The West Central Public Health Partnership

Regional Health Assessment and Plan 2018

1. Introduction

The West Central Public Health Partnership

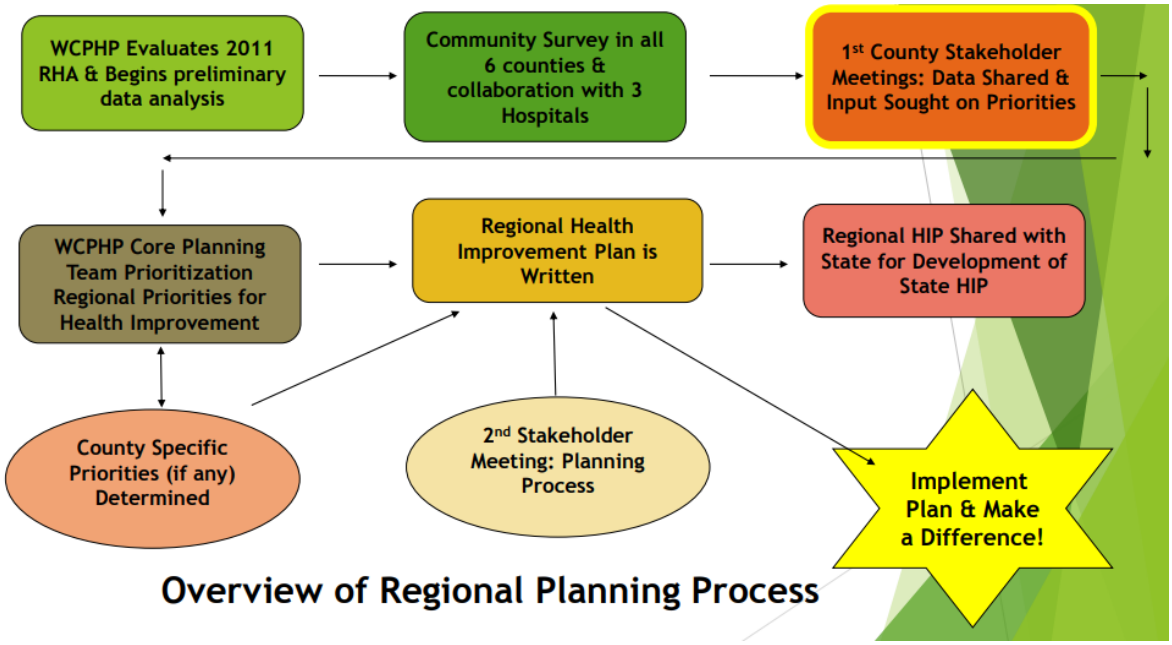
The West Central Public Health Partnership (WCPHP) was formed in 2006 with the purpose of building the infrastructure of the public health system and making local public health agencies more effective and efficient. Public Health assessment and planning was one of the first projects the WCPHP tackled as a region and the process continues to guide the work of the partnership. The WCPHP did a regional public health assessment in 2011 and a public health plan in 2013. This round of assessment and planning began in 2016 and is being completed in 2018.

2008 PH Act

Colorado's Public Health Act took effect in 2008, restructuring our local public health systems statewide. The act established a set of comprehensive requirements for the community assessment and planning processes. The intention of the act is to ensure both the availability and the quality of core public health services to every resident of Colorado, ultimately to improve health outcomes. To be updated every five years, local public health agencies are responsible for planning, implementing and evaluating community needs to increase the efficiency and effectiveness of the public health system and create a Community Health Assessment (CHA) and a Community Health Improvement Plan (CHIP).

Outline of the Health Assessment and Planning Process

The health assessment and planning process included many steps and followed the Colorado Health Assessment and Planning System https://www.colorado.gov/pacific/cdphe-lpha/chaps. The assessment steps included evaluation of the prior health assessment and planning process, data analysis, review and sorting of secondary data by the WCPHP Health Planner and Coordinator. They also worked with partners at local hospitals to collect primary data from a community health survey, and reviewed data with stakeholders and the WCPHP. Assessment and prioritization continued through conducting local stakeholder meetings to collect data on the top five health concerns in each of the 6 counties, which followed the presentation of a health data report to the community. The WCPHP, as the core planning team for the Public Health Improvement Planning process, then reviewed data and completed the prioritization process to choose the three regional health priorities. In 2018 the planning process took place, with strategy areas identified and an Action Plan for Year 1, 2019, created.



2. Health Assessment Process

Evaluation

The evaluation of the prior process included key informant interviews of each public health director on the prior process. One of the main conclusions that the WCPHP drew from the evaluation was that the next assessment and planning process should be more community driven with more partner engagement. The goal would be a community public health improvement plan rather than an agency centric plan.

Review of Secondary Data

The WCPHP Health Planner and the WCPHP Coordinator reviewed secondary data such as the County Health Rankings, the Community Commons Report for each county and Region 10, as well as the Colorado Health Indicators (see Appendix at the end). The WCPHP core planning team decided to focus the data review and data report on the prior four Health Priorities: Mental Health and Substance Abuse, Healthy Eating Active Living, Well Water Quality, and Food Safety. Other key data pieces that were included were health access, tobacco use and injuries. From this overview the WCPHP Health Planner created the data presentation for the WCPHP and for local stakeholders (see below links to the PowerPoint presentations of the Health Data Reports).

Health Data Report from Community Stakeholder Meetings. Please note that with small numbers of people/outcomes the data must be interpreted with caution.

- Delta County
- Gunnison County
- Hinsdale County
- Montrose County
- Ouray County
- San Miguel County

Hospital Collaboration and Community Survey

The WCPHP and the three hospitals in the region began a new process of collaboration in 2016, which included increased sharing of information between assessment processes as well as a Community Survey. The three hospitals collaborated on their Community Health Needs Assessment through Quorum, an outside consultant, to facilitate their planning meeting and to write up their end product: the CHNA for each hospital. Quorum also worked with the WCPHP to provide a community survey and the data analysis of the survey. This community survey was in addition to the survey of stakeholders that the hospitals used as their main source of qualitative data. The hospitals then invited the WCPHP and the public health directors to attend the planning meeting. The WCPHP used the data from the hospital process as an additional dataset for the regional health assessment and prioritization process.

Hospital Community survey results- Region 10 and CHNAs

- Region 10 - Community Health Needs Assessment PowerPoint
- Gunnison Valley Health Community Needs Assessment
- Montrose Memorial Hospital Community Needs Assessment
- Delta County Memorial Hospital Community Needs Assessment

Other data from partners that was reviewed:

- Tri County Health Network Survey - Montrose
- Tri County Network Survey - Ouray
- Tri County Network Survey - San Miguel

Stakeholder Input - Top Five Health Concerns

In the fall and winter of 2016, the WCPHP conducted stakeholder meetings in all 6 counties. The purpose of these meetings was to share regional and county level public health data (see above Health Data Reports), get input on that data, and then to conduct a process of prioritization and data collection on the top five health concerns in each county. The process used is called the Nominal Group Technique. The top concerns from these stakeholder meetings were mental health and substance abuse, as well as access to health care concerns, see the link to the Excel spreadsheet on the WCPHP website: https://www.wcphp.org/data/ under Top Five Health Concerns. Also, below is the link to the color-coded results of the Top Five Health Concerns in all counties on one page.

- Top 5 Health Concerns - Nominal Group Analysis

Capacity Assessment

The Capacity Assessment portion of the health assessment and plan can either focus in on the capacity to address the priority areas or it can focus on the essential public health services of local public health agencies. The WCPHP decided to do a capacity assessment that looked at both. However, due to staff turnover and internal capacity, the partnership focused data analysis on the part of the capacity that had to do with the WPCHP's ability to do regional grants in projects, which is closely related to capacity to address the health priorities.

The WCPHP worked with the Kansas Health Institute to modify a survey they used to measure Kansas health agencies ability to do the essential services (see Kansas Foundational Public Health Services Capacity Assessment below). Overall the members of the partnership have high capacity and capability to participate in regional meetings, but varied capacity and capability to be the fiscal host for a regional project. See below PowerPoint for the results of the regional data from the capacity assessment.

- WCPHP Internal Capacity Assessment PowerPoint | PDF
- WCPHP Internal Capacity Assessment Tool | PDF
- Kansas Foundational Public Health Services Capacity Assessment | PDF

The WCPHP also gathered information from local communities and agencies related to each of the priorities as a way of gathering capacity in each county in order to address the priority areas. After the 3 priority areas were identified (see below Prioritization process), the WCPHP hosted another round of community meetings in each of the 6 counties. During these meetings the WCPHP coordinator and planner facilitated a Strengths, Weaknesses, Opportunities and Threats Analysis (SWOT), which is a brainstorming activity. It was also based on the "World Cafe" model, though did not follow that model exactly. Below are the results of the SWOT analysis showing the opportunities identified for each priority area, as well as overall themes of the responses.

■ World Café-SWOT:

- Healthy Eating Active Living SWOT Analysis | PDF
- Behavioral Health SWOT Analysis | PDF
- Healthy Housing SWOT Analysis | PDF

3. Prioritization Process

The WCPHP Core Planning Team conducted prioritization of health concerns over the course of two planning meetings in the winter of 2016/2017. During those meetings the WCPHP reviewed data, including the combined top health concerns from the Nominal Group Technique, as well as secondary data and the hospital's Community Health Needs Assessment data. The group used the Prioritization Matrix provided by the Office of Planning Partnership and Implementation (OPPI), though it was modified to include whether the health concern was a past priority and whether there was regional consensus that it was a problem. Through the use of this tool the WCPHP weighed the significance of the issue, the ability to address the issue, the capacity to address the issue, as well as whether the issue was a past priority and whether there was consensus across the region (see Prioritization Matrix link below).

Issues of poverty and affordability of health care and housing had come up across the region. The WCPHP core planning team decided to use the Colorado Health Equity Framework for the planning process for the public health improvement plan moving forward. Additionally, the group decided that although health care access and affordability was a concern, it was more of a strategy to attain a health outcome, such as better behavioral health or decreased chronic disease. The group decided to use increasing health access as a strategy in the plan rather than as a Priority Area.

Communicable Diseases also came up as a top health concern. After weighing the issues closely, the WCPHP core planning team decided to make a note that there are concerns with communicable diseases, such as low immunization rates, increasing sexually transmitted infections, food safety capacity, but decided not to choose it

as one of the three health priorities.

Prioritization Matrix

- WCPHP Prioritization of Health Concerns

Stakeholder Meetings

- WCPHP Quarterly Meeting - Prioritization
- WCPHP Priorities from Stakeholder Meetings by County

4. Planning Process

The process of creating the plan included gathering information from community stakeholders and partner agencies across the region, then 2 topic specific planning meetings for each of the priorities, and review by the WCPHP Core Planning Team and the local Boards of Health.

The initial evaluation of the prior cycle of assessment and planning informed the decision to make this current process more of a community-based plan versus an agency specific plan. Also, the core planning team had determined to use the Health Equity Framework and associated tools for the process as well. This meant gathering the voice of people disparately affected by health concerns such as people living in poverty, immigrants, youth, families. Existing data from priority populations was also gathered.

The SWOT analysis that had been done in each of the six counties were used as the beginning point for identifying strategies (see above section on Capacity Assessment). The WCPHP planner and coordinator also gathered information from the Colorado State Public Health Improvement Plan and other evidence-based strategies.

There were three regional planning meetings held in Montrose in the winter and spring of 2017/2018. At those meetings there was a mini training on Health Equity and input gathered on potential strategy areas, as well as priority populations. The WCPHP wanted to know if community stakeholders agreed with potential strategy areas. Also, the WCPHP, in partnership with the Multicultural Resource Services of Gunnison County Health and Human Services, hosted a community meeting in Spanish with Latino families. The purpose of the meeting was to seek input on the public health improvement plan priority areas and other community issues. See below for the PowerPoints from those planning meetings.

Regional Planning Meetings

- HEAL Regional Planning Meeting | PDF
- Behavioral Health Regional Planning Meeting | PDF
- Healthy Housing Regional Planning Meeting | PDF
- Latino Community Meeting in Gunnison | PDF

After the Regional Planning Meetings, the Action Plans were updated based on input from the stakeholders at the meetings. Then key informant interviews were conducted with partner agencies such as Mountain Roots for the HEAL Action Plan and Gunnison County Community Development for the HEAL and the Healthy Housing

Action Plan. The Behavioral Health plan was reviewed and approved by the Regional Behavioral Health Collaborative.

During the latter half of 2018 the Public Health Improvement Plan was presented to and approved by the local Boards of Health. Dates of Board of Health Meetings to review and approve the WCPHP Regional Public Health Improvement Plan:

Silver Thread Health District Board of Health: 7/16/18
Montrose County Board of Health: 9/5/18
Gunnison County Board of Health: 9/18/18
Delta County Board of Health: 9/16/18
San Miguel County Board of Health: 10/24/18
Ouray County Board of Health: 12/5/18

5. The Public Health Improvement Plan

Issue Statements:

Health Equity Framework

Health equity means that all people have an equitable opportunity to be as healthy as possible. The West Central Public Health Partnership recognizes that health inequities exist within our region. Priority populations for Region 10 are the elderly, immigrants, low-income residents, LGBTQ, infants and youth. The social determinants of health are the conditions in which people are born, live, work, and play and explain potential obstacles a person might face in achieving optimal health. They also play an essential role in why health inequities exist. A variety of factors including a person's physical, economic and social environment, education, genetics, health behaviors, and access to health care influence a person's quality of life as well as their life expectancy. For example, in Colorado, a person with a high school diploma or less is 13% more likely to be overweight or obese than a person who graduated college. By navigating our action strategies through the lens of the social determinants of health, the WCPHP aims to reduce health inequities and promote positive health outcomes throughout the region. See Health Equity Snapshot below for more information and data resources.

- Region 10 Health Equity Snapshot | PDF
- CDPHE Health Equity Framework | PDF

Access to Health

All six counties within Region 10 identified access to health as a top priority in 2016. Access to health care plays an important role in prevention, early identification, and treatment of health issues. Yet, many Region 10 residents face barriers to healthcare. Access to health includes affordability of care, health insurance, access to and cost of prescription drugs, availability of providers and specialists, and transportation. It also includes access to preventative measures such as the cost of consuming a healthy diet and availability of safe, recreational activities or areas. A lack of health access leads to unmet health needs, preventable hospital stays, delays in receiving care, financial hardships and ultimately poor individual and community health outcomes. In 2017, nearly 8% of Region 10 residents reported they did not have health insurance. Furthermore, nearly 20% of residents reported in 2017 that they were unable to schedule an appointment with a physician as soon as they

believed was necessary. The ability to access healthcare is innately connected to the social determinants of health. For this reason, both access to health and health equity provide the framework through which Region 10 will address its top three priority areas to improve individual and community health outcomes. See Regional Health Access Snapshot below for data resources.

- Region 10 Health Access Snapshot | PDF
- Colorado Health Access Survey (CHAS) Data | PDF

Healthy Eating Active Living

Although Colorado residents are some of the healthiest nationwide in terms of weight, obesity rates have drastically increased statewide in the course of the past fifteen years. Obesity represents a challenge for our community as it increases the likelihood of developing chronic disease, including heart disease, stroke, type-2 diabetes, high blood pressure and even some kinds of cancer. Chronic diseases require ongoing medical attention and often limit activities of daily living. The level of education a person has achieved may play a role in health outcomes for Colorado residents. Adults with less than a high school diploma are more likely to be overweight or obese compared to those who graduated college. With the top two leading causes of death in Region 10 being heart disease and cancer, Healthy Eating Active Living (HEAL) was identified as a priority area for the WCPHP. Risk factors for developing chronic disease include poor nutrition, lack of physical activity, excessive alcohol consumption and tobacco use. By navigating these risk factors through the lens of the social determinants of health, the WCPHP will continue its focus on chronic disease prevention to reduce the leading causes of death in Region 10. The HEAL Region 10 Snapshot is listed below for more information and resources.

- Healthy Eating Active Living Region 10 Snapshot | PDF

Behavioral Health

The West Central Public Health Partnership has identified Behavioral Health (BH) as a priority area for the PHIP. Mental and emotional well-being are closely connected to overall health and are essential to creating positive health outcomes for Coloradans. Behavioral health, the preferred term to mental health, encompasses mental wellness, suicide prevention and substance abuse prevention. Substance abuse is the immoderation or dependence on habit-forming substances such as alcohol or drugs and is often correlated with depression, anxiety and bipolar disorder. Poor behavioral health stifles a person's ability to cope with the stressors of life, realize their full potential and make meaningful contributions to their community. Early childhood and youth, elderly, low-income, geographically isolated, and LGBTQ populations within Region 10 are disparately affected by poor BH and have been identified as priority populations within our community. With the Rocky Mountain region of Colorado hosting the highest suicide rate in the continental United States, the WCPHP will focus its' prevention strategies on efforts that continue to build capacity for behavioral health, reduce stigma, create health equity, and integrate behavioral health into primary care services throughout Region 10. See the Behavioral Health Region 10 Snapshot below.

- Behavioral Health Region 10 Snapshot | PDF

Healthy Housing

Safe, decent, and sanitary housing is fundamental to preventing injury and disease. Substandard housing can lead to negative health outcomes such as cancer, asthma and unintentional injuries. Lead poisoning is one

healthy housing priority identified for Region 10. Exposure to deterioration of lead-based paint represents a developmental hazard for young children. Lead based paint was banned nationwide in 1978, yet Region 10 has a high percentage of homes built before 1980. Radon exposure also represents a priority for Region 10 healthy housing strategies. When uranium breaks down in soil, it seeps into homes through cracks in basements and crawl spaces and exposes residents to radon gas. Radon gas is the second leading cause of lung cancer. Between 40% and 60% of homes tested in our region are above the EPA radon recommendations. Well water quality is another a healthy housing priority identified for our region. About 10 % of residents in Region 10 get their drinking water from private wells. Private wells do not receive the same testing or regulation as public water systems and may contain natural contaminants that can cause adverse health outcomes such as cancer, gastrointestinal issues, cardiovascular or kidney disease and neurological disorders. In addition, affordable housing is an overarching issue that negatively influences the health status of our community. A unique influence to certain areas of our community are second-homeowners who buy residences in desirable locations and drive the cost of housing up. Nearly half of Region 10 residents are currently paying 30% or more of their gross household income on rent, and the availability of affordable and desirable housing does not currently meet the needs of the community. The WCPHP will continually direct efforts on strategies that enforce positive housing policies, improve community knowledge on health housing practices, and promote affordability. The Healthy Housing Region 10 Snapshot is listed below as a reference.

- Healthy Housing Region 10 Snapshot | PDF

Public Health Improvement Action Plan Year 1 (2019)

Healthy Eating Active Living Action Plan: PDF

- Environmental Strategies Action Plan | PDF
- Evidenced-Based Programs Action Plan | PDF
- Active Transport Action Plan | PDF
- HEAL & Health Equity Action Plan | PDF

Behavioral Health Action Plan: PDF

- Collaboration & Coordination Action Plan | PDF
- Education & Stigma Reduction Action Plan | PDF
- Integration Action Plan | PDF
- Behavioral Health & Health Equity Action Plan | PDF

Healthy Housing Action Plan: PDF

- Education Action Plan | PDF
- Policy Action Plan | PDF
- Healthy Housing & Health Equity Action Plan | PDF

Next Steps

The WCPHP will share this Public Health Improvement Plan back to the community and other audiences, such as community partners, community leaders, and local funders. A general distribution to the larger community is available in PDF format on the West Central Public Health Partnership website under "Public Health Improvement Plan". Further work will continue in 2019 on creating an Evaluation Plan in collaboration with partner agencies. As we move into implementation, the WCPHP recognizes that this PHIP is a living, breathing document that will be used as a dynamic tool for monitoring, evaluating and communicating progress to our community. The WCPHP also acknowledges that for our PHIP to be a success, we must focus our implementation efforts on addressing the concerns of our priority populations to promote health equity and health access throughout the region.

Note of Thanks:
The WCPHP would like to thank the Health Planners who made this process possible and did the bulk of the data analysis and review, creation of PowerPoints, and writing of documents, including: Katherine Melland, Emily Mirza, and Tracee Hume. The WCPHP Coordinator, Margaret Wacker, led the planning process, facilitated stakeholder meetings and helped with writing up the final document.

This assessment and planning process would not be possible without the time and brain power from over 100 different local and regional community stakeholders across our region, including local public health agency staff. Funding and guidance were provided by local county and district Boards of Health and Boards of County Commissioners, the CDPHE Office of Planning, Partnership, and Implementation, Valley Food Partnership and the Colorado Trust. The WCPHP Core Planning Team steered and oversaw the overall development of the assessment and planning process and included:

Karen O'Brien, Ken Nordstrom - Delta County Public Health
Carol Worrall - Gunnison County Health and Human Services
Elizabeth Lawaczeck - Ouray County Public Health
Stephen Tullos, Jim Austin, Danace Arthur, Terry Ballet - Montrose County Health and Human Services
June Nepsky, Chris Smith - San Miguel County Public Health
Tara Hardy - Silver Thread Public Health District

Appendix

1. Demographics
    a. Region 10 Demographics
    b. County Data Reports 2016
        i. Delta
        ii. Gunnison
        iii. Hinsdale
        iv. Montrose
        v. Ouray
        vi. San Miguel
    c. Population Data for 2016 RHA
    d. Region 10 Median Family Income vs Self-Sufficiency Standard Chart
    e. Community Profile by State Demography Office: https://demography.dola.colorado.gov/community-profiles/
        i. Delta
        ii. Gunnison
        iii. Montrose
        iv. Ouray
2. 2015 County Report Cards
    a. Delta
    b. Gunnison
    c. Hinsdale
    d. Montrose
    e. Ouray
    f. San Miguel
3. County Health Rankings Region 10
4. Community Commons Region 10 CHNA Flagged Indicators
5. Colorado Health Indicators Region 10 Data Set
6. Access to Care Index
7. CDPHE VISION Tool
8. CDPHE Maternal and Child Health
9. CDPHE Suicide Dashboard
10. CDPHE Health Equity Framework
11. Health Access- CHAS Survey
12. Human Impact Partners Health Equity Guide
13. Tri-County Network Survey Results:
    a. Tri County Health Network Survey - Montrose
    b. Tri County Network Survey - Ouray
    c. Tri County Network Survey - San Miguel
14. Hospital CHNAs:
    a. Region 10 - Community Health Needs Assessment PowerPoint
    b. Gunnison Valley Health Community Needs Assessment

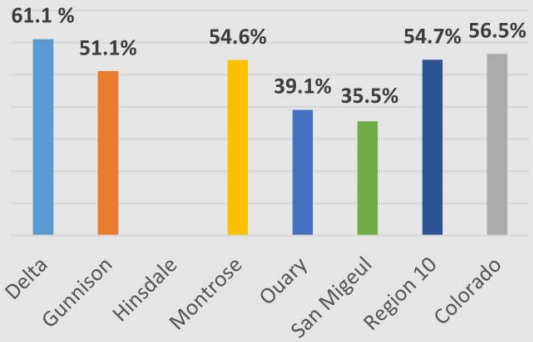
c. Montrose Memorial Hospital Community Needs Assessment
d. Delta County Memorial Hospital Community Needs Assessment

Healthy Eating and Active Living (HEAL) The top two leading causes of death for all six counties in Region 10 are heart disease and cancer (malignant neoplasms), two of the most common and costly chronic diseases.[1] Chronic diseases have four common causes: lack of physical activity, poor nutrition, tobacco use, and excessive alcohol consumption.[2] Continuing to focus on chronic disease prevention through Healthy Eating and Active Living will help reduce the leading causes of death in Region 10.

Eating healthy and maintaining an active lifestyle not only helps to prevent chronic diseases, they are also important for maintaining mental health. The World Health Organization states that ***"there is no health without mental health."***[3]

Studies that link between chronic diseases and depression show that depression is associated with increased prevalence of chronic diseases.[4]

Percent of adults who are over weight or obese (BMI ≥ 25) 2013 – 2015
CDPHE Colorado Health Indicators[5]



https://www.colorado.gov/pacific/cdphe/colorado-health-indicators [3]

Improving the health of our residents through healthy eating and active living provides enormous long term benefits for both physical and mental health.

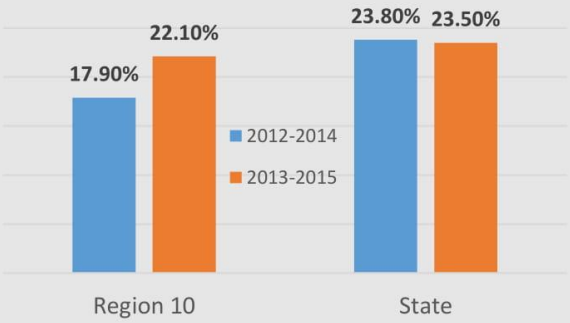
In Colorado adults who have obesity present with higher prevalence rates on other adverse health behaviors including:

- 33.6% of obese adults have no-leisure time physical activity.
- 33% of obese adults have high blood pressure and heart attacks.
- 29.3% of obese adults have not good mental health 14+ days in the past 30 days.[6]

Furthermore it has been shown that children and adolescents with major depressive disorders appear to have a higher risk of becoming overweight later in life.[7]

- 23.8% of children aged 5-14 years are overweight or obese in Region 10

Percent of children aged 5-14 years who are overweight or obese (BMI ≥ 85 Percentile)
CDPHE Colorado Health Indicators[5]



**Wide confidence intervals for regional level data, less reliable estimates.*

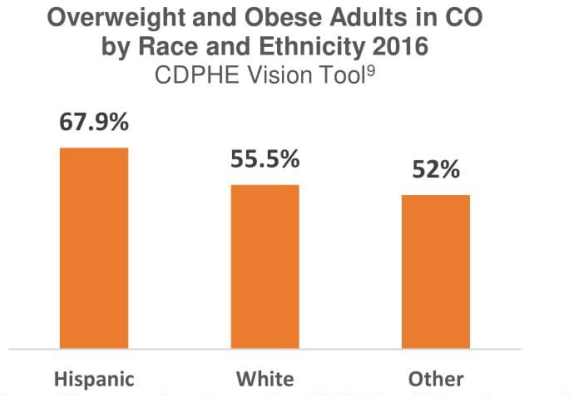
https://www.colorado.gov/pacific/cdphe/colorado-health-indicators [3]

Social Determinants of Health

The social determinants of health are the conditions in which we are born, we grow and age, and in which we live and work. The factors below impact our health and wellbeing.[8]
NHS Health Scotland

Health Equity and HEAL

The overall health of Region 10 residents is influenced by the social determinants of health (see Health Equity handout). One of the key drivers of health outcomes is education level. In Colorado, adults with less education than a high school diploma are more likely to be overweight or obese (64.1%) compared to those who graduated college (51.4%).[9]



https://www.colorado.gov/pacific/cdphe/vision-data-tool

There are racial and ethnic inequities at the state and regional level among adults who are overweight or obese.[9]

The West Central Public Health Partnership (WCPHP) recognizes the need to include health equity focused strategies to improve the health of all Region 10 residents.

Strategies

- **STRATEGY**: Improve access to healthy foods through environmental strategies such as: breastfeeding friendly environments, community gardens, WIC and SNAP at Farmers Markets.
- **STRATEGY:** Increase knowledge and efficacy for healthy eating and active living through evidence-based programs.
- **STRATEGY**: Improve access to active living through Pedestrian and Bike friendly environments, Scholarships to recreation activities, and transportation
- **STRATEGY**: Increase health equity advocacy to address healthy eating and active living.

For more information:

CDPHE Colorado Health Indicators
https://www.colorado.gov/pacific/cdphe/colorado-health-indicators
World Health Organization
http://www.who.int/mental_health/evidence/en/promoting_mhh.pdf
Centers for Disease Control and Prevention
https://www.cdc.gov/chronicdisease/overview/index.htm
CDPHE Vision Data Tool
https://www.colorado.gov/pacific/cdphe/vision-data-tool

West Central Public Health Partnership
Delta • Gunnison • Hinsdale • Montrose • Ouray • San Miguel
www.wcphp.org

QUESTIONS?
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mwacker@gunnisoncounty.org

Healthy Eating and Active Living Sources

1. Colorado Department of Public Health and Environment, Colorado Health Indicators. Age adjusted rate for all causes of death, 2012-2014. http://www.cdphe.state.co.us/cohid. Accessed July 1, 2016.

2. Centers for Disease Control and Prevention, Chronic Disease Overview, Chronic Diseases: The Leading Causes of Death and Disability in the United States http://www.cdc.gov/chronicdisease/overview/. Accessed July 8, 2016.

3. Promoting mental health: concepts, emerging evidence, practice: summary report / a report from the World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation (VicHealth) and the University of Melbourne. (2004).

4. Chapman DP, Perry GS, Strine TW. The vital link between chronic disease and depressive disorders. Prev Chronic Dis [serial online] 2005 Jan [date cited]. Available from: URL: http://www.cdc.gov/pcd/issues/2005/jan/04_0066.htm.

5. Colorado Department of Public Health and Environment, Colorado Health Indicators. Health Behaviors and Conditions, 2013-2015. http://www.cdphe.state.co.us/cohid. Accessed July 1, 2016.

6. Colorado Department of Public Health and the Environment, VISION Tool. Multiple risk factors among adults 2015 or 2016. https://www.colorado.gov/pacific/cdphe/vision-data-tool. Accessed May 7, 2018.

7. Chapman DP, Perry GS, Strine TW. The vital link between chronic disease and depressive disorders. Prev Chronic Dis [serial online] 2005 Jan [*date cited*]. Available from: URL: http://www.cdc.gov/pcd/issues/2005/jan/04_0066.htm.

8. NHS Health Scotland. The right to health. http://www.healthscotland.scot/health-inequalities/the-right-to-health. Accessed August 1, 2018.

9. Colorado Department of Public Health and the Environment, VISION Tool. Data by Demographics. https://www.colorado.gov/pacific/cdphe/vision-data-tool. Accessed August 1, 2018.

Behavioral Health

West Central Public Health Partnership
Region 10: Delta, Gunnison, Hinsdale, Montrose, Ouray, & San Miguel

Priority Area!

Behavioral Health is a **top** health priority in all six counties of Region 10. The West Central Public Health Partnership recognizes behavioral health as:

- mental health promotion,
- suicide prevention and
- substance abuse prevention.

Mental health encompasses many conditions, the most common types are:

- depression,
- anxiety, and
- bipolar disorder.

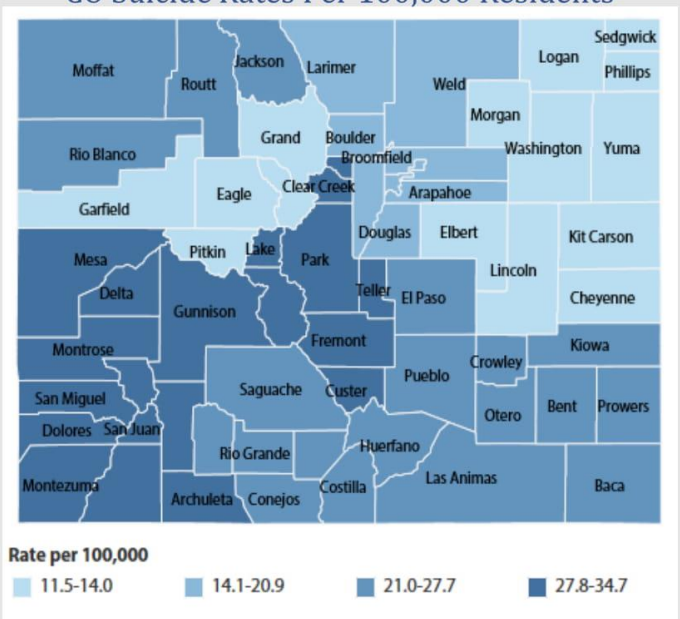
The Center for Mental Health (CMH) is the community mental health center that serves residents of Region 10. During the 2017 fiscal year the CMH served 5,313 unique clients; 49.7% female and 50.3% male.[1] 9% of Region 10 adults reported that their mental health was not good 14 or more days in the past 30 days.[2]

Colorado is in the top ten states with the highest rate of death by suicide in the nation and the Rocky Mountain Region has the highest suicide rate in the contiguous 48 states.[3,4,8]

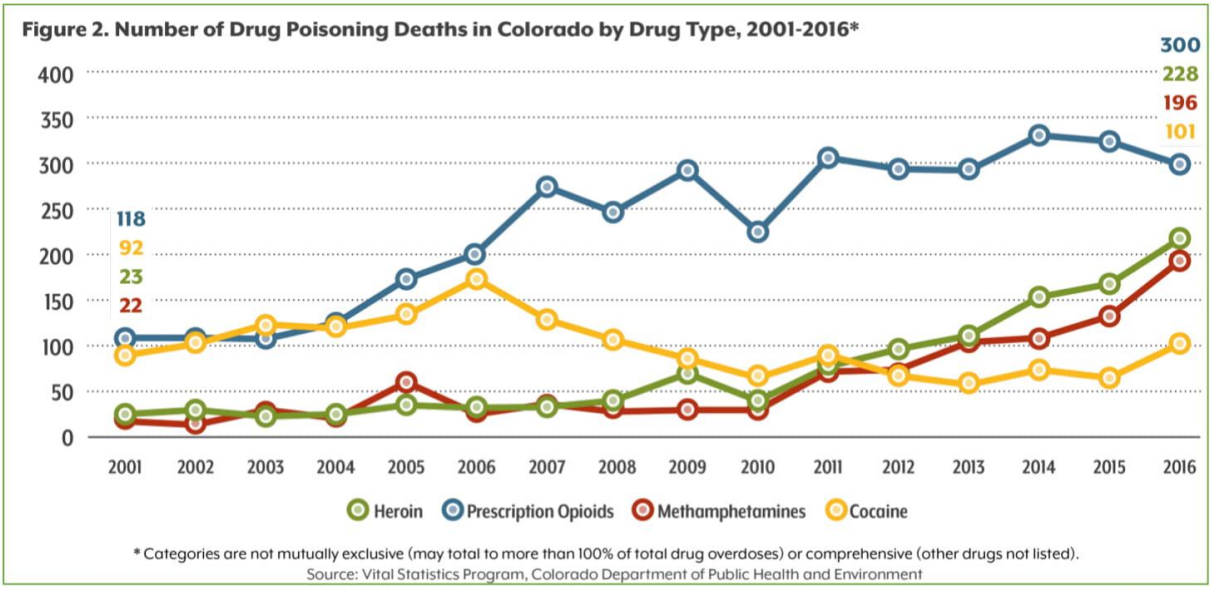
Youth in Region 10 are asked about their mental health through the Healthy Kids Colorado Survey.

- In 2015, 26.3% of high school students had depressive symptoms.[5]
- 6.9% of high school students have attempted suicide at least once in the last year (2015).[6]
- Rate for suicide attempts increased 35.3% from 2013 to 2015 in Region 10[7]

CO Suicide Rates Per 100,000 Residents



Colorado Health Institute. Suicide in Colorado. 2016.[8] *https://www.coloradohealthinstitute.org/research/suicides-colorado-reach-all-time-high*



Health Equity and Behavioral Health

Region 10 stakeholders identified early childhood and youth, elderly, immigrants, low income, geographically isolated residents and LGBTQ as a possible priority populations for behavioral health strategies. For example, 61.5% of LGB (Lesbian, Gay, Bisexual) youth in Colorado report having depressive symptoms in the past year compared to just 25.3% of their heterosexual peers.[9]

Strategies

- **STRATEGY** Increase collaborative efforts across the region to build capacity for Behavioral Health efforts.
- **STRATEGY** Reduce stigma associated with mental health and reduce substance use through community education, media campaigns and evidence-based prevention strategies.
- **STRATEGY** Integration of behavioral health into primary care and other sites (Nursing home, Public Health, Dentists, Human Services, Alternative providers, Opioid prescribers, drug screeners).
- **STRATEGY** Health Equity Advocacy in Behavioral Health.

https://www.coloradohealthinstitute.org/research/death-drugs

For more information:

Colorado Health Institute
www.coloradohealthinstitute.org/
Healthy Kids Colorado Survey
www.colorado.gov/pacific/cdphe/hkcs
Centers For Disease Control and Prevention
www.cdc.gov/nchs/pressroom/sosmap/suicide-mortality/suicide.htm
CDPHE Prescription Drug Data Profiles
www.colorado.gov/pacific/cdphe/prescription-drug-data-profiles
Colorado Consortium for Prescription Drug Abuse Prevention
https://public.tableau.com/profile/omni#!/vizhome/RXConsortiumdashboard/Readmefirst
The Center for Mental Health
www.centermh.org/

Crisis Line Information
Local Crisis Line: 970-252-6220
State Crisis Line: 1-844-493-TALK (8255)
Text "TALK" to 38255
National Suicide Prevention Lifeline:
1-800-273-8255

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www.wcphp.org

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Behavioral Health Sources

1. Center for Mental Health. Center for Mental Health Regional Health PowerPoint 2017.

2. Colorado Department of Public Health and Environment. Colorado Health Indicators. Mental Health. https://www.colorado.gov/pacific/cdphe/colorado-health-indicators. Accessed October 12, 2016.

3. Centers for Disease Control and Prevention. National Center for Health Statistics, 2016. Suicide Mortality by State. https://www.cdc.gov/nchs/pressroom/sosmap/suicide-mortality/suicide.htm . Accessed March 16, 2018.

4. Why Are Ski Towns Seeing More Suicides? Posted by Kelley McMillan on May 16, 2016 http://adventureblog.nationalgeographic.com/2016/05/16/why-are-ski-towns-suicides-happening-at-such-an-alarming-rate/. Accessed March 16, 2018.

5. Colorado Department of Public Health and the Environment, VISION Tool. Data by Demographics. https://www.colorado.gov/pacific/cdphe/vision-data-tool. Accessed April 29, 2018.

6. Healthy Kids Colorado Survey, 2015 Region 10 Reports. Mental Health Among Youth in Colorado. https://www.colorado.gov/pacific/sites/default/files/PF_Youth_MH-Infographic-Digital.pdf. Accessed October 20, 2016.

7. Futyu??? ASK Katherine!

8. Colorado Health Institute. Suicide in Colorado. 2016. Accessed July 31, 2018. *https://www.coloradohealthinstitute.org/research/suicides-colorado-reach-all-time-high*

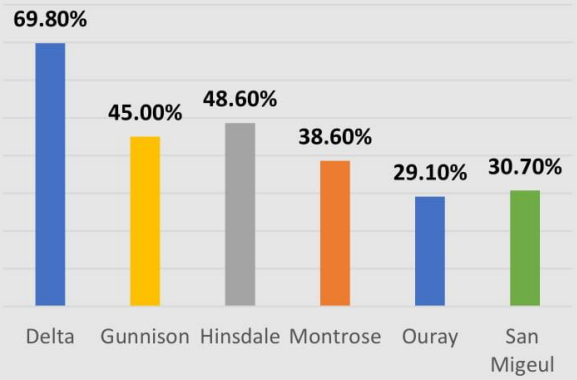
9. Colorado Department of Public Health and the Environment, VISION Tool. Data by Demographics. https://www.colorado.gov/pacific/cdphe/vision-data-tool. Accessed April 29, 2018.

Healthy Housing is fundamental to preventing disease and injury through promoting safe, decent, and sanitary housings. Poor health outcomes can be correlated to substandard housing such as lead poisoning, increased cancer incidence, or asthma. Additionally, creating healthy homes promotes positive development and growth for children and the potential to save on health care costs.[1] Throughout Region 10 exposure to **LEAD** and **RADON** and **WELL WATER** quality have been identified as the highest healthy housing priorities.

LEAD

Region 10 has a high percentage of the housing stock built before 1980. Lead paint was banned in 1978.[2] Lead poisoning can lead to developmental problems for our youngest residents. Lead-based paints deteriorate over time creating surface dust that is unknowingly ingested. The dust may be so fine that it cannot be seen by the naked eye and is difficult to clean up.[3] Often our low income families are living in housing that is substandard, therefore these children have a higher possibility of exposure to lead.

Percent of homes built before 1980 (American Community Survey 2012-2016)[2]

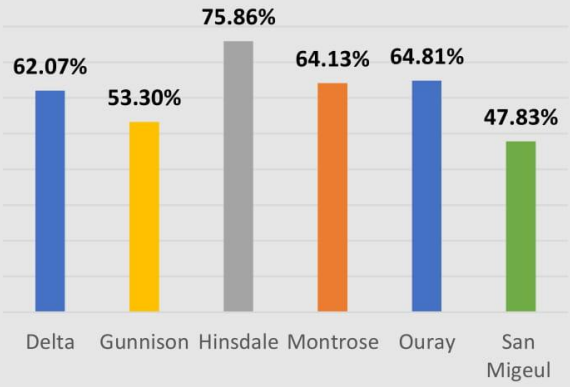


https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml

RADON

Radon is produced when uranium breaks down in the soil. It seeps into homes through cracks and openings in basements and crawl spaces. Radon exposure is the second leading cause of lung cancer after smoking.[4] Of the homes tested throughout Region 10, counties range from 40% to almost 60% with radon limits above the EPA recommendations of 4 picocuries per liter (pCi/L).[5] The entire region is at the highest level, Zone-1 radon potential, meaning it is above the EPA 4pCi/L limit.[6]

Percent of indoor radon results over 4pCi/L (CDPHE 2005-2017)[5]



https://www.colorado.gov/pacific/coepht/radon-data

WELL WATER

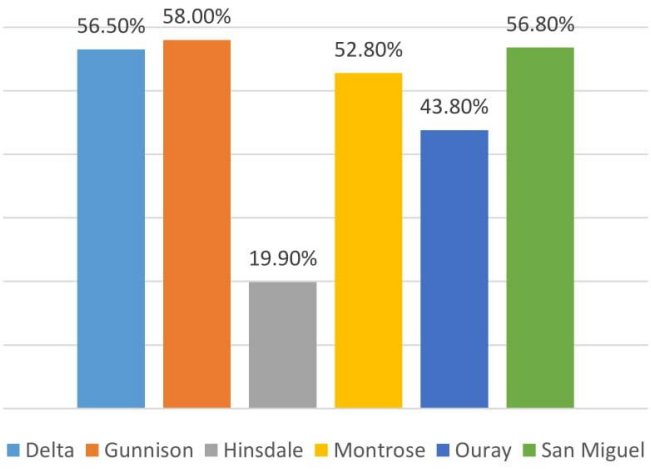
10,000 (10%) Region 10 residents get their well water from private wells.[7] While public water systems are regularly tested, water quality of private wells are not regulated. Private wells may contain natural impurities or contaminants. Health outcomes vary based on frequency of exposure to water, by person, and amount and type of containment. Adverse health outcomes can include cancer, gastrointestinal illness, cardiovascular effects, kidney disease, and neurological development disorders.[8]

Learn more about free well water testing through the WCPHP visit *www.wcphp.com/well-water-testing/*.

Health Equity

The Social Determinants of Health identify housing as one of the core defining areas of Economic Opportunity. These are the basic resources the population needs to thrive and have positive health outcomes including affordable housing.
Affordable housing is defined as long-term, desirable and affordable. It is further defined as families paying no more than 30% of their annual household income including utilities to housing. [9] The graph below indicates that slightly under half of the residents who rent in Region 10 are paying 30% or more of their gross household income to rent.[10]

Percent of Population Paying 30% or more of the Gross Household Income in Rent[10] (American Community Survey 2012-2016)



https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml

Strategies

- **STRATEGY:** Improve community knowledge of healthy housing practices such as testing and mitigation of radon, lead, and well-water.
- **STRATEGY:** Improve access to healthy housing through policies such as health-promoting building codes, enforcing housing codes, and incentivizing mitigation
- **STRATEGY:** Increase health equity advocacy for safe affordable housing through participating in local and regional housing groups and coalitions.

For more information:

American Community Survey
https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml
CDPHE Health Indicators
https://www.colorado.gov/pacific/cdphe/colorado-health-indicators
CHPHE Lead
https://www.colorado.gov/pacific/cdphe/categories/services-and-information/lead
CDPHE Radon Data
https://www.colorado.gov/pacific/coepht/radon-data
CDPHE Radon
https://www.colorado.gov/pacific/cdphe/categories/services-and-information/environment/radon
CDPHE Drinking Water Private Wells
https://www.colorado.gov/pacific/cdphe/drinking-water-private-wells

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Healthy Housing Sources

1. U.S. Department of Housing and Urban Development. Making homes healthier for families. https://www.hud.gov/program_offices/healthy_homes/healthyhomes. Accessed March 20, 2018.
2. United States Census Bureau. 2016 American Community Survey 5 Year Estimates. Selected housing characteristics. https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml. Accessed April 16, 2018.
3. Colorado Department of Public Health and Environment. What are the common sources of lead? https://www.colorado.gov/pacific/cdphe/lead-what-are-common-sources. Accessed March 20, 2018.
4. Colorado Department of Public Health and Environment. Radon and your health. https://www.colorado.gov/pacific/cdphe/radon-and-your-health. March 20, 2018
5. Colorado Department of Public Health and Environment. Radon data. https://www.colorado.gov/pacific/coepht/radon-data Accessed March 20, 2018.
6. United States Environmental Protection Agency. Colorado - EPA map of radon. https://www.epa.gov/sites/production/files/2014-08/documents/colorado.pdf. Accessed March 20, 2018.
7. Colorado Department of Public Health and Environment. Colorado Health Indicators. Physical environment. https://www.colorado.gov/pacific/cdphe/colorado-health-indicators . Accessed April 16, 2018.
8. Colorado Department of Public Health and Environment. Private well water and your health. https://www.colorado.gov/pacific/coepht/private-well-water-and-your-health Accessed March 20, 2018.
9. U.S. Department of Housing and Urban Development. Affordable housing. https://www.hud.gov/program_offices/comm_planning/affordablehousing/. Accessed March 20, 2018.
10. United States Census Bureau. 2016 American Community Survey 5 Year Estimates. Selected housing characteristics. https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml. Accessed April 16, 2018.

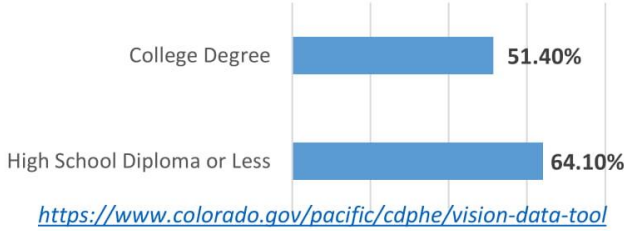
Health Equity

The West Central Public Health Partnership recognizes the critical role the social determinants of health play in population health outcomes. As S. James from the Centers for Disease Control and Prevention (CDC) summarized, "Social determinants of health are life-enhancing resources, such as food supply, housing, economic and social relationships, transportation, education and health care, whose distribution across populations effectively determines length and quality of life."[1] When these resources are not disturbed evenly across populations, health burdens fall more heavily on those lacking the resources.

Health Equity is a model to help explain the role of the social determinants of health on overall population health (see figure here).

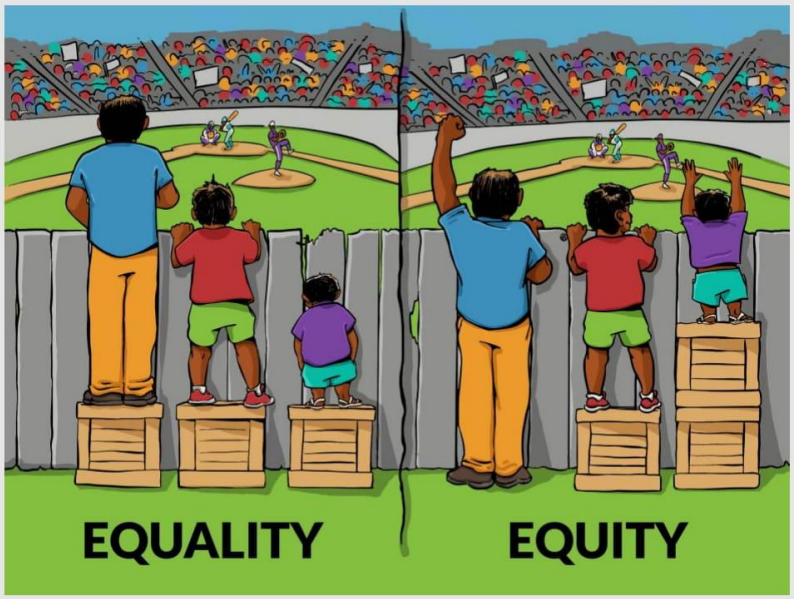
Social factors combined with health factors interact to affect the health of our population. For example, in Colorado the percentage of adults who are overweight or obese is higher among residents with less than a high school diploma compared to those who graduated college.[2]

Education Level for Colorado Overweight and Obese Adults
CDPHE Vison Tool 2016[2]



https://www.colorado.gov/pacific/cdphe/vision-data-tool

The Different of Equality vs. Equity



International Institute for Social Change

"The difference between equity and equality is that of three individuals of different heights who are attempting to peer over a fence. In order to treat them equally, they would all be given the same size box to stand on to improve their lines of sight. However, doing so wouldn't necessarily help the shortest person see as well as the tallest person. In order to give equitable treatment, each person would need to be given a box to stand on that would enable a clear view over the fence."[3]
Milken Institute of Public Health, George Washington University

Social Determinants of Health

The social determinants of health are the conditions in which we are born, we grow and age, and in which we live and work. The factors below impact our health and wellbeing.[4]
NHS Health Scotland

WCPHP and Health Equity

The WCPHP recognizes that health inequity exists within our region. Region 10 stakeholders identified priority populations including: **early childhood and youth, elderly, immigrants, low income residents, LGBTQ, and geographically isolated residents.**

The WCPHP is gathering regional level data from focus groups to better understand our unique health inequities and identify strategies to mitigate these challenges. Preliminary analysis of existing Latino focus group data shows that access to care (see access to care handout) is a primary concern for members of the Latino community in Region 10.

Currently the WCPHP is part of the Health Equity Action Team lead by the Valley Food Partnership in Montrose. This focus of this work is to build capacity and leadership in the region to address health equity.

The Colorado Department of Public Health and Environment created an online data tool that displays state level population health data broken down by age, sex, race/ethnicity, sexual orientation, education level, poverty level and insurance type. It provides a high level understanding of how different populations have differing health outcomes.

- Health outcomes such as length of life and quality of life are determined by factors such as Health Behaviors, Social and Economic Factors, Clinical Care, Physical Environment and Genes and Biology. An estimated 40% of health outcomes are a result of social and economic factors.[5]
- Adverse Childhood Experiences (ACEs) have been linked to risky behaviors, chronic health outcomes, low life potential and early death.[6]

Health Equity in Our Strategies

- Increasing health equity, advocacy, and capacity in all of our priority areas.

For more information:

Social Determinants of Health
https://www.cdc.gov/socialdeterminants/
CDPHE Office of Health Equity
https://www.colorado.gov/pacific/cdphe/ohe
Community Commons
https://assessment.communitycommons.org/Footprint/
CDPHE Vision Data Tool
https://www.colorado.gov/pacific/cdphe/vision-data-tool
CDPHE Health Equity Model
https://www.colorado.gov/pacific/sites/default/files/CHAPS1_Health-Equity-Model-and-Summary.pdf

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Health Equity Sources

1. S. James in Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health, Centers for Disease Control and Prevention, 2008
2. Colorado Department of Public Health and the Environment, VISION Tool. Data by Demographics. https://www.colorado.gov/pacific/cdphe/vision-data-tool. Accessed March 20, 2018.
3. Milken Institute School of Public Health, George Washington University. What's the difference between equity and equality? https://publichealthonline.gwu.edu/blog/equity-vs-equality/ . Accessed July 31, 2018.
4. NHS Health Scotland. The right to health. http://www.healthscotland.scot/health-inequalities/the-right-to-health. Accessed August 1, 2018.
5. County Health Rankings. What is health? http://www.countyhealthrankings.org/what-is-health. Accessed July 15, 2018.
6. Centers for Disease Control and Prevention. Adverse childhood experiences ACEs. https://www.cdc.gov/violenceprevention/acestudy/index.html . Accessed July 15, 2018.

Health Access

West Central Public Health Partnership

Region 10: Delta, Gunnison, Hinsdale, Montrose, Ouray, & San Miguel

All counties in the six county region identified access to health as a top health priority in 2016.[1] Region 10 residents described access as:

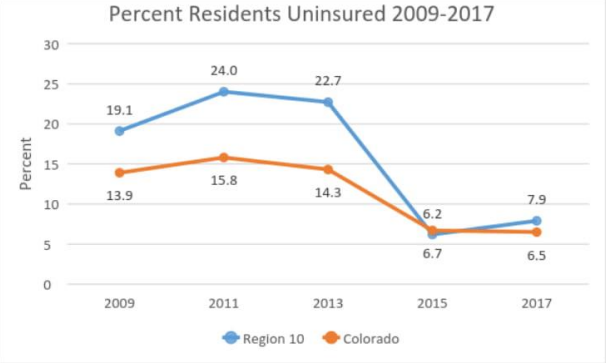
- affordability of car,
- health insurance
- dental health
- prescription drugs
- availability of local providers and specialty care
- affordable, healthy foods
- access to recreational activities
- access to behavioral health services
- transportation to and from care.

All three hospitals in Region 10 also identified access to care as a need in their Community Health Needs Assessments.[2]

A lack of access to care can lead to:

- unmet health needs,
- inability to get necessary preventive services,
- delays in receiving necessary care,
- financial hardships, and
- preventable hospital stays.

Overall, lack of access leads to poor individual and population level health outcomes.



Colorado Health Institute, Colorado Health Access Survey (2009-2017)[3]
https://www.coloradohealthinstitute.org/research/colorado-health-access-survey

Health Care System

The traditional health care system is often the first point of access for personal health- including the health insurance system, medical providers, and health care facilities. The percent of Region 10 residents without health insurance has dropped dramatically since its peak in 2011.

- Approximately 8,000 residents (7.9%) remain without health insurance in 2017.

Despite the increasing number of residents with health insurance for Region 10, five of the six counties in Region 10 are Medically Underserved Areas/Populations.[3] This designates areas with a lack of access to primary care services.

In 2017, 19.1% of Region 10 residents reported they were unable to get an appointment at the doctor's office or clinic as soon as they thought they needed one.[4]

Even if a resident has the necessary insurance, ability to pay, transportation, and time to seek treatment, there may not be a provider available when needed.

Preventative Services & Public Health

Preventative services are offered through traditional health care system as well as public health departments. These services include:

- education,
- immunizations/vaccinations,
- screenings, and
- policies to promote health.

Currently, all six counties in Region 10 have a public health department that can help residents access the preventative services offered. However, the capacity of these small agencies to provide quality preventative services to all those in-need is challenging. As part of the Regional Health

Assessment, the public health directors completed a capacity assessment focused on the department's capacity and capability to provide the Colorado Core Public Health Services and continue regional collaboration. Based on the assessment the ability to hire new staff and expand existing qualified staff are the biggest barriers to regional collaboration.

Health Equity and Access to Health

The ability to access health is directly linked to the social determinants of health outlined in the Health Equity Model (see Healthy Equity Handout).[5] Income, employment, and transportation all influence a person's ability to access health. When economic opportunity, physical environment, and social supports are not equitable for our residents, neither are their health outcomes.

In Region 10, 4.9% of residents making over 400% of the Federal Poverty Level (FPL) were uninsured in 2017 compared to 8.3% of residents making 100% or below the FPL. [6]

From the 2017 Colorado Health Access Survey, 8.0% of Region 10 respondents reported that they were unable to find transportation to the doctor's office or the doctor's office was too far away (CO, 5.5%).[7] Without an adequate public transportation system that is available to everyone, access to care is more difficult for some residents than others.

Residents who do not speak English face an additional barrier to care. Following English, Spanish is most often spoken in the home for Region 10, however a small portion of providers in the whole state of Colorado are fluent in a language other than English and only 3% of physicians in Colorado are Latino. [8,9]

Region 10 Public Health Priorities

- Healthy Eating and Active Living
- Healthy Housing
- Behavioral health
- Health Equity

For more information:

Health Equity Model
https://www.colorado.gov/pacific/sites/default/files/CHAPS1_Health-Equity-Model-and-Summary.pdf
Colorado Health Institute
https://www.coloradohealthinstitute.org/
- Community Health Access Survey
- County Health Profiles
- https://www.coloradohealthinstitute.org/data

Gunnison Valley Health Community Health Needs Assessment
https://www.gunnisonvalleyhealth.org/documents/Community-Health-Needs-Assessment/GVH_2016CHNA_FinalVersion.pdf
Montrose Memorial Hospital Community Health Needs Assessment
http://www.montrosehospital.com/about-mmh/community-health-needs-assessment/
Delta County Memorial Hospital
http://www.deltahospital.org/getpage.php?name=2016chna
Center for Health Progress – Health: A white privilege?
https://centerforhealthprogress.org/blog/publications/health-white-privilege/

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Health Access Sources

1. Gunnison Valley Health. Community Health Needs Assessment and Implementation Strategy. pg 2. https://www.gunnisonvalleyhealth.org/Patient-Resources/Community-Health-Needs-Assessment.aspx?furl=communityhealthneeds. Accessed June 15, 2017.
2. Montrose Memorial Hospital. Community Health Needs Assessment and Implementation Strategy. pg 10. http://www.montrosehospital.com/about-mmh/community-health-needs-assessment/. Accessed June 15, 2017.
3. Delta County Memorial Hospital. 2016 Community Health Needs Assessment. pg 2. http://www.deltahospital.org/docs/2016_CHNA_-_Final.pdf. Accessed June 15, 2017.
4. Colorado Health Institute. Colorado Health Access Survey 2017. Regional Data. https://www.coloradohealthinstitute.org/data. Accessed November 24, 2017.
5. Health Resources and Service Administration, US Department of Health and Human Services. Medically Underserved Area Find (MUA Find). https://datawarehouse.hrsa.gov/tools/analyzers/MuaFind.aspx, Accessed September 22, 2017.
6. Colorado Health Institute. Colorado Health Access Survey 2017. Regional Data. https://www.coloradohealthinstitute.org/data. Accessed November 24, 2017.
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8. Colorado Health Institute. Colorado Health Access Survey 2017. Regional Data. https://www.coloradohealthinstitute.org/data. Accessed November 24, 2017.
9. Percentage of the total population living in households in which Spanish is spoken. US Census Bureau. 2010. https://statisticalatlas.com/state/Colorado/Languages#definitions. Accessed April 24, 2018.
10. Health Equity and Language Access. Colorado Trust. July 2013. http://www.coloradotrust.org/sites/default/files/CT_LanguageAccessBrief_final-1.pdf. Accessed APril 24, 2018.
11. Diversity in Workforce. Association of American Medical Colleges. 2014. Section III: Geographic Distribution of the Physician Workforce by Race and Ethnicity. http://aamcdiversityfactsandfigures.org/section-iii-geographic-distribution-of-physician-workforce/. Accessed April 24, 2018.

Healthy Eating Active Living - Environmental Strategies

Year 1 January 1 2019 - December 31st, 2019

Goal: Increase healthy eating and active living to reduce obesity and chronic disease.

Strategy: Improve access to healthy foods through environmental strategies such as: breastfeeding friendly environments, community gardens, WIC and SNAP at Farmers Markets

	Objectives and Responsible Agency	Action Steps	Status	Priority Population	Resources & Barriers
Community and School Gardens	A) Maintain and build capacity and resources for local community gardens by identifying funding opportunities, organizational trainings, and connecting them to appropriate partners by 12/31/2019. B) Collect regional community and school garden data by 12/31/19 C) Encourage produce donations to local food pantries or other vulnerable populations and explore concurrent education programs 12/31/20.	1) Identify a point person at WCPHP to search for funding and connect community partners to funding sources. 2) Point person at WCPHP regularly connects with agencies that maintain community gardens to community opportunities. 3) Collect data on the number, location, status, and population served of community and school gardens. 4) Develop standardized data collection tool in partnership with Mountain Roots AmeriCorps member. 5) Assess health equity impact of current gardens and efforts to collaborate with food pantries.		Children and Youth	Resources Valley Food Partnership Mountain Roots Food Project Town of Ridgway School Districts WCPHP Rec Centers AmeriCorps - Mountain Roots Barriers Lack of capacity and funding for WCPHP personnel
Farmers Markets	D) Increase the number of farmers and markets that accept SNAP/WIC by 12/31/21. E) Assess current barriers for priority populations for accessing Farmer's Markets and CSAs.	6) Identify a point person at WCPHP to reach out to all farmers market to identify who is not accepting SNAP/WIC and what barriers are by 12/31/19. 7) Identify and share potential funding sources for machine. 8) Develop a data tool for farmers markets/farmers to measure imapct on vulnerable populations		Low-income families and young children	Resources Farmers and Farmers Market Directors Valley Food Partnership Mountain Roots Food Project Telluride Foundation? Barriers Capacity at the federal level Lack of funding for machine
Breastfeeding	F) Build capacity by looking for continuation funding for breastfeeding friendly environments by 12/31/19	10) Continue to provide breastfeeding resources on the WCPHP website. 11) WCPHP personnel actively research and apply for potential funding opportunities. 12) Gather baseline data from Breastfeeding policies passed through recent Public Health as well as WIC and Nurse Family Partnership.		Young children and mothers	Resources Nurse Family Partnership Women Infants and Children Certified Lactation Consultants Early Childhood Councils Barriers Lack of capacity and funding for WCPHP personnel

Indicators

# of people in priority populations accessing food through gardens and farmers markets and food pantries
% of WIC and NFP clients who breastfeed exclusively for 6 months
# of presentations/meetings about health equity
BRFSS: Fruit and Vegetable intacke of adults and youth (by priority populations if available)

Healthy Eating Active Living - Evidenced Based Programs

Year 1 January 1 2019 - December 31st, 2019

Goal: Increase healthy eating and active living to reduce obesity and chronic disease.

Strategy: Increase knowledge and efficacy for healthy eating and active living through evidence-based programs.

	Objectives	Action Steps	Status	Priority Population	Resources & Barriers
Cooking Matters	A) Maintain and build capacity and resources for local Cooking Matters programs by identifying funding opportunities, organizational trainings, and connecting them to appropriate partners by 12/31/19 B) Collect regional data regarding equity and cooking matters enrollment 12/31/19 C) Increase enrollment in Cooking Matters, with emphasis on reaching priority populations by 12/31/2020.	1)Identify a point person at WCPHP to search for funding and connect community partners to funding sources 2) Identify a point person at WCPHP regularly connects with agencies that manage Cooking Matters in our region. 3) Engage all agencies that offer Cooking Matters to collect data, identify gaps, capacity, and barriers in access. 4) Explore development of regional referral/intake form for Cooking Matters. 5) Communicate/market cooking matters at other agencies that interface with priority populations. 6) Increase referrals to cooking matters from community agencies that serve low-income families, such as WIC, Nurse Family Partnership, parenting programs, Medicaid providers, and Human Services.		Low-income families Hispanic Families	Resources Agencies who offer Cooking Matters Mountain Roots Food Project Hilltop Cooking Matters: SW Region (Alexandra Lee). Medicaid providers Food Pantries Health and Human Services Departments WIC and Nurse Family Partnership Valley Food Partnership Barriers Capacity Funding
Evidenced-based Programs	D) Build capacity and resources for evidenced based programs by identifying funding opportunities, organizational trainings, and connecting them to appropriate partners such as Farm-To-Table or Local Farmacy RX by 12/31/2020. E) Explore creating a system for shared learning for evidenced based programs by 12/31/2020.	7) Identify a point person at WCPHP to search for funding and potential evidenced-based programs and connect community partners to funding sources and programs. 8) Engage with community partners and learn about other evidenced -based HEAL programming happening in the region. 9) Convene regional HEAL stakeholders annually and promote shared learning of evidenced-based HEAL programs and a shared learning system.		Community partners HEAL stakeholders	Resources School Districts WCPHP Stakeholders Tri- County Health Network Valley Food Patnership Mountain Roots Food Project WSCU Americorps Barriers Capacity Funding

Indicators

% or # of priority populations participating in Cooking Matters
BRFSS Fruit and Vegetable Intake (by priority population if available)
Obesity and Overweight of adults and youth (by priority population if available)

Healthy Eating Active Living - Active Transport & Access Year 1 January 1 2019 - December 31st, 2019

Goal: Increase healthy eating and active living to reduce obesity and chronic disease.

Strategy: Improve access to active living through pedestrian, bike friendly environments, recreation activities, and transportation

Objectives	Action Steps	Status	Priority Population	Resources & Barriers
A) Build capacity and resources for pedestrian/bike friendly environment by identifying funding opportunities and connecting them to appropriate partners by 12/31/2019. B) Advocate and educate at community meetings about the importance of active transport by 12/31/20. C) Assess built environment and collect data including bike/pedestrian friendly environments 12/31/2019. D) Assess barriers for vulnerable populations for accessing active living opportunities, including trails, and recreation programs 12/31/2020.	1) Identify WCPHP personnel to contact community partners and agencies that support active transport. 2) Identify a point person at WCPHP to search for funding and connect community partners to funding sources. 3) Build relationship between Public Health staff and programs/organizations providing active living and active transportation services. 4) Public health personnel attend community and local government meetings to advocate for active transport, including HEAL Cities and Towns Campaign. 5) Assess health equity impact of current active transport programs and projects including data on priority population and access by 12/31/2020. 6) Work with partners to engage vulnerable populations to learn about barriers, such as transportation, cost of sports physicals, and cost of program. 7) Encourage active transport and recreation programs to include vulnerable population leaders in planning and organizing, as well as other types of community engagement. 8) Provide Health Equity Training to increase advocacy for access to healthy living.		Low income community members Youth and Children Seniors Hispanic Population	Resources Local RTA agencies Valley Food Partnership Community Development/Planning Local trail associations/non profits, Parks and Recreation Departments Senior Centers School Districts LiveWell Colorado City of Montrose Colorado Health Foundation Barriers Funding Capital investments Capacity Reliant on partners

Indicators

Progress - # trained in Health Equity
# of related meetings that Public Health staff attended and advocated at for AT.
# of HEAL Cities and Towns in the region.
priority populations accessing trails and healthy living programs.

Healthy Eating Active Living - Health Equity Year 1 January 1 2019 - December 31st, 2019

Goal: Increase healthy eating and active living to reduce obesity and chronic disease.

Strategy: Increase health equity advocacy to address healthy eating and active living

Objectives	Action Steps	Status	Priority Population	Resources & Barriers
A) Build capacity and resources for local health equity advocates by 12/31/19 B) Increase partnerships among HEAL advocates by 12/31/19. C) Collect regional data on vulnerable populations in a sharable report for HEAL 12/31/19. D) Increase health equity education and training for HEAL advocates 12/31/19. E) Advocate for vulnerable populations access to HEAL programs and services 12/31/19.	1) Identify a point person at WCPHP to search for funding and training opportunities and connect community partners to funding sources. 2) Convene stakeholder meeting annually to increase partnerships, training, and peer learning. 3) Engage with vulnerable populations to learn barriers to access HEAL programs and resources. 4) Build a sustainable detailed strategy for collecting regional data to better understand which Social Determinants of Health to focus on when advocating for HEAL. 5) WCPHP will bring health equity trainings to HEAL advocates. 6) HEAL stakeholders attend community meetings and advocate for vulnerable populations such as bike paths to new developments.		HEAL Stakeholders Low SES population Hispanic population	Resources WCPHP Valley Food Partnership Center for Mental Health Food Banks Faith Based Community Human Services WIC NFP Mountain Roots Food Project LiveWell Data tool Barriers Funding Capacity

Indicators

Attendance at Health Trainings
number of program policies related to health equity that are developed
# of presentations/meetings about health equity

Behavioral Health - Collaboration and Coordination Year 1 January 1, 2019- December 31, 2019

Goal: Improve behavioral health outcomes including reducing suicide, reducing poor mental health days (reduce depression and anxiety), and reducing substance abuse.

Strategy: Increase collaborative efforts across the region to build capacity for Behavioral Health efforts.

Objectives	Action Steps	Status	Priority Population	Resources & Barriers
A) Increase capacity for coordination, communication and alignment across the region by 12/31/19. B) Explore creation of an online hub for regional sharing by 12/31/2020. C) Build capacity and resources for integration of BH into primary care, community education, behavioral health stigma reduction campaigns, and evidence-based programs by 12/31/2020	1) WCPHP partners with Regional Behavioral Health Collaborative, by participating/leading 2 subgroups: Integration of BH in Primary Care and Public Health/Prevention. 2) WCPHP coordinate an annual regional behavioral health stakeholder meeting to learn about programs, services, health equity and communication and align efforts. 3) Identify a point person at WCPHP to search for funding opportunities in order to build capacity to increase trainings, community education and evidence based programs in collaboration with community partners, such as local behavioral health/suicide prevention coalition leaders. 4) Encourage information sharing between Regional Behavioral Health Collaborative and local stakeholders such as training information and other behavioral health efforts. 5) WCPHP will identify potential grant funding and commit to writing grants to continue LPHA capacity to address behavioral health. 6) Build capacity to send local personnel to behavioral health train the trainer trainings to facilitate in English and Spanish. 7) Each LPHA Director of WCPHP shall ensure connection with all agencies and coalitions that support behavioral health within their county.		Behavioral Health Stakeholders Spanish speaking residents	Resources WCPHP Center for Mental Health Regional Behavioral Collaborative Hospitals Collaborative Management Program and System (Gunnison, Montrose, Delta, and Ouray) Hinsdale County Build a Generation Ouray County Voyagers Youth Program Community Health Coalition of the Gunnison Valley Gunnison County Substance Abuse Prevention Project: GCSAPP Montrose Suicide Coalition S.W.E. (Safety Wellness Education - Delta Coalition) Montrose School District Delta BH Coalition San Miguel County Regional Behavioral Health Commission, led by TCHN Unite Montrose Peer Kindness Hilltop Barriers Funding Capacity

Indicators
# of partners engaged in collaboration
Grant dollars generated
# of strategic plans that are aligned

Behavioral Health - Education and Stigma Reduction

Year 1 January 1, 2019 -December 31, 2019

Goal: Improve behavioral health outcomes including reducing suicide, reducing poor mental health days (reduce depression and anxiety), and reducing substance abuse.

Strategy: Reduce stigma associated with mental health and reduce substance use through community education, media campaigns and evidence-based prevention strategies.

	Objectives	Action Steps	Status	Priority Population	Resources & Barriers
Community Education and Media Campaigns	A) Increase community education around Behavioral Health (increase service use) by 12/31/2019.	1) WCPHP implements evidence based stigma reduction campaigns approved by WCPHP SIM Steering Committee in English and Spanish and Opioid Awareness Campaigns. 2) Promote Crisis Services phone and text lines. 3) Promote Colorado Quit Line for tobacco cessation services. 4) Promote community education efforts such as Prescription Take Backs regionally. 5) Promote prescription medication take back locations on the WCPHP website and social media accounts. 6) Collect data on reach of community education and priority populations.		General population Spanish Speaking Low SES LGBTQ adults/youth and their families Families with babies	Resources Center for Mental Health Communities That Care Grant State Innovation Model (SIM) Regional Behavioral Health Collaborative Montrose Suicide Coalition Health Coalition of the Gunnison Valley Colorado Consortium for Prescription Drug Abuse Prevention School Districts Early Childhood Councils
Community Trainings	B) Increase trainings for community members and professionals on suicide prevention, substance abuse prevention (such as opioid abuse) and behavioral health including nontraditional groups of potential "gatekeepers" by 12/31/2019.	7) Collaborate with community partners to offer behavioral health trainings in English and Spanish including QPR/ MHFA/Safe Talks/ASIST/Talk Saves Lives/ Firearms, Suicide Prevention Program/ACEs. 8) See Collaborative plan (Action Step 3) for capacity building for trainings. 9) Collect data on behavioral health trainings including type, frequency, location, number of attendees, and priority populations served. 10) Promote provider education trainings on reducing opioid abuse and prescribing practices through BH Collaborative.		Health Professionals First Responders Bartenders LGBTQ Allies Hairdressers Liquor store staff Dispensary staff	American Foundation for Suicide Prevention (Gunnison and Telluride Chapters) S.W.E (Safety, Education, Wellness - Delta Coalition) Collaborative Management Program and System
Evidenced -Based Prevention Strategies	C) Promote importance of social and emotional development through the life span by 12/31/2020.	11) WCPHP personnel will promote and explore data sharing with partners providing social and emotional development model including Nurturing Parenting Program, Pyramid Model, Incredible Years, High Fidelity Wrap Around Sources of Strength, Youth MHFA and Gender Affirmative Model, American Psychological Association, or Stanford Medicine - Health Across the Gender Spectrum. 12) Youth serving public health staff are trained in evidence based social and emotional development through either Pyramid, Incredible Years, Sources of Strength, Youth MHFA, ACEs/Toxic Stress Prevention, Gender Affirmative Model, American Psychological Association, or Stanford Medicine - Health Across the Gender Spectrum. 13) Recommend community engagement with development of new trainings, communications, and social emotional development projects.		Childcare Centers Home Providers Public Health Staff Youth Serving Professionals LGBTQ Allies	School Districts Tri County Health Network Unite Montrose Hilltop Peer Kindness Barriers Capacity Funding

Indicators

# of people reached by community education, trainings (e.g. FB boost reach, MHFA trained people in region), post-training evaluation results
# of focus groups and trainings with priority populations for guiding new efforts
% of high school youth attempting suicide (HKCS)
% of people experience poor mental days, depression and anxiety, check BRFSS and HKCS (regional data by priority population?)
Suicide Death Rate

Behavioral Health - Integration Year January 1, 2019 -December 31, 2019

Goal: Improve behavioral health outcomes including reducing suicide, reducing poor mental health days (reduce depression and anxiety), and reducing substance abuse.

Strategy: Integration of behavioral health into primary care and other sites (Nursing home, Public Health, Dentists, Human Services, Alternative

Objectives	Action Steps	Priority Population	Resources & Barriers
A) Increase behavioral health access through integration into primary care and other sites by identifying funding opportunities, organizational trainings, and connecting them to appropriate partners by 12/31/2019. B) Increase provider education and trainings in integration of behavioral health services by 12/31/19. C) Increase behavioral health screenings and referrals by primary care by 12/31/2020.	1) Identify a point person at WCPHP to search for funding and connect community partners to funding sources (Ouray County as lead). 2) Continue State Innovation Model (SIM) LPHA work of promoting integration of BH into primary care including adding new sites and promoting screening tools. 3) Explore integration of BH into other types of sites beyond primary care, such as nursing homes, Public Health, dentists and others. 4) Collaborate with providers to offer LGBTQ inclusiveness trainings (safe spaces and gender inclusive language). 5) Work with partners, including Regional BH Collaboration Integration subgroup to provide trainings for providers that may include how to get reimbursed for integration, opioid prescribing practices, and suicide intervention trainings - medication assisted treatment with TCHN and SIM. 6) Continue to monitor data on the number of primary care sites that integrate behavioral health. 7) Continue to monitor data on the type of screening tool and frequency used in primary care sites.	Alternative Providers Primary Care LGBTQ	Resources River Valley FQHC Tri County Health Network Senior Care Centers SIM Grant - WCPHP Center for Mental Health Local Behavioral Health Coalitions Regional Hospitals: Montrose, Delta, Gunnison Regional Behavioral Health Primary Care Clinics WCPHP Human Services Depts. Dentists Unite Montrose Hilltop Peer Kindness Barriers Funding Capacity in primary care

Indicators
# of primary care sites with BH integration # of BH screenings in primary care sites

Behavioral Health - Health Equity Year 1 January 1, 2019 - December 31, 2019

Goal: Improve behavioral health outcomes including reducing suicide, reducing poor mental health days (reduce depression and anxiety), and reducing substance abuse.

Strategy: Increase health equity advocacy and access to behavioral health

Objectives	Action Steps	Status	Priority Population	Resources & Barriers
A) Build capacity and resources for local health equity advocates through trainings by 12/31/2019. B) Increase partnerships to build capacity and strengthen health access C) Collect regional data related to BH and priority populations D) Advocate for behavioral health access for priority populations 12/31/2020.	1) WCPHP to provide training opportunities on Health Equity including LGBTQ trainings and peer services. 2) WCPHP staff to outreach to agencies that provide basic needs (food banks, human services, primary care, and faith based communities) to increase referrals to behavioral health resources such as MHFA, CMH services, stigma reduction campaign materials, the BH Resource Directory or other resource list). 3) Engage with vulnerable populations, such as through focus groups, to learn how they obtain information, utilize services, and barriers to accessing services. 4) Continue to monitor behavioral health data outcomes and priority populations. 5) Gunnison Suicide Prevention Coordinator will create standardized participant form (including information on priority populations served) and evaluation form for trainings related to behavioral health. 6) In partnership with Regional BH stakeholders, WCPHP staff advocate for BH access at community meetings and other opportunities. 7) Explore a future strategy arouund increasing primary care providers who accept Medicaid. 8) Explore regional promotora services.		LGBTQ adults/youth and their families Low SES Spanish speakers General population Men	**Resources** WCPHP Center for Mental Health Food Banks Faith Based Community Human Services WIC NFP Unite Montrose Hilltop Peer Kindsness **Barriers** Capacity Funding

Indicators
# of attendees at trainings
number of trainings offered
of primary care providers who accept Medicaid
% of behavioral health outcomes in priority populations

Healthy Housing Education Year 1 January 1 2019 - December 31st, 2019

Goal: Increase healthy housing throughout the region to reduce exposure to radon, lead, and poor quality well water.

Strategy: Improve community knowledge of healthy housing practices such as testing and mitigation of radon, lead, and well-water.

Objectives	Action Steps	Status	Priority Population	Resources & Barriers
A) Maintain and build capacity and resources for regional education campaign and data collection efforts on radon, lead and well-water by 12/31/19.	1) Identify a point person at WCPHP to search for funding opportunities and connect community partners to funding sources, Delta County possible lead.		Low SES People living in substandard housing	**Resources** CSU Extension
	2) Identify potential grant resources for addressing healthy housing issues and writing grants as approved by WCPHP including Radon Grant.		Families with young children	Housing Authority
	3) Develop consistent educational healthy housing messages across counties with partners such as CSU on radon, lead, well water.		Professionals who serve families with young children.	Primary Care
	4) Develop relationship with organizations serving families with young children to partner on educational efforts on lead.			Municipalities
B) Collect regional data on private well water quality and identify areas of hazards and risks associated with consumption of the ground water 12/31/2019.	5) Collect regional well water quality data and the number of private wells tested and develop a public accessible interactive web based map to display the data.			County Government (Community Development Departments)
	6) Explore development of lead baseline data in targeted, higher risk areas.			Early Childhood serving organizations
C) Promote partner agency healthy housing programs - related to housing improvements or landlord/tenant relationships by 12/31/2020.	7) Identify potential healthy housing programs for promoting to the public and priority populations, including CDPHE Low Income Radon Mitigation Assistance program.			
	8) Use state Radon data for education https://www.colorado.gov/pacific/coepht/radon-data.			**Barriers** WCPHP Capacity Funding

Indicators
# of well water, radon, lead tests
Amount of funding attained addressing healthy housing

Healthy Housing - Policy Year 1 January 1 2019 - December 31st, 2019

Goal: Increase healthy housing throughout the region to reduce exposure to radon, lead, and poor quality well water.

Strategy: Improve access to healthy housing through policies such as health-promoting building codes, enforcing housing codes, and incentivizing mitigation

Objectives	Action Steps	Status	Priority Population	Resources & Barriers
A) Build capacity and resources for addressing policies and incentivizing mitigation across the region related to healthy housing by 12/31/2019. B) Collect and maintain regional data on current radon policies 12/31/2019. C) Increase education and awareness for policy makers around the importance of healthy housing (radon, lead, etc.) by 12/31/2019 (with the end goal of creating a movement toward policy change by 12/31/2020).	1) Identify a point person at WCPHP to search for funding opportunities and connect community partners to funding sources, including funding for mitigation. 2) Collect regional data on current policies such as radon, property maintenance codes, as well as community readiness to address policies (for example current data on radon policies). 3) WCPHP personnel and stakeholders will foster relationships with community development organizations and attend community meetings to advocate for healthy/affordable housing. 4) Explore bringing Mesa County training related code enforcement and health outcomes to policy makers and stakeholders. 5) Maintain and collect regional data on building departments who adopt Appendix F of the International Residential Code (Radon Resistant Construction).		Policy Makers	**Resources** WCPHP Housing Authority Municipalities County Government (Community Development Departments) Mesa County Public Health **Barriers** Resistance to regulation Funding Capacity of staff

Indicators
# of counties and municipalities with radon policy in place
Substandard housing data
# of resources identified, # meetings attended, # of trainings coordinated

Healthy Housing - Health Equity and Advocacy Year 1 January 1 2019 - December 31st, 2019

Goal: Increase healthy housing throughout the region to reduce exposure to radon, lead, and poor quality well water.

Strategy: Increase health equity advocacy for safe affordable housing through participating in local and regional housing related groups and coalitions.

Objectives	Action Steps	Status	Priority Population	Resources & Barriers
A) Build capacity, training and resources for local health equity advocates, including public health staff, related to safe, affordable housing by 12/31/2019. B) Monitoring regional data on safe, affordable housing and health equity 12/31/2020. C) Advocate for healthy housing in the region 12/31/2019.	1) Identify funding for public health staff time to attend community meetings and participate in training opportunities. 2) WCPHP bring health equity training to healthy housing advocates and stakeholders. 3) WCPHP personnel and healthy housing stakeholders will advocate for healthy housing and priority populations affected at community meetings. 4) Use results of (Tobacco Prevention) STEPP Community Profile in determining health equity needs related to indoor air quality.		Healthy Housing Stakeholders	**Resources** WCPHP Housing Authority Municipalities County Government (Community **Barriers** Funding Capacity

Indicators

Progress Indicators: Attendance at Health Equity Trainings and number of presentations/meetings about health equity.
Percentage of housing stock that is substandard.
Percentage of housing that is affordable.