15-25.

The focus group was guided based on the primary questions of the Community Benefit Public Survey, querying around the top health priorities for the community and the top health concerns that Denver Health could most impact. The discussion provided additional details on reasons for concern and actionable suggestions.

Results

Participants

Characteristics of Individuals who Participated in the Focus Group Discussion of Community Health Priorities During the February 2026 Center for Addiction Medicine Community Advisory Meeting (n=32). Participants birth years ranged from 1951 – 1988 (mean = 1973)

GENDER	N(%)
Female	11 (34)
Male	20 (63)
Non-Binary	1 (3)
Prefer Not to Answer	0 (0)

ETHNICITY	N(%)
Hispanic, Latinx	5 (16)

RACE	N (%)
White	17 (53)
Black or African American	5 (16)
American Indian or Alaska Native	1 (3)
Asian	1 (3)
Native Hawaiian or Pacific Islander	0 (0.0)
Other/Multiple Races	3 (9)
Prefer Not to Answer	0 (0)

Top Themes – Community Members Attending the CAM Community Advisory Meeting

- **Access to Care**
 - Long wait times were discussed; with more emphasis on specialty and behavioral healthcare settings.
- **Behavioral Health**
 - Including both mental health and substance use. Discussed the need for more street-level mental health support.
- **Cost of Care**
 - Participants discussed the rising costs for both care and prescriptions, trends that are driving patients to forgo care or go into debt.

Participants also discussed experiencing bias and how misinformation regarding health is impacting care decisions.

Methods for Research Community Advisory Meeting

On February 20, 2026, the Denver Health Community Advisory Panel (CAP) convened for their monthly meeting and were asked to identify the greatest health care concerns facing the community and to explore where Denver Health has the greatest opportunity for impact. The discussion surfaced both the underlying drivers of those concerns and concrete, actionable recommendations. This discussion occurred as a part of the 2026 Community Health Needs Assessment.

CAP is a long-standing community engagement body supported by the Office of Research / Center for Health Systems Research. Established in 2013 through an Agency for Healthcare Research and Quality (AHRQ) Patient-Centered Outcomes Research infrastructure grant and fully operationalized in 2018, the CAP brings together community members who reflect the breadth and diversity of Denver Health's patient population. Panelists include patient advocates, health care consumers, small business owners, and professionals with deep roots in the communities they serve.

The CAP plays an active role in shaping initiatives at Denver Health. They provide culturally responsive perspectives on the development, implementation, and dissemination of programs and research. In recent years, its scope has grown to include input on operational decisions such as key clinical hiring and bioethics discussions.

Results

Participants

There were 12 community participants, however no demographic data was collected at the time of the meeting.

Top Themes – Community Members Attending the CAM Community Advisory Meeting

- **Cost of Healthcare and Insurance**
 - Participants stated that many people are unable to afford premiums and are dropping coverage, defaulting to care through the emergency department. They also highlighted the need for more healthcare literacy through insurance companies (state funded programs, federal programs, and private insurance).

- **Access to Care**
 - The discussion surrounded Social Determinants of Health that inhibit patients from accessing care, as well as organizational barriers such as long wait times, limited community clinic availability, and more.
- **Trust and Safety**
 - The discussion on this subject ranged from marketing and visibility to information sharing and with federal agencies. Community members want to feel safe, while also highlighting that Denver Health is here to serve the underserved populations and the entire community.

APPENDIX D: MEMBERS OF THE DENVER HEALTH COMMUNITY BENEFIT STEERING COMMITTEE

NAME	TITLE/POSITION
Lorena Zimmer	Chief Impact Officer
Rocio Pereria, MD	Medical Director, Community Integrated Healthcare
Magda Herrera	Sr. Director, Philanthropy
Rachel Everhart, PhD	Research Director
Allison Forest	Manager, Counseling Services
Judith Shlay, MD	Associate Director of Physician Services (CSA)
Jeanny Reither	Research Project Manager
Stephanie Syner	Manager, Government Affairs
Adam Manypenny	Operations Coordinator, Office of Community Integrated Healthcare
Sharif Abdelhamid	Chief Patient Experience Officer
Zander Oklar	Specialist III, Community Events
Yael Schenker, MD	Chief Academic Officer
Abbie Steiner	Manager, Epidemiology and Evaluation
Monica Lintz	Senior Administrative Director
Audrey Lookner	Project Specialist II



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