Sangre de Cristo Mountains

Public Health Improvement Plan

San Luis Valley, Colorado 2019

Alamosa, Conejos, Costilla, Mineral, Rio Grande, Saguache Counties

San Luis Valley Public Health Partnership

This report is brought to you by your local public health departments on behalf of the Boards of Health for Alamosa, Conejos, Costilla, Rio Grande, Mineral (Silver Thread Public Health District) and Saguache Counties.

Headwater of the Rio Grande River

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San Luis Valley Public Health Partnership
Public Health Improvement Plan 2019

Health is the state of being free from injury or illness and having a positive well-being.

Summary

This Public Health Improvement Plan describes the process used to create the plan and includes goals and objectives for each priority and evaluative measure. Implementation plans are included in annual local and regional planning.

The San Luis Valley Public Health Partnership gathered data and community input to develop this regional Public Health Improvement Plan. The prioritization process and required delivery of core public health services led to an upstream approach for this regional plan.

A *Community Health Assessment* data booklet was published and distributed across the San Luis Valley in the fall of 2018. This publication is a snapshot of chronic and communicable disease, behavioral and mental health and health access information.
View 2018 Community Health Assessment Print 2018 Community Health Assessment

PRIORITY AREA 1: Health Equity

Strengthen systems that generate health including skills, competencies and capacities that play an essential role in creating comprehensive public health strategies to address health inequities and social determinants of health including privilege, power and bias. Priority 1 Goals:

1. Increase health equity literacy and build capacity within the SLVPHP to alter barriers and systems that limit health outcomes.

2. Increase health equity literacy and build capacity with regional health and local partners to alter structures and systems that limit health outcomes.

3. Work with community partners on systems change via existing and emerging local projects to influence healthy behaviors and conditions.

PRIORITY AREA 2: Capacity Building

Build local and regional capacity to provide quality public health services and programs. Priority 2 Goals:

1. Increase capacity to ensure core public health services in the region.

2. Work with community partners on systems change via existing and emerging local projects to influence healthy behaviors and conditions.

We thank everyone who participated in the process. Your ideas and passion for community improvement help us move forward as health champions in the San Luis Valley and beyond. We look forward to continuing and deepening our professional relationships, working together to improve health and wellness for all.

Goals and Objectives

PRIORITY AREA 1: Health Equity

Strengthen systems that generate health including skills, competencies and capacities that play an essential role in creating comprehensive public health strategies to address health inequities and social determinants of health including privilege, power and bias.

Goal 1.1	**Increase health equity literacy and build capacity within the SLVPHP to alter structures and systems that limit health outcomes.**
Obj. 1.1.1	Local Public Health Agency Directors and Deputy Directors participate in the "Health Equity Toolkit for Rural and Remote Areas" training.
Obj. 1.1.2	Develop and implement a regional *health equity training schedule* for LPHA staff and field staff.
Obj. 1.1.3	Improve equitable practices in LPHA staff recruitment, interviewing and hiring.
Goal 1.2	**Increase health equity literacy and build capacity with regional health and local partners to alter structures and systems that limit health outcomes.**
Obj. 1.2.1	Advocate for health equity practices.
Obj. 1.2.2	Work with community partners to influence health behaviors and conditions.
Goal 1.3	**Work with community partners on systems change via existing and emerging local projects to influence health behaviors and conditions.**

PRIORITY AREA 2: Build Public Health Capacity

Build local and regional capacity to provide quality, necessary public health services and programs.

Goal 2.1	**Increase capacity to ensure core public health services in the region.**
Obj. 2.1.1	Review statewide public health modernization assessment results and identify areas for improvement.
Obj. 2.1.2	Develop and implement strategies to support the provision of core services consistent with public health modernization.
Obj. 2.1.3	Increase professional capacity to provide public health services.
Goal 2.2	**Collaborate with state and community partners to support population health improvement efforts.**
Obj. 2.2.1	Build and define a shared community health assessment process with local hospitals.
Obj. 2.2.2	Share rural and partnership perspectives with statewide organizations and alliances.

Introduction

Public health work protects communities. The American Public Health Association explains:

> "Public health promotes and protects the health of people and the communities where they live, learn, work and play.
>
> While a doctor treats people who are sick, those of us working in public health try to prevent people from getting sick or injured in the first place. We also promote wellness by encouraging healthy behaviors.
>
> From conducting scientific research to educating about health, people in the field of public health work to assure the conditions in which people can be healthy. That can mean vaccinating children and adults to prevent the spread of disease. Or educating people about the risks of alcohol and tobacco. Public health sets safety standards to protect workers and develops school nutrition programs to ensure kids have access to healthy food.
>
> Public health works to track disease outbreaks, prevent injuries and shed light on why some of us are more likely to suffer from poor health than others. The many facets of public health include speaking out for laws that promote smoke-free indoor air and seatbelts, spreading the word about ways to stay healthy and giving science-based solutions to problems.
>
> Public health saves money, improves our quality of life, helps children thrive and reduces human suffering."[1]

The Colorado Public Health Act of 2008 requires local public health agencies to complete a planning process every five years (section 25-1-505, C.R.S. et seq.) The *Community Health Assessment and Planning System* (CHAPS) includes an examination of quantitative and qualitative data, a capacity assessment, prioritization process and this report.[2]

[1] Https://apha.org/what-is-public-health.

[2] Colorado Department of Public Health and the Environment (CDPHE) guidance for the planning process is located here: https://www.colorado.gov/pacific/cdphe-lpha/chaps. A link to the history of the planning process is available on this webpage, as well as links to the planning status of Colorado health departments and a summary of local priorities and strategies.

[2019 Model Reproduced with permission from CO Association of Local Public Health Officials.]

The Colorado public health planning process is designed to reach beyond the core public health services. The process requires specific plans to meet priority public health and environmental needs. An assessment of resources to meet these needs is integral to the process. Addressing the root causes of health inequities, particularly racism, is paramount. Plans include working with community partners to develop strategies for targeted health improvements. At the same time, effective implementation of core public health services may increase access to care and reduce overall health care costs.

Public Health Modernization

A statewide effort is underway to improve effectiveness of service delivery and respond to the growing demand for public health services. Foundational local public health capabilities have been defined and a cost-assessment was completed to estimate the cost to fully implement public health modernization across the state. The statute defining mandatory local funding remains at the **$1.50 per capita set in 1941.**

Local funding is difficult to establish and maintain in our counties, five of which were ranked within the ten poorest in the state; the sixth was not ranked.[3] During the last decade, Colorado's population has grown by more than 17%. At the same time, state public health funding has decreased by 19%. This is a per-person decrease of 31% when adjusted for inflation[4].

Investing in Colorado's Public Health Infrastructure will:

- Reduce overall health care costs,
- Continue to ensure safe food, clean air and water, and disease monitoring and control,
- Improve disaster readiness for our community.

Health is Wealth

Why Invest in Public Health?

Public Health has a highly successful track record in promoting health change, such as increasing our life span by 30-years through reducing disease, tobacco use, and epidemics. These kinds of changes do not happen overnight; they take time and dedicated resources. State and Federal legislatures seem to try to resolve public health issues by channeling money into short-term programs, such as the opioid crisis. This is appreciated and useful in the short-term, but does not allow programs to be structured around long-term change.[1]

What do we really need?

- Increases in sustainable, long-term funding sources that are not tied to deliverables on one specific issue.
- Buy-in from all levels of government towards fostering an effective public health system.
- Funding foundational shifts in the social determinants of health as a whole, meaning the conditions in which people are born, grow, live, and age.

J. Kemp, Whitepaper "Investing in Colorado's Public Health Infrastructure" Alamosa County Public Health, 2019. Adapted from documents by Colorado Association of Local Public Health Officials.

[3] 2019 County Health Rankings, RWJF.
[4] CALPHO Public Health Transformation, Policy Update Email, 12-03-19.

Area Overview and County Profiles

The San Luis Valley (SLV) is a six-county rural, intermountain valley in south central Colorado with approximately 47,000 residents[5] in a land area the size of Connecticut. Three of the six counties are designated as frontier with fewer than six people per square mile. The average altitude is over 7500 feet above sea level and annual rainfall averages less than ten inches.

The Valley economy relies on agriculture, tourism and local services. About half of residents are Hispanic and half are non-Hispanic white. The median annual income remains below state and national averages, with 29 to 45 percent of children living in poverty in five of the six counties.[6]

SLV residents have higher rates of chronic disease, obesity, poverty, and lack of education than the state overall.[7] The SLV counties are identified as a Health Professional Shortage and Medically Underserved Areas.

The San Luis Valley was long part of the lands of the Utes. Mount Blanca, or "Sis Najini", marks the traditional eastern border of the Navajo nation. Spain, and later Mexico, slowly inhabited the area during the seventeenth and eighteenth centuries. The area was administered as part of Spain and later became the province of Nuevo Mexico until the area was acquired by the United States as part of the Treaty of Guadalupe Hidalgo in 1848. Extensive settlement began in the Valley by Hispano farmers and ranchers in the 1850s. In 1851 the town of San Luis, Costilla County, was established; it is the oldest continuously occupied community in Colorado. Today, the Valley has the largest native Hispanic population in Colorado and many families are directly descended from the original Nuevo Mexicano settlers. The Valley became part of the Territory of Colorado in 1861. For the remainder of the 19th century, the Valley saw the removal of Native Americans to reservations, and the slow migration of farmers and ranchers into the area. Three of Colorado's eight National Wildlife Refuges (NWR) are in the San Luis Valley, including the Alamosa, Baca and Monte Vista NWR.[8]

[5] U.S. Census Bureau, Quickfacts.census.gov, 2019.
[6] Ibid.
[7] Colorado Department of Public Health and Environment Health Statistics Section, 2012.
[8] Portions of the "Area Overview" and all county profiles modified from the Rocky Mountain MIRECC's Together With Veterans "Community Profiles for San Luis Valley Colorado". Used with permission.

County Profiles

Alamosa County

Alamosa County sits at an elevation of 7,500 feet and covers a land area of 724 square miles. The North-Eastern portion of Alamosa County is the home of the Great Sand Dunes National Park and Preserve, and the Rio Grande River passes through Alamosa County. The city of Alamosa is a commercial hub at the intersections of Highways 285 and 160. The city is home to Adams State University and Trinidad State Junior College campuses, San Luis Valley Health (hospital and physician services) and Alamosa School District. Two tiny towns, Hooper and Mosca, lie north of Alamosa; they and the surrounding rural area comprise Sangre de Cristo School District.

Quick facts[9]:

- 2019 population of Alamosa County was 16,233
- 8% population growth since 2000
- 24% of the population is under the age of 18
- 48% are white non-Hispanic and 46% are Hispanic/Latino
- 50% of the population is female
- Median income is $39,191
- 19% of the total population is below the Federal Poverty Level
- High school graduation rate is 87%
- 51% of workforce is employed privately, 19% by government and 30% are self-employed[10]
- Agriculture is a large part of the area economy; major products are livestock, hay, potatoes and grain
- Migrant farm workers and families are present during the summer and early fall
- 24% of children live in poverty[11]

[9] U.S. Census Bureau, Quickfacts.census.gov, 2019.
[10] http://www.city-data.com/county/Alamosa_County-CO.html.
[11] https://www.countyhealthrankings.org/app/colorado/2020/rankings/alamosa/county/outcomes/overall/snapshot.

Conejos County

Conejos County was one of the original 17 counties created by the Colorado legislature on November 1, 1861. Although it was first called Guadalupe County it was renamed Conejos, the Spanish word for "rabbits", one week later. The original boundaries of the county included much of the southwestern corner of Colorado. In 1874, most of the western and northern portion of the county was broken away to form parts of Hinsdale, La Plata and Rio Grande Counties. Conejos County achieved its modern borders in 1885 when its western half was taken to create Archuleta County. Today, County government is based in the community of Conejos. Because it is the site of some of the earliest settlements in Colorado, rural Conejos County contains some important historical sites. The town of Antonito is home to the Cumbres and Toltec Scenic Railroad, a narrow-gauge steam engine railroad constructed in 1880 which makes the daily trek from Antonito to Chama, New Mexico during the summer and fall. Just north east of the town of Sanford is Pikes Stockade, the site where Zebulon Pike raised the American flag in 1807 over what was then Spanish Territory. The stockade was reconstructed using Pike's journal and is maintained by the Colorado Historic Society. Conejos, the County seat, is also home to Our Lady of Guadalupe Catholic Parish, the oldest parish church in Colorado. The community of Manassa hosts Pioneer Days each July. The event celebrates the arrival of Mormon pioneers and is one of the largest events in the San Luis Valley. The Jack Dempsey Museum, also located in Manassa, honors the "Manassa Mauler" who held the world heavyweight boxing title from 1919 to 1926.
Quick facts[12]:

- 2019 population of Conejos County was 8,205
- Less than 1% population decrease since 2010
- 26% of the population is under the age of 18
- 52% are Hispanic or Latino and 42% are white non-Hispanic
- 50% of the population is female
- Median income is $34,746
- 21% of the total population is below the Federal Poverty Level
- High school graduation rate is 87%
- 47% of workforce is employed privately, 9% by government and 44% are self-employed[13]
- 28% of children live in poverty.[14]

[12] U.S. Census Bureau, Quickfacts.census.gov, 2019.
[13] http://www.city-data.com/county/Conejos_County-CO.html.
[14]https://www.countyhealthrankings.org/app/colorado/2020/rankings/conejos/county/outcomes/overall/snapshot.

Costilla County

Costilla County is known as the first area in the State of Colorado to be colonized with recorded history dating back to 1540. It is also home to the oldest town in Colorado which is San Luis and is a part of the San Luis Valley region in Southern Colorado. Costilla County is considered a frontier area which consists of several smaller communities. These other communities are Blanca, Fort Garland, Chama, San Pedro, Los Fuertes, Garcia, Jaroso, San Francisco, San Acacio, and Mesita (State of Colorado). The Costilla County region covers a total of 1230.44 square miles. Costilla County is surrounded by beautiful mountains where residents enjoy outdoor activities such as fishing, hunting, hiking, 4-wheeling, etc. These types of activities put residents at risk for certain unintentional injuries that may differ from other locations. (United States Census Bureau, 2012).

Quick facts[15]:

- 2019 population of Costilla County was 3,887
- 10% population increase since 2010
- 19% of the population is under the age of 18
- 60% are Hispanic or Latino and 35% are white non-Hispanic
- 48% of the population is female
- Median income is $30,593
- 25% of the total population is below the Federal Poverty Level
- High school graduation rate is 79%
- 42% of workforce is employed privately, 6% by government, and 52% are self-employed[16]
- 37% of children live in poverty[17]

[15] U.S. Census Bureau, Quickfacts.census.gov, 2019.
[16] http://www.city-data.com/county/Costilla_County-CO.html.
[17] https://www.countyhealthrankings.org/app/colorado/2020/rankings/costilla/county/outcomes/overall/snapshot.

Mineral County

Mineral County is a unique rural community set deep within the San Juan Mountains that is the second least populated county in Colorado. The Mineral County Public Health office and services are based in the City of Creede—the only town within the frontier county with over 95% public lands. Established in 1892, Creede's history and economy has been built on silver mining and continues today through tourism which produces a population flux greater than 600% between June and September. Art galleries, shopping, fine dining, historical tours, and the Creede Repertory Theatre attract thousands of visitors every year. The demands upon the Public Health office differ greatly between June and September in response to the summer residents and in the off season to those needs of the full-time residents.

Quick facts[18]:

- 2019 population of Mineral County was 769
- 8% population increase since 2010
- 15% of the population is under the age of 18
- 90% are white non-Hispanic and 6% are Hispanic or Latino
- 50% of the population is female
- Median income is $61,058
- 9% of the total population is below the Federal Poverty Level
- High school graduation rate is 97%
- 80% of workforce is employed privately, 15% by government, and 6% are self-employed[19]
- 16% of children live in poverty[20]

[18] U.S. Census Bureau, Quickfacts.census.gov, 2019.
[19] http://www.city-data.com/county/Mineral_County-CO.html.
[20] https://www.countyhealthrankings.org/app/colorado/2020/rankings/mineral/county/outcomes/overall/snapshot.

Rio Grande County

Rio Grande County is located is the San Luis Valley in southwest Colorado. It is named for the Rio Grande River that runs through the county. The approximate county size is 912 square miles/584,382 acres. Of this land, slightly more than 50% is public land acreage, the majority being federal land. Elevations range from 7,000 to 13, 000 feet. There are three municipalities within the mostly rural county: Monte Vista, Del Norte and South Fork. Agriculture, tourism, and government are the major industries.
The gateway to the San Juan Mountains, Rio Grande County attracts visitors and residents seeking outdoor recreational activities such as camping, climbing, hiking, biking, fishing, hunting, and winter sports. It is home to the Monte Vista National Wildlife Refuge, a stopover for migratory sand hill cranes, the Rio Grande National Forest, Old Spanish National Scenic Trail, and the Silver Thread Scenic Byway.
Quick facts[21]:

- 2019 population of Rio Grande County was 11,267
- 6% population decline since 2010
- 23% of the population is under the age of 18
- 53% are white non-Hispanic and 44% are Hispanic or Latino
- 50% of the population is female
- Median income is $38,639
- 15% of the total population is below the Federal Poverty Level
- High school graduation rate is 84%
- 37% of workforce is employed privately, 3% by government, 52% are self-employed and 8% in unpaid family work[22]
- 23% of children live in poverty[23]

[21] U.S. Census Bureau, Quickfacts.census.gov, 2019.
[22] http://www.city-data.com/county/Rio_Grande_County-CO.html.
[23] https://www.countyhealthrankings.org/app/colorado/2020/rankings/rio-grande/county/outcomes/overall/snapshot.

Saguache County

Saguache is a frontier county with a population density of 2 people per square mile[24]. There are five main municipalities in Saguache County: Saguache, Center, Crestone, Moffat and Sargents. In addition, there are several unincorporated communities, including Bonanza and Villa Grove. The county experiences an increase in population in the summer months, particularly Center (which experiences an influx of agricultural labor) and Crestone (related to spiritual tourism and second homes). In the fall, hunters come to federal lands in Saguache County during elk and deer season.

Quick facts[25]:

- 2019 population of Saguache County was 6,824
- 12% population growth since 2010
- 21% of the population is under the age of 18
- 59% are white non-Hispanic and 36% are Hispanic/Latino
- 50% of the population is female
- Median income is $34,410
- 25% of the total population is below the Federal Poverty Level
- High school graduation rate is 80%
- 54% of workforce is employed privately, 2% by government and 44% are self-employed[26]
- 31% of children live in poverty[27]

[24] www.city-data.com/county/Saguache_County-CO.html.
[25] U.S. Census Bureau, Quickfacts.census.gov, 2019.
[26] www.city-data.com/county/Saguache_County-CO.html.
[27]https://www.countyhealthrankings.org/app/colorado/2020/rankings/saguache/county/outcomes/overall/snapshot.

Public Health Partnership

The San Luis Valley Public Health Partnership (SLVPHP) is comprised of the Directors of following public health departments; Alamosa County Public Health Department, Conejos County Public Health and Nursing Service, Costilla County Public Health Agency, Silver Thread Public Health District on behalf of Mineral County, Rio Grande County Public Health Agency, Saguache County Public Health Department.

Each county in the SLV Partnership houses a single county public health agency governed by a board of health with members - elected officials (County Commissioners) - designated by statute. The Rio Grande County Board of Health also includes representatives from Del Norte, Monte Vista and South Fork.

The mission of the SLVPHP is to collaborate to develop and sustain public health systems to improve health outcomes throughout the San Luis Valley. The partnership also serves as a forum for exchanging information, sharing ideas and evaluating opportunities. Working together increases our capacity for public health work while maintaining local staff to address core services and unique local needs. The partners meet monthly, usually by conference call.

The partnership works together under an informal operating agreement. Every three years county commissioners approve an inter-governmental agreement affirming the counties' support for shared activities.

Planning Process

This plan is our first fully regional community health assessment and public health improvement plan. In the prior planning cycle, each of the six San Luis Valley Public Health Agencies developed their own community health assessment and goals. Each of these plans included two shared regional goals: 1. Establish a public health partnership and, 2. Develop a regional environmental health program. Both goals were met in the prior cycle.

After partnership directors agreed to share a regional Community Health Assessment, we identified a coordinator and a planning team. In 2016, the team created an initial timeline and workplan and began gathering quantitative data. Our current goal was to select one to three shared priorities to focus on over the next five years.

Throughout 2017 we reviewed data from various sources while we surveyed population-health activities underway in our region. We interviewed peers about the community health assessment process, data management capacity and strategies for rural community engagement and communication. (Interviewees included Chaffee County Public Health Director Andrea Carlstrom, Margaret Whacker, West Central Partnership Coordinator Margaret Whacker and Kelley Vivian, Development and Strategic Initiatives Officer, El Paso County Public Health.)

We reviewed literature on social determinants of health and how to consider and measure health equity in our planning and prioritization processes. Equity models that helped us included: Colorado Health Equity Model[28] and the Colorado Opportunity Framework[29]. The Bay Area Regional Health Inequities Initiative (BARHII) Framework for reducing health inequities was particularly helpful.[30] (Appendix A.)

In 2018 we held community engagement events across the region and published a brochure on our Community Health Assessment results. In December 2018 we completed the prioritization process, which signaled the end of the "Community Health Assessment" segment and the beginning of the PHIP implementation process. In 2019 we completed other elements of the process while implementing first-year activities.

[28] Colorado Department of Public Health and Environment, Social Determinants of Health Workgroup, *Explanatory Model for Conceptualizing the Social Determinants of Health*. Accessed 2/1/20. https://www.colorado.gov/pacific/sites/default/files/CHAPS1_Health-Equity-Model-and-Summary.pdf.
[29] Colorado Department of Health Care Policy and Financing, *Colorado Opportunity Framework*, www.colorado.gov/pacific/hcpf/colorado-opportunity-framework. Accessed 2/1/20.
[30] Bay Area Regional Health Inequities Initiative, www.barhii.org/framework. Accessed 2/1/20.

Equity and Community Engagement

The Colorado Public Health Association defines Health Equity as "the active assurance that everyone is afforded the opportunities essential to attaining their highest level of health". The planning process engaged people to think about the resources, barriers and responsibilities each of us has in improving the health of our community.

We identified a broad list of community sectors to invite to our planning events. The Public Health Director in each county compiled a list of individuals to include. Email invitations were sent with some follow-up telephone reminders. This is a general list of those invited to participate:

Community members
Veterans
Elected officials
Health system partners
School representatives
Public Health leaders
Government employees
Civic organizations
Faith-based organizations
Higher education institutions
Medical Director
Community Health partners

Presentations were made to eight groups in five of six counties. One presentation was made in Mineral County and one in Conejos County. Costilla County and Saguache County each held two events. Alamosa County also held two events – one specific to Alamosa County and one for regional partners. Rio Grande County Hospital & Clinics held their Community Health Status Assessment during the same period. The Rio Grande County Public Health Director participated in this process and the results of that assessment were factored into our compiled health assessment results.

The goals for community engagement events were to:

- Share quantitative community health assessment data.
- Build an understanding of public health issues.
- Gather qualitative data from people and sectors from whom we do not usually hear.
- Identify grassroots and emerging community initiatives and support systems.

We applied for external grant funding to establish a semi-permanent stakeholder group and community communication plan but did not receive this funding. Each county held one or more community engagement events. Invitees included individuals and representatives from non-profit organizations, health-sector organizations, education and local government. We had an average of eight participants per meeting, with a total of eight meetings across six counties. We used the *nominal group technique* for prioritizing issues identified by each group.

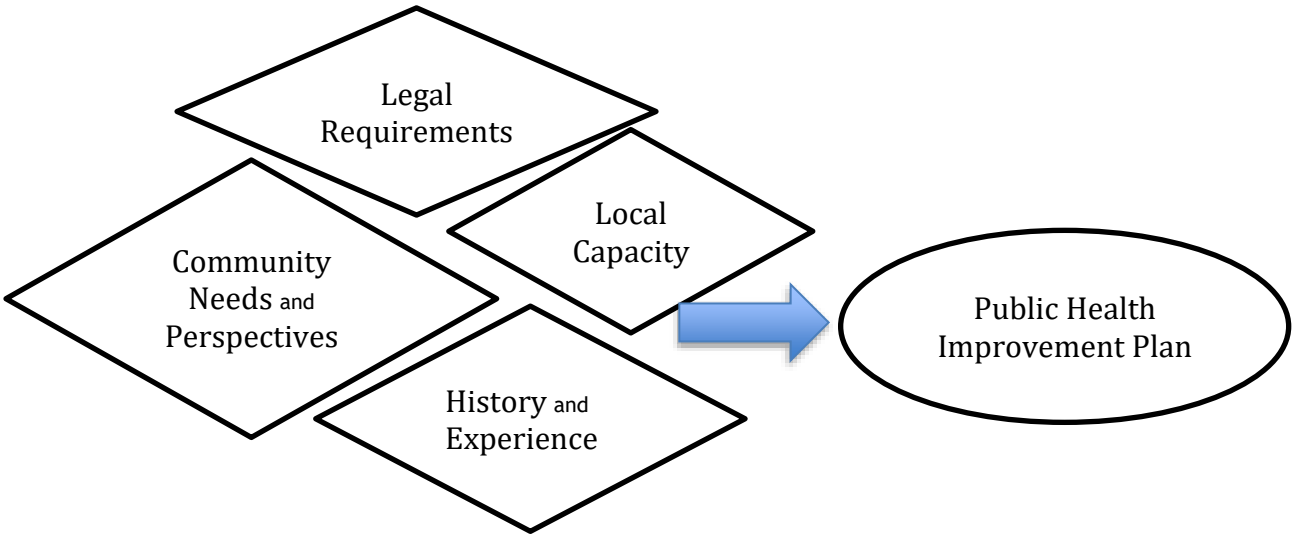
As we engaged in this planning process, other equity initiatives were taking place within the region. These include the Colorado Trust's "Community Partnerships on Equity" in the Town of Saguache in Saguache County, San Luis in Costilla County, and Antonito in Conejos County. (The resulting equity plans focus on limited economic development and poverty among youth and young adults, and disengagement and

disconnection among Hispano youth and young adults in Saguache County. San Luis identified similar foci and included revitalizing the Manito culture among youth and young adults.) We were able to coordinate a community health assessment engagement meeting with the group in San Luis.

Both regional hospitals conducted their own Health Assessments during our data-gathering phase; partnership representatives participated in both processes. These activities led to one of the objectives in our action plan: aligning assessment processes and intervals with hospital partners.

We found it challenging to explain to participants that their input was not the only driver of the forthcoming improvement plan. We created this graphic to show all the major inputs for the Public Health Improvement Plan.

Fig. 1. Factors Influencing the Public Health Improvement Plan



Conduct a Community Health Assessment

Our goal for the health assessment was to create a "snapshot in time" that described the state of health in the San Luis Valley. We sought reliable data to provide a trustworthy overview of community health, identify measures of program success and monitor population health trends. Data is necessary for policy and financial decision-support. Quality data is need to:

- Identify gaps in services.
- Identify where to focus our efforts.
- Evaluate programs.
- Identify statistics that define higher risk groups.
- Improve health and healthcare equity.

To begin this process, the partnership reviewed the region's previous Community Health Assessments and public health priorities from across the state[31]. A summary of SLV county priorities for 2012-2018 is shown in Appendix B.

Partnership members discussed strengths and weaknesses of the previous process. Sourcing local data was identified as a strength of the prior process. The time and resources used to develop individual county plans was identified as the primary weakness of the prior process.

To develop an outline for data gathering, we engaged two interns to begin gathering information on relevant data sources. We compared that list with prior assessment priorities and statewide local priorities.

We developed six focus areas for the initial survey of community health;

- Community Description – population and community characteristics.
- Economic Opportunity – income, employment, education and housing.
- Physical Environment – built environment, safety and environmental quality.
- Health Behaviors and Conditions – healthy eating and active living, substance use, immunization, maternal and child health, behavioral and mental health, injury and violence.
- Access, Utilization and Quality of Care – preventative care, health insurance, provider availability.
- Population Health Outcomes – quality of life, chronic disease morbidity, communicable disease morbidity, occupational health, birth defects morbidity, infant mortality and mortality.

As we collected quantitative data, we obtained a small grant from National Network of Public Health Institutes through the Center for Sharing Public Health Services (phsharing.org) for technical support to develop data management strategies. "Lessons learned" are shown in Appendix C.

With this funding, we explored best-practice models for data collection and management, creating data standards and defining capacity requirements for a regional population health data dashboard. We also explored various formats and learned about data sharing agreements.

[31] CDPHE Office of Planning and Partnerships, Local Priorities Grid 2012 – 2018, https://www.colorado.gov/pacific/sites/default/files/OPP_LPHA-WB-Grid-Dec-2016.pdf. Accessed 2/1/20.

Over the course of a year, we compiled and reviewed community health assessment data for each focus area. We identified a universe of 225 data points relevant to our work, and established the following criteria for selecting data sources:

- Reliability.
- Validity.
- Affordability.
- Source is longitudinally available.
- Aligns with data-partner preferences.

Additionally, we favored data sets from publicly available sources which are likely to be available over time. We did not have the capacity to gather or utilize local primary data.

Quantitative Data

The six SLV counties make up Health Statistics Region 8 for the state. Region 8 quantitative data were compiled and organized into these groups:

- Demographics and health indicators.
- Chronic disease.
- Injury.
- Access to care.
- Communicable disease.
- Substance use and mental health.

Once the quantitative data collection was completed, we published and printed 2500 copies of a booklet to share this information with the public. View or print online:

View 2018 Community Health Assessment Booklet[32]
Print 2018 Community Health Assessment Booklet[33]

The Colorado Health Institute is an important health policy facilitator throughout the state. The Community Health Access Survey of over 10,000 households has been conducted every other year since 2009. The following two pages show regional results from the survey for the San Luis Valley.[34]

[32] http://www.slvphp.com/community-health-assessment/.
[33] http://www.slvphp.com/wp-content/uploads/2019/05/SLV_CHA_Booklet_100218.pdf.
[34] Colorado Health Institute, 2019 Colorado Health Access Survey. Accessed 050420. https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/HSR%208_0.pdf.

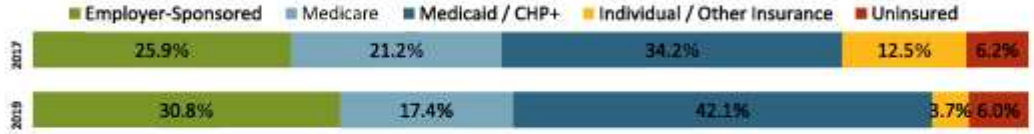
COLORADO HEALTH ACCESS SURVEY 2019

COLORADO HEALTH INSTITUTE

HEALTH STATISTICS REGION (HSR) 8

Alamosa, Conejos, Costilla, Mineral, Rio Grande, and Saguache County

INSURANCE COVERAGE



Lost, switched, or gained coverage in the past 12 months*

17.1%

Lowest HSR: 12.4%
Highest HSR: 24.4%

*Ages 0-64

SOCIAL FACTORS

10.9%

Ate less than they should due to lack of money

Lowest HSR: 2.4%
Highest HSR: 19.1%

5.3%

Were concerned about having stable housing within the next two months

Lowest HSR: 3.5%
Highest HSR: 14.5%

16.2%

Were sometimes or often treated unfairly while getting medical care (lifetime)***

Lowest HSR: 7.5%
Highest HSR: 28.2%

Of those who were sometimes or often treated unfairly...

82.0%

experienced stress as a result of unfair treatment in a clinical setting ***

Lowest HSR: 64.7%
Highest HSR: 87.4%

*** Asked of those 18 years of age or older

AFFORDABILITY

25.8%

Had a surprise medical bill in the past 12 months

Lowest HSR: 23.5%
Highest HSR: 34.8%

20.1%

Had problems paying medical bills in the past 12 months

Lowest HSR: 12.1%
Highest HSR: 29.7%

ACCESS TO CARE

Usual Source of Care and Health Care Utilization in the Past 12 Months

Had a usual source of care

Lowest HSR: 83.5%
Highest HSR: 94.4%

Visited a general doctor

Lowest HSR: 69.5%
Highest HSR: 86.6%

Visited a specialist

Lowest HSR: 30.8%
Highest HSR: 51.7%

Visited the emergency room

Lowest HSR: 13.4%
Highest HSR: 28.5%

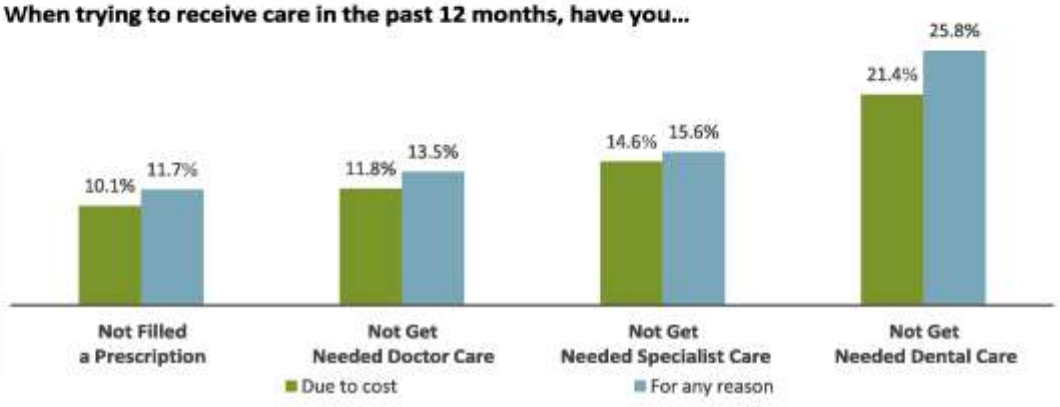
BARRIERS TO CARE

In the past 12 months...	2013	2015	2017	2019
You couldn't get an appointment as soon as you needed one	19.3%	28.7%	12.0%	22.8%
The doctor's office wasn't accepting patients with your type of insurance**	5.6%	8.4%	8.9%	6.3%
The doctor's office wasn't accepting new patients	4.6%	11.8%	10.2%	8.3%

** Asked of currently insured

FOREGONE CARE

When trying to receive care in the past 12 months, have you...



COLORADO HEALTH ACCESS SURVEY 2019

COLORADO HEALTH INSTITUTE

HEALTH STATISTICS REGION (HSR) 8

Alamosa, Conejos, Costilla, Mineral, Rio Grande, and Saguache County

HEALTH STATUS

23.2%

Of Coloradans report poor general health

Lowest HSR: 10.7%

Highest HSR: 28.4%

29.3%

Of Coloradans report poor oral health

Lowest HSR: 9.8%

Highest HSR: 31.1%

16.8%

Of Coloradans (ages 5+) report poor mental health

Lowest HSR: 8.5%

Highest HSR: 20.3%

MENTAL HEALTH

9.2%

Did not get needed mental health care in the past 12 months

Lowest HSR: 5.4%

Highest HSR: 17.7%

13.4%

Talked with a general doctor about their mental health

Lowest HSR: 11.6%

Highest HSR: 25.7%

16.1%

Talked with a mental health provider about their mental health

Lowest HSR: 9.5%

Highest HSR: 23.4%

ORAL HEALTH

68.4%

Has dental insurance

Lowest HSR: 59.1%

Highest HSR: 85.6%

58.6%

Visited a dentist in the past 12 months

Lowest HSR: 58.6%

Highest HSR: 87%

SUBSTANCE USE

Have you, a loved one, or a close friend ever...

Taken a prescription painkiller without a prescription* **18.6%**

Lowest HSR: 11.7%

Highest HSR: 35%

Been addicted to prescription painkillers or heroin* **14.9%**

Lowest HSR: 5%

Highest HSR: 20.4%

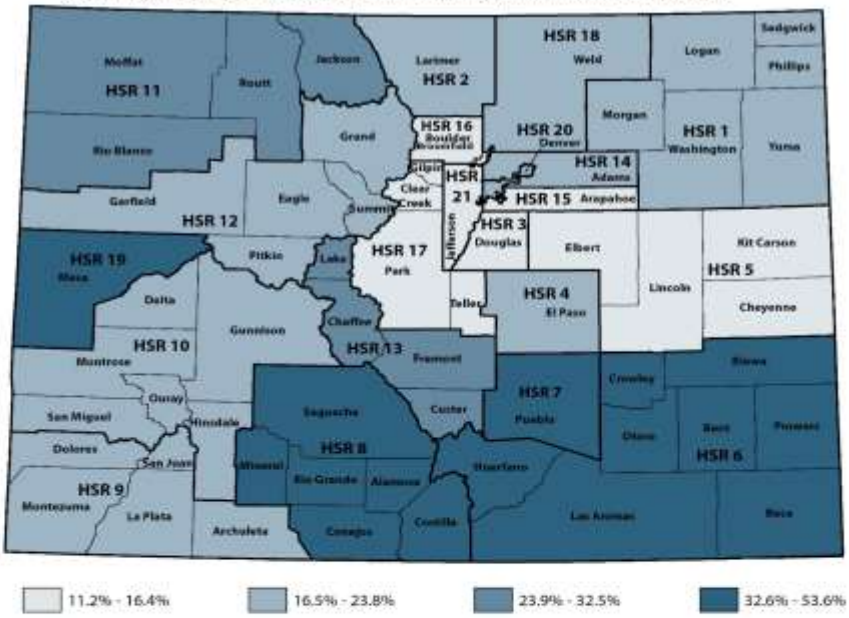
Been addicted to alcohol or drugs other than prescription painkillers or heroin* **22.5%**

Lowest HSR: 15.6%

Highest HSR: 34.1%

* Asked of those 18 years of age or older

Opioid Addiction Is a Major Problem in Your Community (Self-Reported)



The CHAS is primarily funded by **The Colorado Trust** and **The Colorado Health Foundation**. Special thanks also to the the **Colorado Office of Behavioral Health** and the **Colorado Department of Health Care Policy and Financing** for sponsorship of items on the 2019 survey.

Download profiles for all 21 Health Statistics Regions and the State of Colorado at colo.health/CHAS

The Colorado Health Institute is a trusted source of independent and objective health information, data, and analysis for the state's leaders. CHI has served the state in this capacity since 2002. The Colorado Health Access Survey is the premier source of information on health insurance coverage, access to health care, and use of health care services in Colorado.

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Contact: Eli Boone, Research Analyst, at 720.975.9250 or BooneE@coloradohealthinstitute.org

Qualitative Data

Qualitative data was collected through eight community engagement events. Appendix D is a compilation of health concerns raised by community participants who participated in our Community Health Assessment process.

Qualitative data for Rio Grande County was obtained from a joint community engagement process and participation in Rio Grande Hospital & Clinics Community Health Status Assessment processes.[35]

A simple survey was created to gather information from individuals with population sector knowledge for the purpose of affirming the group priority results we obtained. The survey is shown in Appendix E.

Overall Community Priorities

- Access to behavioral health including local counseling and services -- not just at the regional center.
- Child and elder abuse and the lack of family support systems, especially for multi-generational or grandparent care.
- Senior citizen programs, care and support.
- Lack of prevention/health education, especially for tweens and younger.
- Substance use treatment and addiction's financial impact on families.
- Transportation issues.

[35] Rio Grande Hospital & Clinics' Community Health Needs Assessment; 9/24,10/23, 11/29. https://riograndehospital.org/wp-content/uploads/2018/12/RGH2018CommunityHealthNeedsAssessment-1.pdf.

Prioritizing Issues

Planning guidance suggested using a "lens of best practice" to develop targeted priorities that consider health equity issues and community standards of care. We reviewed the Ten Colorado Winnable Battle and surveyed best practices for public health workforce training and similar assessments and improvement plans in Colorado.

Ten Colorado Winnable Battles

Clean Air
Clean Water
Infectious Disease Prevention
Injury Prevention
Mental Health and Substance Abuse
Obesity
Oral Health
Safe Food
Tobacco
Unintended Pregnancy

Survey of Evidence Based Strategies

Sources for likely evidence-based intervention strategies and standards were identified. To ensure our implementation strategies were going to be current, we reviewed evidence-based health strategies and priorities.

- Healthy People 2020.[36]
- Robert Wood Johnson Foundation (RWJF) "What Works for Health" (guidance, action center and resources).[37]
- RWJF Community Health Rankings.[38]
- SAMHSA Practices Resource Center.[39]
- Bridges Out of Poverty.[40]
- Centers for Disease Control (CDC) "We Can Prevent ACEs".[41]
- CDC's Best Practices for Cardiovascular Disease Prevention Programs: A Guide to Effective Health Care System Interventions and Community-Clinical Links".[42]
- Hospital Transformation Program Priorities.[43]
- The Community Guide.[44]

[36] https://www.healthypeople.gov/2020/topics-objectives.
[37] https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health.
[38] https://www.countyhealthrankings.org/.
[39] https://www.samhsa.gov/ebp-resource-center.
[40] https://www.bridgesoutofpovertysb.org/about_us.
[41] https://www.cdc.gov/injury/features/adverse-childhood-experiences/index.html.
[42] https://www.cdc.gov/dhdsp/pubs/docs/Best-Practices-Guide-508.pdf.
[43]https://www.colorado.gov/pacific/sites/default/files/2020%20February%20Hospital%20Transformation%20Program%20Overview.pdf.
[44] https://www.thecommunityguide.org/.

Survey of Best Practices for Public Health Workforce Training

- Public Health Foundation: 3-Step Competency Prioritization Sequence.[45]
- Council on Linkages Between Academia and Public Health Practice – to improve public health education, training, practice and research.[46]
- How to Focus Your Training and Professional Development Efforts to Improve the Skills of Your Public Health Organization: Workshop Presentation for the 2011 American Public Health Association Annual Meeting.[47]

Survey of Similar Plans

To ensure we addressed current relevant issues, we surveyed a sample of other similar plans. We reviewed:

- Regional hospital entities' health assessments, processes and results.
- Colorado State Public Health Improvement Strategies document.
- Colorado's Health IT Initiatives Summary (11/2017).
- Tri-County Health Department Public Health Improvement Plan 2019- 2024.
- West Central Public Health Partnership 2011 and 2018.
- San Juan Basin Public Health Improvement Plan 2019 – 2023.
- Park County Public Health Community Assessment and Improvement Plan (2013).
- The Jeffco Community Health Improvement Network.

The National Association of City and County Health Officials (NACCHO) Guide to Prioritization Techniques offers a PEARL test for proposed interventions: is it **Proper**, **Economical**, **Acceptable**, **Feasible** and **Legal**?

[45] http://www.phf.org/resourcestools/Pages/3Step_Competency_Prioritization_Sequence.aspx.
[46] http://www.phf.org/programs/council.
[47] http://www.phf.org/resourcestools/Pages/APHA2011_Prioritization_Matrix_Core_Competencies.aspx.

Criteria to Identify Priorities

In the summer of 2018, as community engagement events were taking place, the partnership members developed criteria for evaluating potential priorities:

- Does this issue affect a large number or high percentage of people in our community?
- Does this issue have community and political support?
- Is a local organization prepared to take the lead on the issue?
- Will our prioritization make a difference?
- Will adequate resources be available?

In December 2018 after the Community Health Assessment meetings were completed, members met to select Public Health Improvement priorities. We outlined the major elements of our work and discussed barriers to resources for needed projects and leadership capacity.

Next, we reviewed and affirmed the qualitative priorities gathered at our community engagement events. Priorities from all six counties were grouped into ten topic areas:

Mental Health
Substance Abuse
Seniors
Family Environments and Abuse
Chronic Disease
Low cancer screening rates
Education and Prevention
Environment
Dental Care
Access to care

The partnership considered these ten areas, together with local issues brought to light in our quantitative data review. We weighed these against our agreed-upon prioritization criteria and discussed this question: ***"Using a lens of best practices, consideration of health equity issues and community standards of care, what is most important?"***

As a partnership working at a regional level, we agreed that **"as a group we believe a systems-change approach for dismantling social injustices will have the broadest impact on a vast multitude of health behaviors and outcomes."**

"Health equity also translates to our organizations and the inequities we experience as rural and frontier communities. If we are to provide equitable services to our constituents, we must also feel support by the systems that allow us to do so. Therefore, capacity building is also at the forefront of our priorities. Without having the right support for and within our organizations, our ability to meet our communities' needs is disadvantaged." (Tara Hardy, Silver Thread Public Health District.)

"Health equity is part of everything we do and we felt it was very important to address. Equity concerns came up in a variety of forms in our sessions with stakeholders. They also identified a number of issues that could fall under the broad umbrella of "capacity-building" within public health agencies, as well as succession planning and how we interact with our community partners." (Della Vieira, Alamosa County Public Health Department.)

As we reviewed the issues and barriers to expanding necessary services, we realized that one over-arching issue was ongoing: a lack of capacity and resources to manage more activities and a lack of infrastructure to meaningfully expand staff.

We then rated the two upstream priorities on a scale of 1 to 3 using the criteria we developed earlier.

Health Assessment Prioritization Scoring Tool						
Rate each issue according to criteria on a scale of 1 to 3: **1** = "no" **2** = "somewhat" **3** = "yes".						
	Significance	**Popularity**	**Capacity**	**Ability to Impact**	**Funded**	
	Does the issue impact a large number or high percentage of people in our community?	**Does this issue have community and political support?**	**Is a local organization prepared to take the lead on the issue?**	**Will our prioritization make a difference?**	**Will adequate resources be available?**	**Total score:**
Issue 1. Health Equity	3.00	1.75	3.00	3.00	3.00	13.75
Issue 2. Public Health Capacity	3.00	3.75	3.00	3.00	2.50	15.25

Develop a Public Health Improvement Plan

Throughout 2019 the partnership defined objectives and action steps for implementing the selected priority goals (see pp. 2 – 3). We included both long-term and short-term objectives.

We included local activities that were already planned or being implemented. These are included in Goal 1.3: *"Work with community partners on systems change via existing and emerging local projects to influence health behaviors and conditions."*

The following are anticipated outcomes from implementing the goals and objectives:

	Health Equity	Public Health Capacity
Short Term Outcomes 1-3 years (About learning)	**Public health staff are informed on issues, strategies and indicators of health disparity.**	**Gaps and needs are identified through an analysis of the public health Cost Assessment.**
Mid Term Outcomes 4 - 6 years (About action)	**Public health works within our communities to remedy systemic and longstanding disparities.**	**Identify appropriate entity, management and staffing size for the partnership, and scope of services.**
Long Term Outcomes 10 years (About conditions)	**No matter which community you live in, you have an equitable opportunity to benefit from core public health services.**	**The public health system in the SLV is capable and has the capacity to consistently provide core public health services.**

Other Equity Outcome Indicators:

- Substandard housing
- Food scarcity and insecurity
- Income disparity
- Access to medical providers, behavioral health providers, tele-health and non-siloed providers
- Local provision of services; reduced medical travel

Capacity to Implement Goals

Although Public Health Accreditation Board (PHAB) compliance is not required in the state of Colorado, these standards for performance are accepted as a model for public agency effectiveness, accountability and capacity to provide services. An annual check on San Luis Valley readiness to implement PHAB standards for accreditation continues to reveal a lack of capacity to prepare for accreditation.

We specifically reviewed Public Health Accreditation Board requirements for Standard 5.2: Conduct a comprehensive planning process resulting in a health improvement plan. (Appendix F.) Although we met some of the requirements, our regional capacity prohibited a survey of resources and community assets and the depth of community engagement, data management, analysis and reporting required.

We identified eight areas where local public health agency capacity could be improved:

A. Communication
B. Staffing
C. Planning and Analysis
D. Political Environment
E. Partnerships and Collaboration
F. Organizational Stability
G. Information Technology

In October 2019, the partnership met with the Colorado Legislative Health Care Review Committee to discuss public health capacity issues in the region. The report and information provided to the Committee is shown in Appendix G.

Assumptions, Resources and Threats

Health Equity

Assumptions
Will we have leadership, time and capacity to implement health equity training.
We assume the curriculum will fit our needs.
County Public health staff consider health equity a priority, are willing to be educated and are willing to make improvements.

Resources
Partners are willing. The curriculum is free and there are free resources to help describe systemic differences.

Threats
We do not have any funding for a facilitator or for mileage or participant time.
Participation is not required.
Racism and apathy.
Will funding for existing local programs continue?

Capacity Assessment

Assumptions
Our efforts will increase capacity.
Public Health capabilities and capacities will be the foundation of any model we develop.
We will be able to plan a strategy and capacity building and come up with something meaningful.
Planning is a good use of our time and we will produce a meaningful plan.
We will find the appropriate candidates for what we need done.
CDPHE will continue to fund the Partnership Coordinator position.

Resources
Regular partnership meeting schedule.

Threats
"We don't know what we don't know."
Knowing the gaps does not solve the problems.

Implement, Promote and Monitor

Evaluation measures for implementation strategies can include quantity, quality and effectiveness. We created an evaluation plan to monitor implementation activities. (Appendix H.) Models for evaluation of a public health improvement plan were researched. Since our regional goals are upstream of usual local public health goals, we adopted a self-reporting evaluative measure in many instances.

PHIP Dissemination

The completed plan will be available on the partnership website (SLVPHP.com) and will be shared with strategic and community partners.

Periodic reports

We will assess implementation according to an evaluation plan. Health status reports will be designed and provided to Local Boards of Health on a determined frequency.

Inform the State Plan

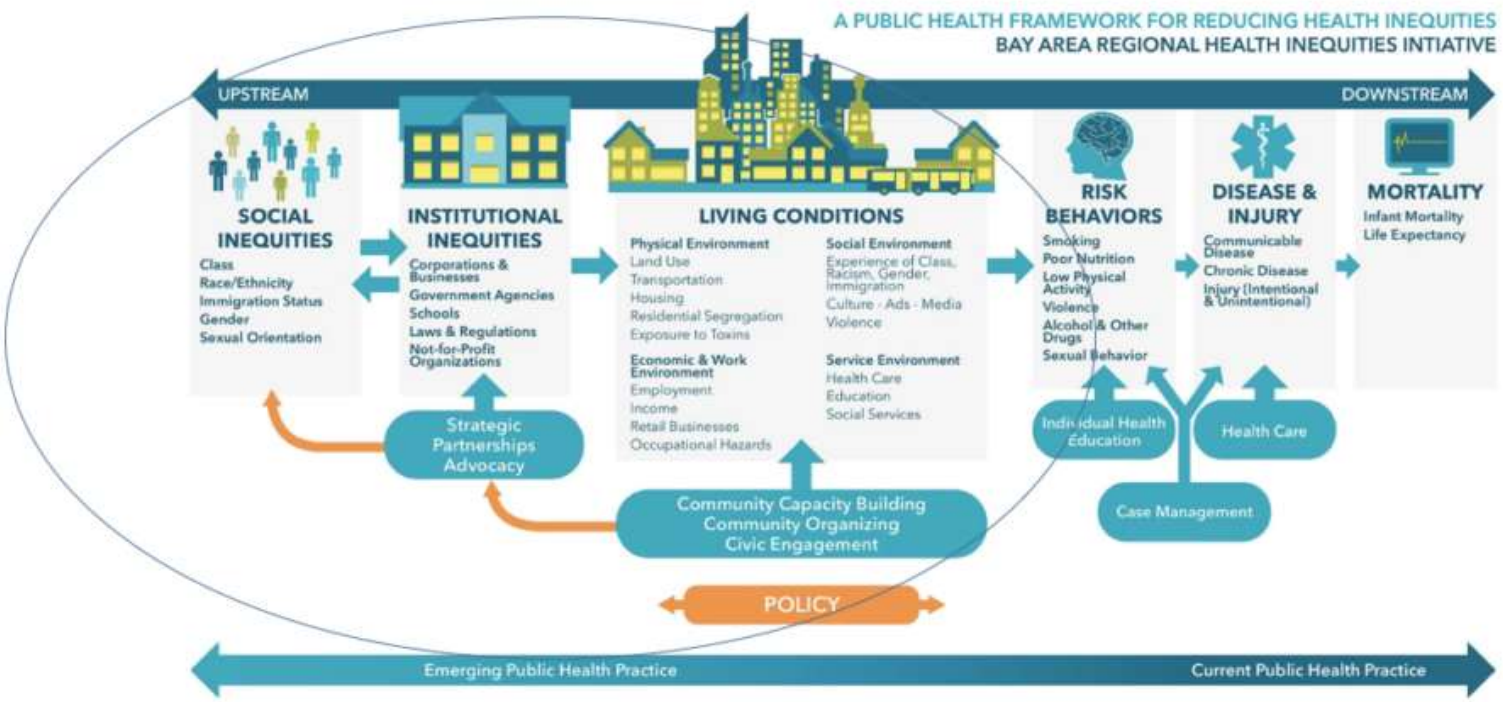
After local Boards of Health acceptance, this plan is submitted to Colorado Department of Public Health and Environment for approval.

The partnership is committed to participating in statewide and national population health improvement initiatives. In 2018 and 2019 we participated in these activities:

- National Association of City and County Health Officials (NACCHO) Board
- Colorado Association of Local Public Health Officials (CALPHO)
- Colorado Governor's Task Force for Behavioral Health
- Colorado Network of Health Alliances
- CALPHO Public Health Transformation planning to define capabilities

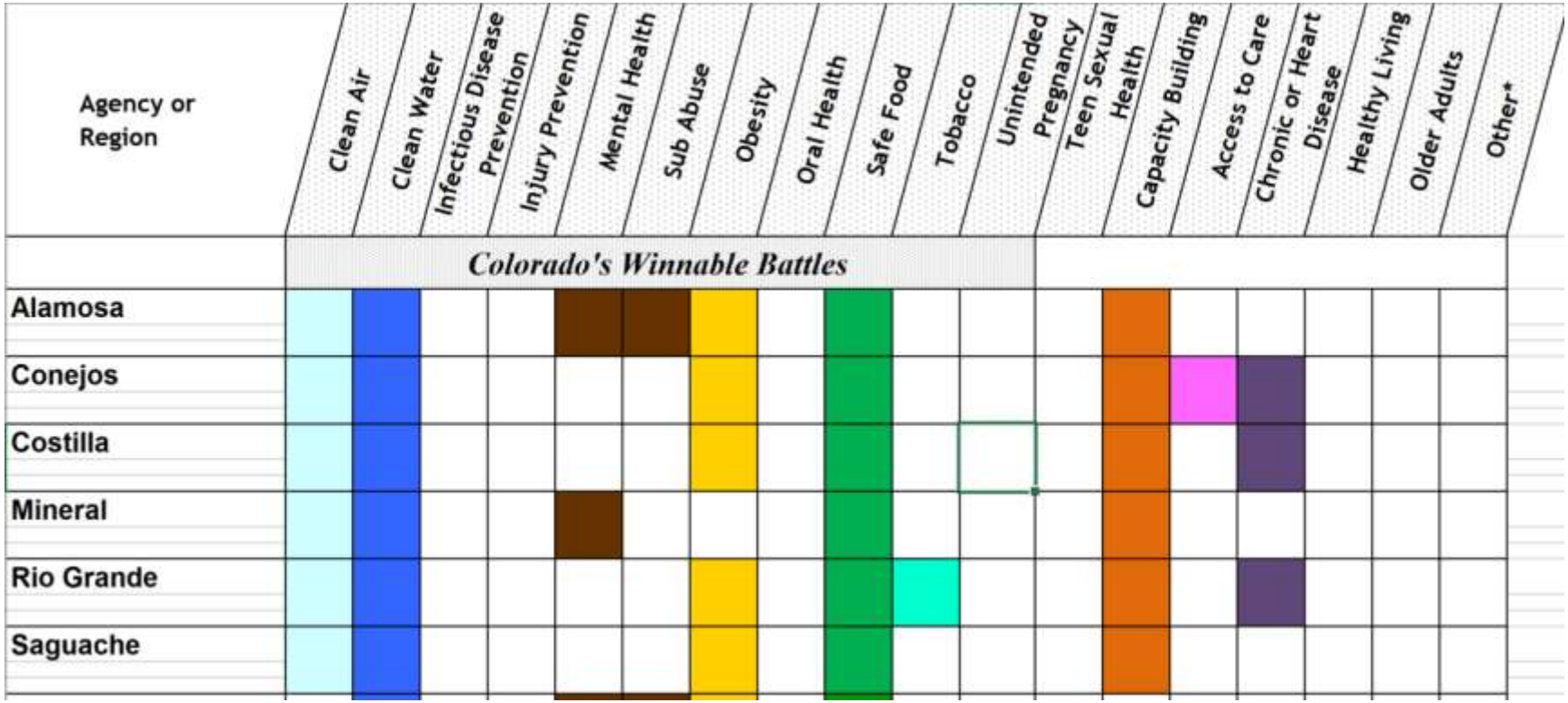
APPENDICES

APPENDIX A: BARHII Framework for Reducing Health Inequities



http://barhii.org/framework/ Graphical upgrade provided by CA Department of Public Health.

APPENDIX B: CDPHE Regional Summary of Prior Improvement Goals - Dec. 2016



APPENDIX C: Data Management Project Activities and Lesson Learned

The Center for Sharing Public Health Services (CSPHS) Cross-Jurisdictional Sharing Small-Grant Program funded a project to explore and implement best-practice models for cross-jurisdictional data collection and management. (Edited excerpts from final report.)

Activities

Reviewed literary resources including tools available through a statewide dashboard product, commercial dashboards and database applications.

Identified factors affecting data and source selection: reliability, validity, affordability, source is longitudinally available, data-partner preferences.

Identified requirements for a data management tool which are: format compatibility for data import and export, affordable, minimal training investment (easy to use) and stability of the tool in the marketplace.

Lessons Learned

We underestimated the complexity of the project and the logic needed to establish our database.

We learned that data collection and management require education, training and experience to select and properly represent and utilize available data. ("Data Literacy".)

Data management will require ongoing, sustainable and dedicated staff time to support data management, standard reporting and data sharing.

Developing relationships and trust are necessary preliminary steps toward negotiating data-sharing agreements in the region. Sharing data is not on-the-radar for many of our collaborative agency partners beyond established reporting and specific project requirements. As we are able to demonstrate the value of data management and sharing within our partnership, we may have a better case for shared resources across health-related agencies in the region.

Since much of our data comes from the state health department, we decided to follow much or their formatting including naming conventions, column titles and layout.

Capturing information about data sources, data limitations/scope, update frequency and local report schedules helps keep the information manageable and useful into the future.

Deciding to keep it simple and not try to manipulate data across multiple sources was helpful. Data comes in many different forms including raw and aggregated, and data may not be well-defined. Pay attention to date ranges.

We were not aware of the level of detail we would need to consider for queries from some data sources such as the need to capture search parameters.

We learned that there is a need for two types of data-related community collaborative groups – one for data managers and the other for data users.

Many funders encourage collaboration to share resources to establish a data management system, or initiate data sharing agreements without substantial support. An outline of the process with a template for a regional shared data-management database might support data management for these already-stretched agencies.

APPENDIX D: All Priority Health Concerns by County

6/21/18 Mineral County -- Creede
"What are the top five health concerns in Mineral County?"

1. Substance abuse all ages (youth prevention, drunk driving, pregnant women, young families) 35
2. Senior citizen care and support (including Alzheimer's and dementia) 25
3. Mental health (suicide, opioid use, depression – all ages, lack of access) 21
4. Chronic disease (heart disease, respiratory disease, obesity) 15
5. Youth education (injury prevention, dangers of environment) 10

Other issues mentioned included:
Bullying, peer pressure, online/electronic addiction.
Family planning, exercise, diet, youth and families.
Healthy housing (availability radon, lead).
Low vaccination rate (children and elderly).

7/16/18 Saguache County -- Moffat
"What are the top five health concerns in Saguache County?"

1. Local access to mental health services including substance abuse counseling and detox. (1.75)
2. Poverty resulting in food insecurity, lack of housing (including lifestyle choices) and food scarcity. (2.0)
3. Issues for senior citizens including isolation, health and poverty. (2.0)
4. Environmental pollution including radon and water quality. (3.3)
5. Dental affordability. (3.5)

Other top issues included:
Access to health-care specialists for children and adults with disabilities. (4)
Home health care and community-based options (community paramedics, sliding scale and medical scholarships). (4)
Lack of provider knowledge about obscure health issues (hanta virus, etc.). (4.5)
Lack of skills to communicate health issues to provider.

7/17/18 Saguache County -- Center

1. Drug use and addiction
2. Dental care
3. Access to care
4. Self-harm
5. Sanitation: households lack of home bathrooms and sewage disposal

Other issues mentioned included:
Lack of prevention activities
Water quality
Animal-borne diseases
Food-borne illness

Access to alternative pain management tools
Cancer
Neglectful lifestyle choices
Public education on animal disease risks

7/17/18 Saguache County – Center – (continued)
Apathy
Obesity
Maternal and infant health
Medical transportation
Elderly food insecurity leading to poor immunity and reluctance to vaccinate
More well and home testing for arsenic and radon so make a case for funding remediation
Investigate if high opioid use is related to older population.

8/14/18 Costilla County -- San Luis
"What are the top five health concerns in Costilla County?"

1. Substance abuse: all
2. Access to prevention and self-help information
3. Diabetes, obesity, hypertension, malnutrition, and cultural food challenges.
4. Access to care and treatment for substance abuse, dental and pre-natal care
5. Depression and behavioral health

Other issues mentioned included:
Motor vehicle and ATV accidents
Transportation
Hanta virus
Attempted suicide
Occupational illness/ agricultural exposure to pesticides

8/15/18 Costilla County -- Ft. Garland

1. Addictions to alcohol, opioids and smoking
2. Mental health through the lens of trauma
3. Early initiation of substance abuse
4. Financial access to healthy food and health care to prevent chronic disease
5. Lack of prevention activities for the youngest people (6-14?)
6. Access to dental, behavioral health and health care services

Other issues mentioned included:
Obesity
Cancer
Low adult vaccination rate
Drunk driving
Suicide
Carbon monoxide deaths
Elder abuse and neglect
Lack of elderly transportation

9/18/18 San Luis Valley (Regional)

1. Substance use and impaired driving
2. Diabetes
3. (tie) Water quality (Drinking water /equality)
3. (tie) Low cancer screening rates
3. (tie) Air quality (open burning and radon)

Other issues mentioned included:

Access to fresh healthy food
Mental health / adverse childhood experiences
Illegal dumping of trash and access to disposal and recycling
Respiratory diseases including tuberculosis
Poor diet and exercise habits
Access to open space
Suicide
Financial barriers to health care (poverty and knowledge of benefits)
Cardiovascular disease

10/3/18 Conejos County – La Jara

1. Healthy family environments; family stability and resources (time, money and information), support for single parents and grandparents raising children, adequate childcare. Address generational abuse.
2. Behavioral health options and stigma, anxiety, depression and suicide.
3. Access to care; transportation, health, dental, behavioral health and mental health options, lack of providers and poverty, lack of resources for community and families
4. Addiction and substance use; and financial impact on families.
5. Lack of health education apathy and stigma.

Other issues mentioned included:

In-patient substance-use treatment options
Obesity
Risky sexual behaviors
Motor vehicle accidents
Support for aging population
Financial impact of substance use on families.
Vaccinations
Sexual abuse

In Conejos County we also asked: How Can Public Health Support You?
Community Education on addiction and self-harm
Assistance with health and dental care options.

10/24/18 Alamosa
1. Substance use and lack of treatment resources
2. Elder abuse and child abuse and out-of-home placement rates
3. Nutrition, obesity, and heart disease: poverty and access to healthy food and nutrition education
4. Mental health: suicide, depression, bullying and dual-diagnoses
5. Social determinants of health: transportation, housing, access to low-cost and effective exercise options, increased need for community-based services.

Other issues mentioned included:
Substance-exposed newborns
Lack of sex-education
Chronic disease: cardiovascular, respiratory, diabetes and cancer
Environmental health concerns – groundwater
Low insurance coverage rates
Low screening rates
Low vaccination rates
Risky driving behavior: seat belts and impaired driving
Youth education around vaping and marijuana
Access to specialty care

APPENDIX E: Community Health Assessment Informal Survey

San Luis Valley Public Health Partnership Community Health Survey

PLEASE PRINT

Your Name ___________________________ **Today's Date** ________________

(Anonymous is ok!)

County you live in _______________________

Thank you for participating in our public health community health assessment. The Public Health Department is managed by our county. We work to keep people safe and healthy on a large scale. Colorado law requires us to set new goals every five years. We are gathering information to help us set these goals.

1. **Do you identify as any "special population" (elder, veteran, gay, native…)?**

____

____

2. In general, our goals are in these four areas: Chronic diseases, intentional and unintentional injury, communicable diseases, behavioral and mental health.
   What are the biggest health issues in your community?

____

____

____

____

3. **How do you prefer to receive important community information such as emergency situations?**

____

____

- -

PLEASE sign up to receive information by telephone in an emergency! Go to www.SLVemergency.org and click on the link to "sign up for emergency notifications…" Or, you can call 719-480-8469 and someone can sign you up over the phone.

APPENDIX F: Public Health Accreditation Board Standard 5.2

Conduct a comprehensive planning process resulting in a health improvement plan

Participation by a wide range of community partners representing various sectors of the community *(5.2.1.a page 133)*
Issues and themes identified by stakeholders in the community *(5.2.1.c page 133)*
Community members' definition of health and of a healthy community must be included *(5.2.1.c page 133)*
Community assets and resources identified and considered in the community health improvement process *(5.2.1.d page 133)*
Measurable outcomes and priorities that include consideration of addressing social determinants of health, causes of higher health risks and poorer health outcomes of specific populations, and health inequities *(5.2.2.a page 138)*
Policy changes must include those that are adopted to alleviate the identified causes of health inequity *(5.2.2.b page 139)*

APPENDIX G: Capacity Assessment: Health Care Review Committee

Discussion with Health Care Review Committee 10/2/19 LPHA Session

- Pop estimates from 6/2018 = 47,580, 33.6% of whom identify as Hispanic/Latino (range 6% Mineral to 60% Costilla).
- 29% speak a language other than English at home.

Our state needs to invest in a public health system that works everywhere for everyone in Colorado.

- Diminished investment in our PH system is affecting the health of our communities. State funding has not kept up with population growth and emerging challenges.
- Unwieldy nature of multiple funding streams that are mostly small amounts for rural and frontier agencies; overhaul the funding processes: streamline revenues and reporting as part of the PH Transformation process.

Propose alignment between HCPF/CDPHE/CDHS (OBH) in terms of:

- Contract design and processes.
- Joint funding for shared priorities in community health like SUD planning, treatments, and safety nets.
- Determine local capacity through a process like the FRMS we ALREADY do with CDPHE contracting?

Consider building in upstream support for mental health/behavioral health/SUD initiatives, rather than always focusing on treatment.

- Some of the best work can be done through addressing ACEs in the 0-5 population to promote health throughout the life cycle.
- Continue supporting the alignments around early childhood (0-5) currently underway in collaboration with DU and UC Anschutz to break the cycle of ACEs in our SLV communities.
- Increase access to self-management of mental health and chronic disease conditions by promoting existing programs. (Web MD, Johns Hopkins, Mayo Clinics.)

When designing funding for new initiatives, consider need as a weighted factor for rural and frontier communities.

- Costs per capita are higher in our communities due to lack of infrastructure (broadband access and IT), longer travel times and distances, limited local and regional resources (medically underserved area).
- Consider how foundational economics factor into need and capacity. For example, agricultural production/processing/transport. When these systems are disrupted, the health of the community is impacted.
- Prioritizing investments in PH infrastructure will reduce healthcare costs, support economic development, improve disaster readiness and allow families and children to thrive.

Discussion with Health Care Review Committee 10/2/19

Health Care Review Committee <u>Community Meeting Notes</u>

Overview of SLV counties demographics and review of some key data points from regional CHA. Pop estimates from 6/2018 = 47,580, 33.6% of whom identify as Hispanic/Latino (range 6% Mineral to 60% Costilla). 29% speak a language other than English at home. The SLV, like other communities in Colorado, have modern PH priorities: behavioral health, food insecurity, access to care, housing and homelessness, emergency preparedness, etc. Healthcare access: SLV has 62% fewer physicians per 100,000 that Colo; 75% fewer psychologists; 39% fewer dentists, and 45% fewer physical therapists. 30% do not feel secure paying for healthcare needs, and 18% don't fill prescriptions due to cost. 13% of us lack health care coverage. Twice as many report transportation (access & distance) as a barrier to healthcare compared to Colo overall.

Thank you for recent funding opportunities to address SUD/OUD in our communities: SB 228 which supports prevention & PH, SB 008 which supports harm reduction, SB 001 which expands the MAT pilot. Where is HB 1287 in process for treatment capacity building in rural communities? How can the prevention work taking place in our communities be supported by the state to build local capacity? Can this be done by eliminating fragmented funding and aligning funding streams across state departments to support this work? 20.2% of us live in poverty. Crucial investments like SNAP benefits and school lunch programs help parents ensure that their children are getting regular meals and are ready to learn when they go to school each day. Please do what you can at the state level to ensure continued steady funding let your federal counterparts know how critical these programs are to families in our communities.

Policy change to allow behavioral healthcare providers to share information more freely with medical providers for patient care coordination (with patient approval).

Safeguard rural hospital funding. Rural hospitals, including critical access hospitals, are vital to the survival of rural and frontier communities. While there are many challenges associated with our current healthcare system in the United States, treating all hospitals as equal (by eliminating rural facility payments) makes it very difficult for rural facilities to keep their doors open. As an example, we have one hospital that delivers babies in the SLV; that's already a 1 to 1 ½ hour trip for some of our moms. If that facility had to close its doors, delivering mothers would have to travel to 2-3; that's not safe. No one is suggesting this is happening anytime soon, but it is a risk we should not have to consider just because we live in a rural or frontier community.

Many of our communities are aging, and many experience higher levels of chronic disease (38.5% have 2 or more) and disability (21.3%). Many working adults are not only raising their children, but they are also caring for elderly parents or disabled family members. What can be done at the state level to support the "sandwich generation?" How about a pilot program to identify promising community collaborations to support caregivers?

APPENDIX H: SLVPHP PHIP Evaluation Plan 1/1/2019 – 12/31/2024

SLVPHP Public Health Improvement Plan (PHIP): EVALUATION PLAN

SLVPHP 2019 Public Health Improvement Plan EVALUATION PLAN **Health Equity - Strengthen systems that generate health including skills, capacities and competencies that play an essential role in creating comprehensive public health strategies to address health inequities and social determinants of health including privilege, power and bias.**				
Goal 1.1 Increase health equity literacy and build capacity <u>within the PHP</u> to alter structures and systems that limit health outcomes.				
Objective	Indicators	Data Collection Sources	Data Collection Method	Data Collection Timing
Local Public Health Agency Directors, Deputy Directors and contractors participate in the "Health Equity Toolkit for Rural and Remote Areas" training.	1. Number of Local Public Health Agency (LPHA) Directors, Deputy Directors and contractors that complete the training.	Participants	Training attendance roster shows number of people that completed this training.	4/27/21
	2. Participants can define local public health agency's role in impacting health equity, bias and examples of institutional racism.	Participants	Participant survey.	Completion of training
	3.Participants are familiar with CLAS standards: Culturally and Linguistically Appropriate Services in health and health care.	Participants	Participant survey.	Completion of training
	4. Participants can describe how racism and other forms of systemic oppression shape the way we understand health data.	Participants	Participant survey.	Completion of training

Develop and implement a regional health equity training schedule for LPHA staff and field staff.	A system is established for equity training and includes an on-boarding curriculum.	SLVPHP Chair	Yes/ No	7/31/20
LPHA staff complete introductory equity training according to the training plan.	1. Number of LPHA staff that complete the training.	LPHA Directors	Staff rosters and training completion dates to SLVPHP Chair.	Completion of training
	2. Participants can define local public health agency's role in impacting health equity, bias and describe examples of institutional racism.	Participants	Participant survey.	Completion of training
Improve equitable practices in LPHA staff recruitment, interviewing and hiring.	List of recommendations.	LPHA Directors	List provided to SLVPHP Chair.	12/31/2021
Goal 1.2 Increase health equity literacy and build capacity <u>with regional health and local partners</u> to alter structures and systems that limit health outcomes.				
Objective	Indicators	Data Collection Sources	Data Collection Method	Data Collection Timing
Identify and support community partner activities that improve health equity practices.	Identify systems and strategies that limit or address health equity.	LPHA Directors and SLVPHP Contractors	Quarterly reporting of systems, structures and strategies to Coordinator (or develop Google reporting system).	As occurs with annual summary.
Goal 1.3 Work with community partners on systems change via existing and emerging <u>local</u> projects to influence health behaviors and conditions.				
Objective	Indicators	Data Collection Sources	Data Collection Method	Data Collection Timing
Develop, continue or complete <u>local projects</u>.	Per project deliverables.			

SLVPHP 2019 Public Health Improvement Plan EVALUATION PLAN Public Health Capacity				
Goal 2.1 Increase capacity to ensure core public health services in the region.				
Objective	Indicators	Data Collection Sources	Data Collection Method	Data Collection Timing
Review statewide public health modernization assessment results and identify areas for improvement.	Identified priority gap areas.	LPHA Directors	Summary of priority gap areas.	Begin 1/27/20
Build a sustainability plan to protect priority and essential services.	Sustainability Plan is developed.	LPHA Directors	Yes/ No	12/31/21
Develop and implement strategies for improvement to support the provision of core services consistent with public health modernization.	Strategies are identified.	LPHA Directors	Yes/ No	12/31/2020
Increase professional capacity to provide public health services.	A new employee orientation toolkit is developed for LPHAs.	LPHA Directors	Yes/ No	12/31/21
Goal 2.2 Collaborate with state and community partners to support population health improvement efforts.				
Objective	Indicators	Data Collection Sources	Data Collection Method	Data Collection Timing
Build and define a shared community health assessment process with local hospitals.	Hospital entities agree and establish a process to develop elements of a CHA process.	LPHA Directors report to Chair.	Describe partners, process and shared assessment goals.	3/31/20 6/30/20 9/31/20 12/31/20
Share rural and partnership perspectives with statewide organizations and alliances.	List of meetings and general topics discussed.	LPHA Directors, Deputy Directors and SLVPHP Contractors.	Google survey from SLVPHP Coordinator quarterly.	3/31/20 6/30/20 9/31/20 12/31/20 +
Report progress on PHIP objectives and activities.	Evaluate PHIP implementation progress.	LPHA Directors	Summary report on objectives and activities.	Annually early spring