

Public Health Improvement Plan

Adams, Arapahoe and Douglas Counties, Colorado 2014–2018



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Executive Summary

In 2008, Colorado's Public Health Act was signed into law. (C.R.S. 25-1-505). One of the requirements of the Act was that every five years, each local health department in Colorado conduct assessments of community health and of local public health capacity and use the results of the assessments to develop a five-year local Public Health Improvement Plan (PHIP) that engages community partners in improving the health of their communities. To guide the development of local plans, the Colorado Department of Public Health and Environment created the Colorado Health Assessment and Planning System (CHAPS), a standardized process to assist local health departments in meeting the assessment and planning requirements of the Public Health Act of 2008. This document represents the results of the public health improvement planning process led by Tri-County Health Department (TCHD) using CHAPS for its diverse jurisdiction comprised of Adams, Arapahoe and Douglas Counties.

After creation of an internal team, TCHD engaged a diverse array of more than 100 community stakeholders to provide input into the planning process. Stakeholders represented sectors including Hospitals, Healthcare organizations/Community Health Centers, Mental Health organizations, First Responders, Schools, Government agencies, Animal-related agencies, Health-related non-profit agencies, Businesses, Insurance companies, Faith-based organizations, TCHD Board of Health, and TCHD County Commissioners. The role of the stakeholders was to provide input into the assessments of community health and system capacity, the final prioritization of health issues, and ultimately the development of the Public Health Improvement Plan for Adams, Arapahoe and Douglas Counties.

Following community engagement, we conducted a community health assessment to help inform the selection of a priority focus area for the Public Health Improvement Plan. This assessment consisted of three primary components: 1) Analysis of health indicator data for our jurisdiction; 2) Focus groups of Community Stakeholders/Partners; 3) A survey of the staff of Tri-County Health Department. Each of these three processes resulted in the identification of the same three priority health areas for the jurisdiction: Obesity, Mental Health and Access to Health Care.

We then conducted a system capacity assessment to determine current and future capacity for our community to address the three identified top priority health issues. We surveyed stakeholders to assess each organization's capacity to deliver services in the following forms: Direct patient care (e.g., screening, treatment, counseling, case management, programs), Health Education (e.g., health educators, educational messaging, community referrals) and Policy and Advocacy (e.g., lobbying, facilitation of community coalitions/advisory groups). For all three identified priority health issues, approximately 31-50% of organizations responded

that they currently provide direct patient care, health education, and/or policy/advocacy with no significant difference among the three priority health issues. In addition, 15-30% of organizations indicated potential future capacity for direct patient care, health education, and/or policy/advocacy for each health issue, with no significant differences among the three health issues.

Following these assessments, we convened our stakeholders to make a final prioritization of the top health issues to select one to be the focus of a five-year Public Health Improvement Plan for Adams, Arapahoe and Douglas Counties. During this meeting, we reviewed the data from the assessment phases of our process and evaluated a list of evidence-based strategies that exist for each health issue selected from national sources. Specifically, the group evaluated the “actionability” of the strategies, which considered current momentum in the community, ability to collectively implement, and ability to impact the issue in a sustainable way. At the end of the process, we asked each partner organization to cast a vote for which of the three priority issues would be their choice for our community to focus on in the next five years. The results were tabulated, and **Mental Health** received twice as many votes as either Obesity or Access to Care.

The final phase of the process was to develop the specific five-year Public Health Improvement Plan to improve Mental Health Promotion in Adams, Arapahoe and Douglas Counties. Guided by input from our stakeholders and aligned with the mental health goals selected by the Colorado Office of Behavioral Health, the PHIP consists of the following Goals and Objectives:

Goal 1: Reduce stigma associated with mental health issues by shifting social norms so that mental health issues are considered no different than other health issues.

Objective 1.1: By December 2018, work with partners to develop and disseminate common messaging that promotes mental health as integral to total health.

Objective 1.2: By December 2018, work with community partners to identify opportunities to frame their activities in a context of mental health promotion.

Goal 2: Increase prevention of and early intervention for mental health issues by recognizing and promoting the interrelatedness of mental health and physical health in existing community efforts.

Objective 2.1: By December 2018, integrate prevention of and early intervention for mental health issues with chronic disease prevention initiatives at TCHD.

Objective 2.2: By December 2018, increase the number of community partners trained in Mental Health First Aid across community partner sectors in Adams, Arapahoe and Douglas Counties.

Objective 2.3: By December 2018, participate in collaborative efforts to support evidence-based programs in community settings that foster prevention or early intervention for mental health issues and their inter-relatedness with physical health.

Goal 3: Enhance access to mental health care services in the community by creating a system of interconnected access points.

Objective 3.1: By December 2018, participate in a regional effort to create a system of interconnected access points to mental health services (e.g., “no wrong door”).

Objective 3.2: By December 2018, work with partners to increase integration of mental and physical health services in healthcare settings.

Goal 4: Enhance existing population-level data collection efforts for mental health promotion and mental illness in Colorado

Objective 4.1: By December 2018, establish a standard set of Behavioral Risk Factor Surveillance System (BRFSS) questions that measure indicators related to mental health for Colorado.

Objective 4.2: By December 2018, develop a core set of indicators related to mental health in Colorado by integrating data collection efforts of public health, health care and mental health entities.

Because of the collaborative nature of the envisioned effort, the PHIP will be guided by a Leadership Team of key stakeholders. We anticipate that work plans for each goal will be developed over the first year and modified each subsequent year based upon progress and emerging opportunities and resources. The plan will be evaluated by process monitoring to assess the progress of each work plan and output/outcome evaluation of short-and medium term outputs for each goal and long-term health outcomes that cut across all four goals.

I. Tri-County Public Health Improvement Planning Process

A. Background/Introduction

In 2008, Colorado's Public Health Act was signed into law. (C.R.S. 25-1-505). The purpose of the Act was to assure that core public health services are available to every person in Colorado, regardless of where they live, with a consistent standard of quality.

One of the requirements of the Act was that every five years, the Colorado Department of Public Health and the Environment (CDPHE) develop a statewide Public Health Improvement Plan (PHIP), the first of which was completed in 2009.¹ Following completion of the statewide plan, the statute directed each local health department to conduct assessments of community health and of local public health capacity and use the results of the assessments to develop a five-year local Public Health Improvement Plan that engages community partners in improving the health of their communities.

To guide the development of local plans, the CDPHE created the Colorado Health Assessment and Planning System (CHAPS). CHAPS provides a standard mechanism for assisting local health departments in meeting the assessment and planning requirements of the Public Health Act of 2008. It consists of eight phases, which all local health departments must complete:

1. Plan the Process
2. Identify and Engage Stakeholders
3. Conduct a Community Health Assessment
4. Conduct a System-wide Capacity Assessment
5. Prioritize Issues
6. Develop a Local Public Health Improvement Plan
7. Implement, Promote and Monitor the Plan
8. Inform and Participate in Statewide Public Health Improvement Planning

This document represents the results of Phases 1-6 of the CHAPS process led by Tri-County Health Department (TCHD) for the jurisdiction comprised of Adams, Arapahoe and Douglas Counties.

B. Description of Jurisdiction

Tri-County Health Department’s jurisdiction includes Adams, Arapahoe and Douglas Counties, which border the City and County of Denver on the north, east and south. (Denver is not part of the TCHD jurisdiction.) The three counties cover a wide range of geographies – urban, suburban and rural. The population of the three-county region is approximately 1.3 million, which represents more than one-quarter of the entire population of the state of Colorado. The Colorado Demography Office estimates the 2012 populations of the three counties as follows: Adams - 459,555; Arapahoe - 594,731; Douglas - 298,167. The population of the jurisdiction is very diverse, ranging from very low to very high income with representation from a multitude of racial and ethnic groups. The jurisdiction’s largest municipality, Aurora, is the first in the state in which racial and ethnic minority groups make up the majority of the city’s population.

C. The CHAPS Process – Phases 1-6

CHAPS Phase 1: Plan the Process

The first step in the process was to develop our internal team and designate a project manager to lead the process. We created a timeline and a work plan for completing all requirements.

CHAPS Phase 2: Community Stakeholder Engagement

The second step in the process was to engage a diverse array of community stakeholders to participate in the process. The purpose of community stakeholder engagement was to identify and engage community partners and TCHD staff in a strategic manner throughout all phases of the Public Health Improvement Planning process, with consideration for the type of input they can provide and how they can influence the ultimate success of the plan.

With input from the TCHD Board of Health, the PHIP Team identified 15 “sectors” or groups of potential partners from which to seek input and participation in the planning process:

1. Hospitals
2. Healthcare organizations/Community Health Centers/Clinics
3. Mental Health organizations/providers
4. First Responders

5. Schools/Education
6. Government agencies – Human Services-related
7. Government agencies – Environment-related/ park & recreation/city planning
8. Animal-related agencies
9. Health-related non-profit agencies
10. Businesses
11. Insurance companies
12. Faith-based organizations
13. TCHD Board of Health
14. TCHD County Commissioners
15. TCHD Staff

For a complete list of community partners who have participated in the PHIP process for Adams, Arapahoe and Douglas Counties, see Appendix 1.

The following sections detail the many levels on which we engaged partners from these sectors to provide input into the assessments of community health and system capacity, the final prioritization of health issues, and ultimately the development of the Public Health Improvement Plan for Adams, Arapahoe and Douglas Counties.

CHAPS Phase 3: Community Health Assessment

Following community engagement, the next step of the CHAPS was to conduct a multi-pronged community health assessment to help inform our selection of a priority focus area for our Public Health Improvement Plan. Our community health assessment consisted of three primary components:

- Analysis of health indicator data for our jurisdiction
- Focus groups of a wide variety of representatives from each sector of Community Stakeholders/Partners described in the previous section of this document
- A survey of the staff of Tri-County Health Department

The methods and results of each component will be described below.

a. Health Indicator Data Analysis

For many years, TCHD has had an established practice of conducting an annual analysis of the most recent year of community health data for our jurisdiction from the following sources (all housed at the CDPHE):

- Vital Records (birth and death) data
- Behavioral Risk Factor Surveillance System (BRFSS)
- Colorado Electronic Disease Reporting System (CEDRS)

These annual analyses are published for each of the three counties in our jurisdiction and posted on our website (www.tchd.org) as “County Health Profiles.”

In addition, since 2002, TCHD has produced, every 3-5 years, a more extensive analysis of 10 year trend data for all of the indicators in the annual County Health Profiles and many additional indicators as well. At the start of our PHIP process, we had recently (2011) published this more extensive document, our “Community Health Profile,” which contained the majority of the community health data needed for our PHIP Community Health Assessment. This is available on our website http://www.tchd.org/pdfs/community_health_profile_2010.pdf

We also determined that we needed additional community health data on several key topics that were not included in our Community Health Profile: perinatal health, hospitalizations, access to care, mental health, substance abuse, and additional health behaviors.

We obtained these data from sources that included the Pregnancy Risk Assessment Management System (PRAMS), Behavioral Risk Factor Surveillance System (BRFSS), Substance Abuse Mental Health Services Administration (SAMHSA), Colorado Health Institute, Colorado Child Health Survey, and Council for Disability Awareness and the Colorado Hospital Association.

Through our comprehensive analysis of these data sources, several domains of health emerged as having the greatest impact on Adams, Arapahoe and Douglas Counties:

- Obesity and its related risk factors (e.g., poor nutrition, lack of physical activity), which contributes to many chronic diseases (e.g., cardiovascular disease, cancer, diabetes) that are the leading causes of death in Adams, Arapahoe and Douglas Counties
- Mental Health issues (across the spectrum from mild depression to severe mental illness including suicide, access to mental health and preventive services)
- Access to Health Care (including dimensions such as lack of health insurance, lack of providers who accept Medicaid, Medicare and Child Health Plan+)

The leading causes of death in the TCHD jurisdiction for 2012 are noted below.

Leading causes of death for Adams, Arapahoe, and Douglas Counties combined, 2012

	Age-adjusted rate ^a
All cancers	146.7
All heart diseases	117.4
Chronic lower respiratory diseases ^b	51.5
Unintentional injuries	44.6
Alzheimers disease	40.4
Cerebrovascular diseases ^c	29.3
Suicide	17.2
Diabetes mellitus	16.5
Nephritis, nephrotic syndrome, and nephrosis ^d	11.5
Parkinsons disease	11.1

- a. Rates are per 100,000 population and age-adjusted to the 2000 census population. Source: Health Statistics Section CO Dept of Public & Environment
- b. Includes asthma, chronic bronchitis, emphysema.
- c. All diseases that affect the blood vessels in the brain; stroke is an example of a cerebrovascular disease.
- d. Kidney diseases.

b. Stakeholder/Partner Focus Groups

In order to obtain community perspective on the health issues that have the greatest impact on the residents of Adams, Arapahoe and Douglas Counties, we conducted a series of focus groups of representatives from our community partners (Appendix 1). In other, less populated parts of Colorado, some of our local public health colleagues obtained this community perspective by conducting surveys, focus groups or town hall meetings of members of the general public who were interested enough to participate. Due to the size of the TCHD three-county jurisdiction (1.3 million people), we felt it would be more efficient, and would provide more representative information if we gathered this input from the community organizations that address health-related issues across the jurisdiction.

We hired an outside facilitator from Non-Profit Impact, a consulting firm that specializes in public health issues, to facilitate the focus groups and compile the resulting data. We held 11 focus groups representing the following partner sectors:

1. Hospitals
2. Healthcare organizations/Community Health Centers/Clinics
3. Mental Health organizations/providers
4. First Responders

5. Schools/Education
6. Government agencies – Human Services-related
7. Government agencies– Environment-related/ parks and recreation/city planning
8. Animal-related agencies
9. Health-related non-profit agencies
10. TCHD Board of Health
11. TCHD County Commissioners

We also attempted to convene focus groups of business leaders, insurers, and faith-based organizations, but were unsuccessful in recruiting participants.

The 11 focus groups consisted of 74 participants representing 59 community partner organizations. They were asked a scripted series of questions, which addressed issues of their perceptions of the health issues that had the greatest impact on the community. These were very open ended questions and the field of possible responses was not narrowed in any way.

The focus group facilitators took detailed notes, which were analyzed by TCHD staff for key themes both within and across focus groups. Despite the wide scope of possible health themes that existed, the focus group discussions generally centered on a surprisingly small number of topics. Of these, the three that clearly rose to the top were the same ones identified in the analysis of indicator data: obesity, mental health, and access to health care.

c. TCHD Staff Survey

In addition to our Community Partner focus groups, the other important perspective on the health issues impacting our communities was obtained through a survey of TCHD staff. We developed a brief electronic survey in Survey Monkey that contained questions that mirrored those asked in our Community Partner focus groups surrounding what they felt are the major health issues impacting our communities. An email was sent out to all TCHD staff that invited them to participate and contained a link to the survey.

A total of 154 TCHD staff responded to the survey. The range of health issues identified by TCHD staff was greater than those identified by the focus groups. However, when we analyzed the frequencies with which the issues were mentioned, there was complete concordance in identification of the same top priorities as in the other two assessment components.

CHAPS Phase 4: System Capacity Assessment

The purpose of the system capacity assessment was to determine current and future capacity for our community to address the three identified top priority health issues – obesity, mental health and access to health care. We conducted a written survey (which was also made available on-line) of 105 stakeholders and assessed each organization’s capacity to deliver services in the following service categories: **Direct patient care** (e.g., screening, treatment, counseling, case management, programs), **Health Education** (e.g., health educators, educational messaging, community referrals) and **Policy and Advocacy** (e.g., lobbying, facilitation of community coalitions/advisory groups). Organizations were asked the following question for each health issue, “In what capacity could your organization offer these services/resources to a potential community-wide effort around [health issue]?”

For each of the service categories, organizations were provided with the following responses and asked to choose the one best answer: a) We could not provide this type of service/resource, b) We don't currently provide this service/resource, however we could add it to our scope of work, c) We could provide through our current services/resources, d) We could provide through our current services/resources AND could go above and beyond our current services/resources.

The response rate to the survey was 85%. For all three identified priority health issues, approximately 31-50% of organizations responded that they currently provide direct patient care, health education, and/or policy/advocacy. The percentage of organizations indicating that they currently provide these types of services did not significantly differ among the health issues. In addition, 15-30% of organizations indicated potential future capacity for direct patient care, health education, and/or policy/advocacy for each health issue, with no significant differences among the three health issues.

Finally, we asked each organization to “rate the level of interest your organization would have in addressing each health issue as part of a potential community-wide effort on a scale of 1-6, with 1 representing 'LOW INTEREST' and 6 representing 'HIGH INTEREST'.” Once again, the results were very similar. The mean score for Obesity (Healthy eating, physical activity) was 4.5, mental health, 4.3, and access to healthcare, 4.2.

CHAPS Phase 5: Prioritization Process and Results

Following completion of the Community Health and System Capacity Assessment phases of our CHAPS process, we undertook the prioritization phase. The purpose of this phase was to take a closer look at the three issues that consistently rose to the top in the assessment phases and select one to be the focus of a five-year PHIP for Adams, Arapahoe and Douglas Counties.

Some local health departments in Colorado chose to create a Public Health Improvement Plan that focused on multiple health priorities. However, due to the size and diversity of the population of Adams, Arapahoe and Douglas Counties (1.3 million people) and after discussion with our Steering Committee, Board of Health and community partners, we made the strategic decision to select one issue to be the focus of our plan. In order to have a significant impact on the health of our entire population and in the absence of identified new resources, we felt we needed to create plan that focused on one health issue, rather than more superficially attempting to address several issues.

A key element of the CHAPS process was the assessment of evidence-based strategies that exist for each health issue under consideration. We consulted several national sources of evidence-based health strategies including:

- Healthy People 2020
- Guide to Community Preventive Services recommendations
- National Prevention Strategy
- Centers for Disease Control and Prevention guidelines and recommendations
- Robert Wood Johnson Foundation's County Health Rankings Roadmaps to Health
- Institute of Medicine reports

The resulting list of evidence-based strategies was narrowed down by TCHD staff based on the following criteria:

- Scientifically supported by numerous studies or systematic reviews with strong positive results and not substantial contradictory evidence
- Ability to be implemented by one or more of our community partners
- Ability to measure impact

For Obesity, we identified 43 evidence-based strategies, which we narrowed down to 18, based on the above criteria. For Mental Health, we identified 23 evidence-based strategies, which we narrowed down to 14. For Access to Healthcare, we identified 25 evidence-based strategies, which we narrowed down to 12.

At this point, we convened a selection of our community partners to participate in the final prioritization process. At this meeting, we presented the detailed results of the Community Health Assessment and System Capacity Assessment processes for their consideration and also enlisted their help in examining the narrowed-down list of evidence-based strategies for each of the top three priority areas. Specifically, we led them through an exercise to determine the level of “actionability” of the strategies for each of the three areas.

We defined “actionability” as the ability to act on the strategies quickly, so that by the end of five years, we would be able to show a sustained positive outcome on the selected health issue in our communities. We broke down “actionability” into three components:

1. Momentum/timing: the amount of momentum that currently exists in the community to catalyze our work moving forward
2. Ability to implement: the extent to which we can implement the strategies collectively to make a significant impact within five years, considering existing resources, diversity of partners, and feasibility of strategies
3. Sustainability/opportunity to leverage: the extent to which partners can pool resources and collaborate to impact this issue in a sustained way

Our partners evaluated each set of evidence-based strategies on these criteria resulting in actionability scores for each of the three priority areas.

At the end of the process, we asked each partner organization to consider all of the information presented and discussed during the session and cast a vote for which of the three priority issues would be their choice for our community to focus on in the next five years.

The results were tabulated, and **Mental Health** received twice as many votes as either Obesity or Access to Care. While all of the participating partners indicated that they felt that all three issues were very important to the health of our population, one of the reasons for selecting Mental Health as the focus for the PHIP was the relatively greater attention already being paid to the other two issues through other efforts.

CHAPS Phase 6: Develop the Public Health Improvement Plan

Based on the prioritization results, we developed a Public Health Improvement Plan for Adams, Arapahoe and Douglas Counties focusing on mental health promotion. The remainder of this section provides an overview of the importance of mental health as a public health issue, while the full plan is outlined in the subsequent section (section II)

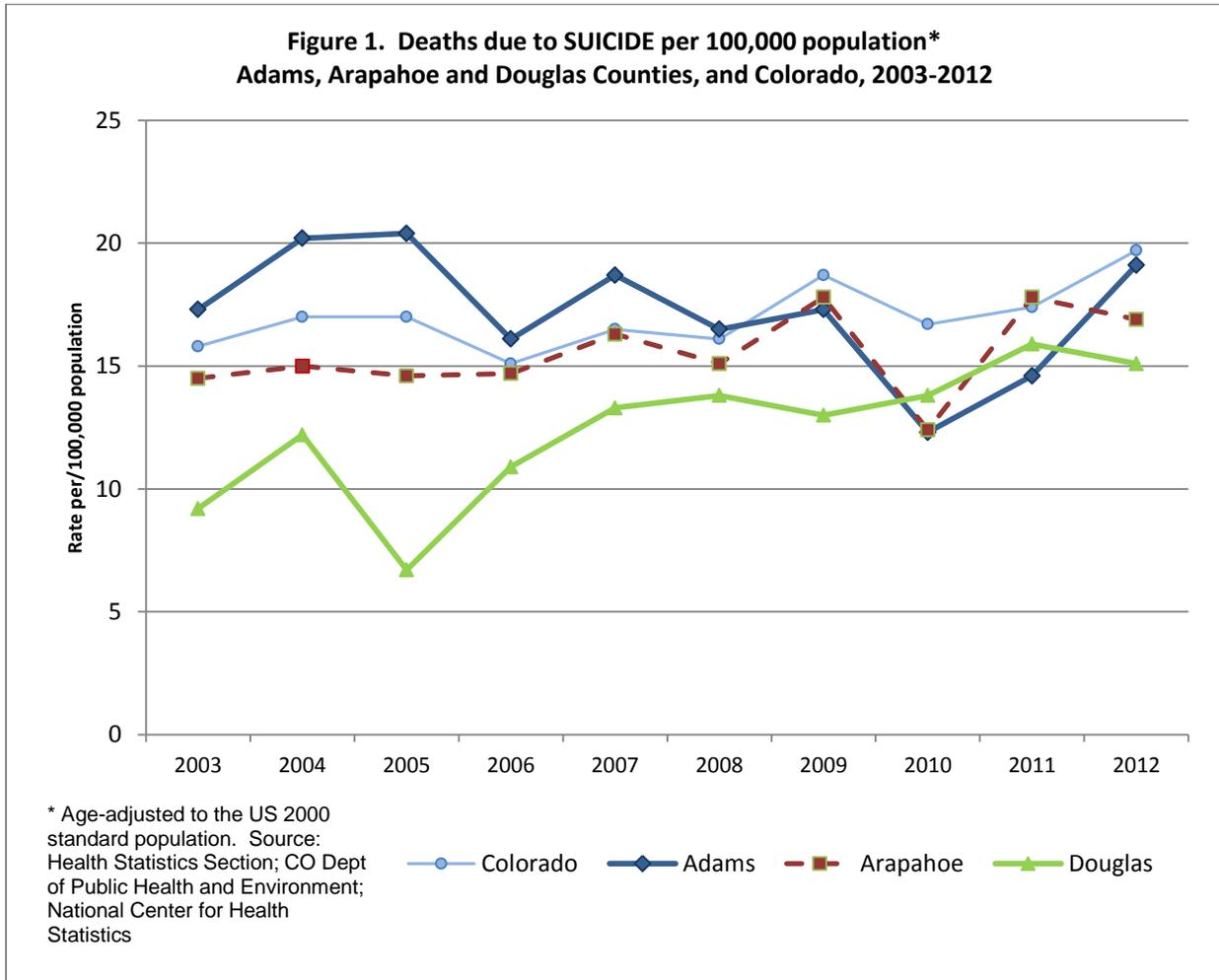
Mental health, which includes mental, emotional and behavioral components of well-being, is fundamentally linked with physical health. This relationship is highlighted by The World Health Organization's (WHO) definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity", with WHO emphasizing that "there is no health without mental health."² Successful mental function can contribute to a productive life, meaningful relationships, positive contributions to society, and the ability to navigate changing circumstances.³

Because mental and physical health are inter-related in how they contribute to the overall health of our population, it is becoming increasingly important to focus public health promotion and prevention expertise on the promotion of mental health. Mental disorders are among the leading causes of disability in the United States. In fact, 25% of all years that are lost to disability or premature death are due to mental health related problems.⁴ In addition, mental health issues are strongly associated with multiple health risk factors, chronic disease and mortality:

- Suicide is the eleventh leading cause of death in the United States for all ages with an additional 25 suicide attempts occurring for each one completed.⁵
- Suicide mortality rates are higher in Colorado than in the nation for people 18 years and older. More Coloradoans die from suicide than from illnesses such as diabetes, pneumonia or breast cancer.⁶
- Epidemiologic studies have provided evidence of a strong link between mental illness, mental health, and physical health, especially as it relates to chronic disease occurrence, course, and treatment.⁷
- Adults with mental disorders are more likely than those without mental illness to have high blood pressure, asthma, diabetes, heart disease or stroke.⁸
- Alcohol dependence is four times more likely to occur among adults with mental illness than among adults with no mental illness (9.6-percent versus 2.2-percent).⁹
- Smoking is more common in adults with mental illness than other adults: 36% of adults with mental illness smoke cigarettes compared with 21% of adults with no mental illness.¹⁰

In Adams, Arapahoe and Douglas Counties—Tri-County Health Department's jurisdiction—mental health-related issues follow these national and state trends.

In 2012, suicide was the seventh leading cause of death in the TCHD jurisdiction with trends similar to Colorado and with rates climbing over the past several years, particularly in Douglas County (Figure 1). Suicide accounted for 235 deaths (rate of 17.2 per 100,000) in the three counties combined in 2012.¹¹



- Most who died from suicide were suffering from depression at the time of death.¹²
- In 2012, an estimated 10.0% of Adams and Arapahoe County residents and 4.0% of Douglas County residents reported symptoms consistent with depression on the BRFSS survey.¹³
- Approximately 16.0% of postpartum women in Arapahoe County and 9% of postpartum women in Douglas and Adams counties reported postpartum depressive symptoms in 2009-2010 (the most recent year data are available).¹⁴

- The 2009-2011 average annual rate of hospitalization for mental health and heart disease issues were similar (2,912 hospitalizations /100,000 population and 2,502 hospitalizations/100,000 population, respectively).¹⁵

If we are to meet our charge of protecting and promoting the public's health, mental health promotion and protection must be incorporated into public health's overall goal for health promotion. "The goal of total health for the population as a whole will require an integrated approach, with all health professionals working across disciplines, organizations, and health systems, including those addressing physical health and mental health and those encompassing primary care, mental health, and public health."¹⁶

This approach should include evidence-based strategies – strategies that have been scientifically proven to positively impact mental health outcomes. Examples of these were identified during our assessment and prioritization process and evaluated for their feasibility in Adams, Arapahoe and Douglas Counties. These include a wide range of strategies, from those that have impact at the individual level all the way to strategies that work at the policy level.

Strategies such as these will be useful for consideration in implementation of the plan. The specific strategies implemented will be selected by our community partners who will determine which strategies best fit their organization's activities. Illustrative examples of these evidence-based strategies can be found below.

Examples of Evidence-Based Strategies for Mental Health*

- Centering Pregnancy (group support for pregnant women)
- Clinic-based depression care management
- Home-based depression care management
- Cognitive-Behavioral therapy to reduce recidivism in criminal justice settings
- Collaborative care for the management of depressive disorders
- Kinship care for children removed from home due to maltreatment
- Incredible Years (parent, teacher and child training for children up to age 12 at risk for behavioral problems)
- Fitness programs in community settings
- Activity programs for older adults
- Housing assistance initiatives
- Telemedicine programs
- Whole school violence prevention programs
- Increasing green space and parks
- Mental health benefits legislation

*Strategies and supporting evidence found in the Robert Wood Johnson Foundation's County Health Rankings & Roadmaps¹⁷

II. The Public Health Improvement Plan for Adams, Arapahoe and Douglas Counties, 2014-2018

A. Introduction

The Public Health Improvement Plan (PHIP) for Adams, Arapahoe and Douglas Counties is a strategic community approach to addressing mental health promotion as a key factor in supporting optimal health and well-being of our communities.

This plan includes an overarching vision and mission for a focus in the area of mental health promotion. It is designed to guide the implementation of community collaborative efforts among TCHD and community partners over a five-year period of time. The goals, objectives and strategies provide the broad framework within which TCHD and its partners will develop work plans and implementation activities aligned with community and partner activities and needs as well as available resources. The major focuses of the first year of the five-year period will be assembling a Leadership Team comprised of community partners from a variety of sectors in the first three months and the development of the work plans for each goal in the PHIP by month nine. Each year during the five-year period, progress and lessons learned will be evaluated, and the next year's work plan will be developed to incorporate needs, opportunities and resources that arise.

Vision: Our community promotes mental and physical health as one interconnected path to optimal health and well-being and a thriving population across the lifespan.

Mission: To improve the health of our community through the integration of mental and physical health at multiple levels:

- Alignment with the goals of the Colorado Office of Behavioral Health (OBH)
- Encouragement and coordination of community partner efforts around the integration of mental and physical health
- Identification and measurement of collective and integrated indicators

B. Goals, Objectives and Strategies

Goal 1: Reduce stigma associated with mental health issues by shifting social norms so that mental health issues are considered no different than other health issues.

Objective 1.1: By December 2018, work with partners to develop and disseminate common messaging that promotes mental health as integral to total health.

Strategies:

- 1.1.1 Collaborate with OBH and Colorado Department of Public Health and Environment (CDPHE) and local mental health partners to develop common messaging.
- 1.1.2 Develop and implement a plan to disseminate the common messaging across community partners as well as all staff at TCHD.
- 1.1.3 Collaborate with OBH, CDPHE and other local health departments focusing on mental health in their PHIPs to collect baseline data by adding selected additional questions to the BRFSS to measure behavioral impacts of stigma associated with mental health issues.

Objective 1.2: By December 2018, work with community partners to identify opportunities to frame their activities in a context of mental health promotion.

Strategies:

- 1.2.1 Work with selected community partner sectors in identifying opportunities to frame their activities in a context of mental health promotion.
- 1.2.2 Work with selected community partner sectors to integrate mental health promotion language into their policies, procedures, marketing, communication and programming.

Goal 2: Increase prevention of and early intervention for mental health issues by recognizing and promoting the interrelatedness of mental health and physical health in existing community efforts.

Objective 2.1: By December 2018, integrate prevention of and early intervention for mental health issues with chronic disease prevention initiatives at TCHD.

Strategies:

- 2.1.1 Identify “Mental Health Promotion” as the 2014-2016 Key Theme of TCHD’s intra-agency Chronic Disease and Injury Prevention Team collaboration.
- 2.1.2 Inventory relevant TCHD services and establish baseline of integrated activities.
- 2.1.3 Identify and implement strategies to integrate Mental Health Promotion into chronic disease prevention initiatives across TCHD.
- 2.1.4 Develop model for incorporating mental health promotion in diverse programs across a local public health agency and adapting it to other community partners.

Objective 2.2: By December 2018, increase the number of community partners trained in Mental Health First Aid across community partner sectors in Adams, Arapahoe and Douglas Counties.

Strategies:

- 2.2.1 Identify organizations that provide Mental Health First Aid training.
- 2.2.2 Train selected TCHD staff in Mental Health First Aid.
- 2.2.3 Identify and work with community partners interested in being trained in Mental Health First Aid to access that training or an equivalent. Identify community partner sectors in which gaps exist to prioritize for training.

Objective 2.3: By December 2018, participate in collaborative efforts to support evidence-based programs in community settings that foster prevention or early intervention for mental health issues and their inter-relatedness with physical health.

Strategies:

- 2.3.1 Engage with mental health partners to identify opportunities to provide physical health promotion (e.g., physical activity, healthy eating, tobacco prevention) for their staff and clients.
- 2.3.2 Engage school districts to identify policy opportunities for providing health education that integrates mental and physical health elements.
- 2.3.3 Engage with additional partner sectors to identify and begin implementing opportunities to increase interventions that integrate mental and physical health elements.

Goal 3: Enhance access to mental health care services in the community by creating a system of interconnected access points.

Objective 3.1: By December 2018, participate in a regional effort to create a system of interconnected access points to mental health services (e.g., “no wrong door”).

Strategies:

- 3.1.1 Inventory access points within TCHD and community partner segments for referrals to mental health care in the community.
- 3.1.2 Participate with regional partners to strengthen interconnection of the identified access points and the system of referral through them.

Objective 3.2: By December 2018, work with partners to increase integration of mental and physical health services in healthcare settings.

Strategies:

- 3.2.1 Survey health care providers to assess status of integration of mental and physical health care services.
- 3.2.2 Engage community partners to identify opportunities to increase implementation of strategies such as the U.S. Preventive Services Task Force (USPSTF) recommendation for depression screening in appropriate health care settings.
- 3.2.3 Inventory and disseminate integrated healthcare models.

Goal 4: Enhance existing population-level data collection efforts for mental health promotion and mental illness in Colorado

Objective 4.1: By December 2018, establish a standard set of Behavioral Risk Factor Surveillance System (BRFSS) questions that measure indicators related to mental health for Colorado.

Strategies:

- 4.1.1 Collaborate with state and local partners to identify or create selected additional BRFSS questions that measure indicators related to mental health.
- 4.1.2 Identify resources to ensure sustainability of these questions on an ongoing basis.
- 4.1.3 Collect, analyze, and disseminate data from mental health-related BRFSS questions.

Objective 4.2: By December 2018, develop a core set of Colorado mental health-related indicators by integrating data collection of public health, health care and mental health entities.

Strategies:

- 4.2.1 Inventory current surveillance systems and surveys in public health, health care and mental health agencies and organizations.
- 4.2.2 Convene discussions of public health, health care and mental health agencies and organizations to discuss results of the inventory and develop shared operational definitions of mental health, mental illness, and determinants associated with each by using clinical, public health, mental health, and policy perspectives.
- 4.2.3 Identify or create a core set of indicators and establish the mechanisms for data collection, analysis and dissemination.

C. Monitoring and Evaluation

The monitoring and evaluation plan consists of two components: process monitoring and output/outcome evaluation.

Process Monitoring

For each of the five years of the plan implementation, a detailed work plan will be developed by TCHD and its partners. For each of the four goals in the plan there will be a work plan that will detail activities, time frame and responsible parties as well as milestones that will serve as the process monitoring tools.

On a quarterly or as needed basis, the PHIP Leadership Team will convene to evaluate the progress toward the milestones and make any adjustments needed to keep the work on track.

On an annual basis, the PHIP Leadership Team will convene to review the progress of the past year and develop the detailed work plan for the next year. This approach will allow for the flexibility to respond to emerging needs and opportunities that will likely arise over the five-year implementation period.

Output/Outcome Evaluation

For each of the four goals in the PHIP, a series of key outputs and short- and medium-term outcomes have been identified. In addition, a set of long-term outcomes have been identified that cut across all four goals. See Appendix 2 for a table outlining Key Outputs and Outcomes.

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Appendix 1: Acknowledgements

The Public Health Improvement Plan for Adams, Arapahoe and Douglas counties is a collaborative effort of the many organizations with a commitment to improve the health and well-being of residents. The following list represents community partners that have contributed to this process to date:

Access-a-ride	CHP+
Adams 12 Five Star Schools	City of Englewood
Adams 50 School District	City of Sheridan
Adams County Human Services	City of Thornton
Adams County Parks and Community Resources Department	City of Westminster Fire Department
Adams County School District 14	Clinica Family Health
Adams County Sheriff	Colorado Access
Advanced Pediatric Associates	Colorado Community Health Network
African Community Center	Colorado Dept. of Public Health and Environment, Refugee Health Program
Almost Home, Inc.	Colorado Rural Health Center
Anythink libraries	Colorado State University Extension in Arapahoe County
Arapahoe County Coroner	Community Enterprise
Arapahoe County Department of Human Services, Children, Youth and Family Services	Community Health Services
Arapahoe County Early Childhood Council	Community Reach Center
Arapahoe County Sheriff's Office	County Commissioners, Adams, Arapahoe & Douglas
Arapahoe Douglas Mental Health Network	Cooking Matters/Share Our Strength Colorado
Arapahoe House Inc.	Cunningham Fire District
Asian Pacific Development Center	Deer Trail School District 26J
Aurora EMS	Doctors Care
Aurora Health Access	Douglas County Coroner's Office
Aurora Mental Health Center	Douglas County Department of Human Services
Aurora Planning & Development Services	Douglas County Early Childhood Council
Aurora Public Schools	Douglas County Libraries
Bemis Library	Douglas County School District
Bennett School District	Douglas County Sheriff's Office
Brighton 27J School District	Englewood Fire Department
Brighton Police Department	Englewood Public School District
Byers 32J School District	Gateway Battered Women's Services
Castle Rock Adventist Hospital	Highlands Ranch Metro District
Castle Rock Fire and Rescue Department	House of Hope - The Family Tree
Centennial Medical Plaza	Hunger Free Colorado
Center for African-American Health	Jewish Family Services
Cherry Creek School District	Hyland Hills Park and Recreation District
Children's Hospital Colorado	Kaiser Permanente

Littleton Adventist Hospital
Littleton Public Schools
Mapleton Public Schools
Mental Health America of Colorado
Metro Community Provider Network
Mile High Council-Comitis
National Jewish Health
North Metro Community Services
Office of Behavioral Health,
Colorado Dept. of Human Services
North Suburban Medical Center
Parker Adventist Hospital
Pennock Center of Counseling
Parker Police Department
Plains Medical Center
Platte Valley EMS
Platte Valley Medical Center
Rocky Mountain Youth Clinics
Salud Family Health Center
Sheridan School District #2
Sky Ridge Medical Center
South Metro Fire
South Metro Health Alliance
South Suburban Parks and Recreation
Spalding Rehabilitation Hospital
St. Anthony North Hospital
Unit on Aging, Colorado Dept. of Human Services
Strasburg School District 31J
Swedish Medical Center
The Center
The Early Childhood Partnership of Adams County
The Medical Center of Aurora
The Senior Hub
The Women's Crisis & Family Outreach Center
Town of Bennett
Town of Parker
Tri-County Health Department Board of Health
University of Colorado Hospital
Vibra Hospital / Vista View Care Center
Volunteers of America Colorado Branch
YMCA of Metropolitan Denver

Appendix 2: Key Outputs and Outcomes

PHIP Goal	Key Outputs	Short- and Medium-Term Outcomes	Long-Term Outcomes (10+ years)
<p><u>Goal 1:</u> Reduce stigma associated with mental health issues by shifting social norms so that mental health issues are considered no different than other health issues.</p>	<p>Development of common messaging that promotes mental health as integral to total health by collaboration between local and state public health and mental health partners.</p> <p>Common messaging disseminated throughout TCHD and community partner agencies and incorporated into their programming.</p>	<p>Decreased self and public stigma.</p> <p>Positive change in attitude toward mental health and individuals with mental health issues.</p> <p>Individuals and families will talk openly about mental health issues.</p> <p>Individuals will seek care for mental health issues.</p> <p>Families will support family members seeking care for mental health issues.</p>	<p>Integrated mental health data collection firmly established and key indicators used to monitor progress in Colorado</p> <p>Decreased feelings of hopelessness</p> <p>Decreased post-partum depression</p> <p>Decreased thoughts of suicide</p> <p>Decreased attempted and completed suicides</p>
<p><u>Goal 2:</u> Increase prevention of and early intervention for mental health issues by recognizing and promoting the interrelatedness of mental health and physical health in existing community efforts.</p>	<p>TCHD and other community partners will implement strategies to integrate physical and mental health elements in their organizations and programs.</p> <p>Mental Health First Aid trainings provided to organizations throughout Adams, Arapahoe and Douglas Counties</p> <p>Mental Health partners will increasingly integrate physical health promotion opportunities for their clients.</p>	<p>Individuals and organizations will:</p> <p>Recognize that chronic diseases and mental health are inter-related</p> <p>Learn about the risk factors and warning signs for and the impact of mental health problems; how to assess a situation; select and implement appropriate interventions; help individual in crisis connect with professional care</p> <p>Individuals will:</p> <p>Increase health promoting behaviors, e.g., physical activity, tobacco cessation, healthy eating, getting enough sleep, etc.</p> <p>Engage in self-help activities to improve mental health.</p> <p>Seek out professional care for mental health problems when needed</p> <p>Organizations will increase appropriate referrals to mental health services</p>	<p>Optimal mental and physical health</p> <p>Improved quality of life</p>

Appendix 2: Key Outputs and Outcomes (continued)

PHIP Goal	Key Outputs	Short- and Medium-Term Outcomes	Long-Term Outcomes (10+ years)
<p><u>Goal 3:</u> Enhance access to mental health care services in the community by creating a system of interconnected access points.</p>	<p>An inventory of access points to mental health services in the region</p> <p>An inventory of healthcare models that integrate physical and mental health services</p>	<p>Development of collaborative pathways, partnerships and protocols between agencies in Adams, Arapahoe and Douglas Counties</p> <p>Increased number of healthcare providers who integrate mental health and physical health care services</p> <p>Increased implementation of strategies such as the U.S. Preventive Services Task Force (USPSTF) recommendation for depression screening in appropriate health care settings.</p> <p>Increased utilization of mental health services</p>	<p>Same as previous page:</p> <p>Integrated mental health data collection firmly established and key indicators used to monitor progress in Colorado</p> <p>Decreased feelings of hopelessness</p> <p>Decreased post-partum depression</p> <p>Decreased thoughts of suicide</p> <p>Decreased attempted and completed suicides</p> <p>Optimal mental and physical health</p>
<p><u>Goal 4:</u> Enhance existing population-level data collection efforts for mental health promotion and mental illness</p>	<p>Create a standard set of BRFSS questions that measure indicators related to mental health for Colorado</p> <p>An inventory of current data collection efforts in public health, mental health and health care organizations</p> <p>Core set of indicators related to mental health to be used in public health, mental health and health care surveillance efforts</p>	<p>Established plan for sustaining the annual implementation and analysis of the standard set of mental health BRFSS questions in Colorado</p> <p>Established plan for sustaining the regular collection, analysis and dissemination of the core set of mental health indicators</p>	<p>Improved quality of life</p>

