2019-2024 Public Health Improvement Plan

Mid-Term Update

Tri-County Health Department

Adams | Arapahoe | Douglas

Colorado

Released November 2021

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Letter from the Executive Director

Dear Residents, Partners, and Staff:

Since 2014, the mission of the Tri-County Health Department (TCHD) has been *to promote, protect and improve the lifelong health of individuals and communities in Adams, Arapahoe, and Douglas Counties through the effective use of data, evidence-based prevention strategies, leadership, advocacy, partnerships, and the promotion of health equity*. As part of the Colorado Public Health Improvement Act of 2008 and best practice recommendations from the US Centers for Disease Control and Prevention (CDC) Essential Public Health Services and the Public Health Accreditation Board (PHAB), we are providing an update on our 2019-2024 Public Health Improvement Plan (PHIP). The purpose of the PHIP is to organize and coordinate a systematic effort to address the top health issues identified in our 2018 Community Health Assessment and prioritized by our partners, our community members, and our staff. This report is to provide a mid-term update on our six-year Plan. This report allows us to assess our progress, to check in with the communities that we serve and with partners and stakeholders, and allows us to adjust and adapt our work for the remainder of the six-year plan period.

Our 2019-2024 PHIP includes three primary Priority Ares and one developmental Priority Area. These include: Access to Mental and Physical Health Care Services, Mental Health, Health and Food, and the developmental Priority Area, Health and Housing. TCHD is facing unprecedented organizational changes including the COVID-19 pandemic, but also governance changes with Douglas County withdrawing from TCHD in October 2021 and with Adams County announcing its decision to withdraw from TCHD in January 2023. TCHD will continue to provide high-quality public health services and to use this PHIP to guide our work on cross-cutting issues of social determinants of health (SDoH) prioritized in this plan.

This mid-term update demonstrates the tremendous amount of thoughtful work our staff, along with partners and community groups, have completed to improve the health of all communities that we serve, to provide services in an equitable manner, and to continue to promote work around social determinants of health to address root causes of ill health and health inequities. TCHD continues to strive to play an effective role as a Chief Health Strategist for our communities and to form and strengthen strategic partnerships to address our Priority Areas. Even with the unprecedented challenges of the COVID-19 pandemic and our evolving organizational structure, TCHD remains committed to continue working together with our partners and community members to assure the conditions in which everyone can be healthy.[1]

Sincerely,

John M. Douglas, Jr., MD

Executive Director

[1] Public Health 3.0: A Call to Action to Create a 21st Century Public Health Infrastructure. (2016) Office of the Assistant Secretary for Health, U.S. Department of Health and Human Services. Accessed October 26, 2021 at https://www.healthypeople.gov/sites/default/files/Public-Health-3.0-White-Paper.pdf

Executive Summary

We are excited to share the meaningful progress made on the 2019-2024 Tri-County Health Department Public Health Improvement Plan (PHIP) for Adams, Arapahoe, and Douglas Counties. The plan was informed by the TCHD 2018 Community Health Assessment (CHA), which highlighted twelve health issues that were identified by our partners, our community members, and TCHD staff. The subsequent planning process led to the prioritization of four distinct Priority Areas and the creation of the 2019-2024 PHIP. The Priority Areas are:

Priority Area 1: Access to Mental and Physical Health Care Services

Goal 1 Improve access to care through advocacy, policy development and implementation, and alignment of quality and/or performance measures

Goal 2 Improve access to care through health insurance enrollment support and health care system navigation

Goal 3 Decrease barriers to care

Priority Area 2: Mental Health

Goal 1 Improve mental and behavioral health through advocacy, policy development and implementation, and shared performance measures

Goal 2 Reduce poor health outcomes related to mental health

Priority Area 3: Health and Food

Goal 1 Increase access to safe, nutritious, affordable and culturally relevant food, especially in communities with limited resources and communities of color

Goal 2 Promote food security and healthy eating habits through messaging, education, advocacy, and policy development

Priority Area 4: Health and Housing (Developmental)

Goal 1 Improve quality of housing for TCHD population, especially for those most vulnerable in our communities.*

Goal 2 Improve access to attainable housing for TCHD population, especially for those most vulnerable in our communities.

Goal 3 Prevent displacement of TCHD populations, especially for those most vulnerable in our communities.

*The most vulnerable in our communities often include people of color, immigrants and refugees, and people with insufficient income.

The work accomplished as part of the 2019-2024 PHIP thus far has been the result of collective effort by staff from diverse TCHD divisions and programs, our partners, and engaged community-based organizations. This report summarizes significant accomplishments by Priority Area and is organized by goals and objectives within each Priority Area. This report also provides information regarding next steps and areas of future work for TCHD in these PHIP Priority Areas through 2022. Our PHIP continues to be a living document and our work plans evolve as new information and opportunities become available. This plan will continue to be used to encourage collaboration and alignment with partners to build healthier communities across Adams, Arapahoe, and Douglas Counties. Priority Area-specific work plans continue to evolve as new science, information, and opportunities become available that inform our work. We look forward to continue improving community health and having an increased focus on health equity in the year to come. Notably, Douglas County voted to withdraw from the TCHD jurisdictional health department in October 2021, and has acquired an independent contractor to develop a Douglas County-focused Community Health Assessment and Public Health Improvement Plan. TCHD will continue to provide services related to the 2019-2024 PHIP in Douglas County through an intergovernmental agreement.

Priority Area One: Access to Care

Summary

In a healthy community, all people across the life course, regardless of their income or other circumstances, can access high quality physical health, mental health, and substance use services. The first goal of the PHIP Access to Care priority area is to increase the proportion of persons who are insured, with a focus on increasing coverage for those eligible for Medicaid, Child Health Plan Plus (CHP+), or coverage through Connect for Health Colorado (the marketplace). Health insurance coverage remains an important social determinant of health (SDoH) that allows people access, opportunity, choice, and financial stability as it relates to their physical and mental health. The Affordable Care Act has greatly expanded eligibility for health coverage, and Colorado made significant strides in the number of individuals with who are covered by their employer or a public program such as Medicaid, Medicare, or Connect for Health Colorado. The second goal focuses on utilization of care and increasing the proportion of people accessing preventive care. Access to preventive health care prevents both disease and early death.

The information presented on coverage and access in the following section includes activities conducted through September 2021. From March 2020 through July 2021, most of TCHD's Access to Care team members were fully activated in the COVID-19 response and the team's focus shifted from its original goals and objectives in order to support the pandemic response. The Access to Care Team continues to reassess the landscape of health care coverage and health care access among Tri-County residents and is actively working on its 2022 work plan to address emerging and ongoing issues related to access to physical and mental health care.

Population Health Measures	2017	2018	2019	2020	2024 Target
Proportion of persons who are insured[1]					
Adams	94.2	N/A	90.9	N/A	**99.4**
Arapahoe	96.9	N/A	93.1	N/A	**103.8**
Douglas	98.6	N/A	96.8	N/A	**100.7**
Proportion of persons who are unable to obtain or delay in obtaining necessary medical care due to cost[1]					
Adams	12.5	N/A	16.9	N/A	**8.3**
Arapahoe	8.2	N/A	13.4	N/A	**5.8**
Douglas	4.1	N/A	9.8	N/A	**3.6**
Proportion of persons who are unable to obtain or delay in obtaining necessary dental care due to cost[1]					
Adams	15.8	N/A	25.5	N/A	**11.3**
Arapahoe	12.9	N/A	20.7	N/A	**9.4**
Douglas	7.5	N/A	13.5	N/A	**6.6**
Proportion of persons who are unable to obtain or delay in obtaining necessary prescriptions due to cost[1]					
Adams	11.3	N/A	14.3	N/A	**10.2**
Arapahoe	9.8	N/A	10.6	N/A	**8.1**
Douglas	4.4	N/A	7.3	N/A	**2.6**

Population Health Measures	2017	2018	2019	2020	2024 Target
Proportion of persons who had a visit for a check-up, physical examination or other preventive care in the past 12 months[1]					
Adams	57.9	N/A	72.6	N/A	**70.2**
Arapahoe	61.6	N/A	74.5	N/A	**75.5**
Douglas	72.1	N/A	81.0	N/A	**79.2**
Proportion of children who saw a doctor, nurse, or other provider for preventative medical care, such as physical exam or well-child checkup 1+ times in Past 12 Months[2]					
Adams	93.9	N/A	N/A	N/A	**97.0**
Arapahoe	91.5	N/A	N/A	N/A	**93.4**
Douglas	94.8	N/A	N/A	N/A	**99.0**
Proportion of adults with mental health disorders who receive treatment[3,§]					
Adams	16.8	N/A	10.6	N/A	**17.6**
Arapahoe	15.7	N/A	13.9	N/A	**16.0**
Douglas	14.0	N/A	13.0	N/A	**14.4**

[1]Colorado Health Access Survey, Colorado Health Institute (surveys conducted every two years, in 2017 and 2019)

[2]Colorado Child Health Survey (phased out in 2018)

[3]Behavior Risk Factor Surveillance System (BRFSS), Colorado Department of Public Health and Environment. 2020 data not yet available

§ Methodology changed in 2019

Goal 1: Increase the proportion of persons who are insured.

Objective 1: Provide consumer assistance to community members to increase the percentage of eligible Coloradans enrolled in Medicaid.

Key areas of activity conducted to increase enrollment into Medicaid, CHP+, and Connect for Health Colorado included: expanding availability of enrollment assistance through Presumptive Eligibility (PE) clinics, walk-in enrollment clinics, and sites where enrollment assistance services are co-located with other key services. The COVID-19 pandemic greatly impacted this area of work at the direct service level, and changes to this work are described below.

With the rise in unemployment as the COVID-19 pandemic hit, many community members lost their private insurance, and the number of those without insurance was expected to rise. In response to this need, Connect for Health Colorado opened a special enrollment period for health insurance from March 20 through April 3, 2020 and TCHD began a virtual co-location with Connect Aurora, a Connect for Health Colorado enrollment assistance partner. This co-location arrangement included a shared funding model between TCHD and Aurora Mental Health Center to support a health coverage guide (1.0 FTE). This position enabled more opportunities for TCHD community members to sign up for health insurance through the marketplace.

Many individuals are enrolling in Medicaid or through Connect for Health Colorado for the first time and have little knowledge of where to go for care or how to navigate their new health insurance. The Healthy Communities program at TCHD was responsible for providing navigation for Medicaid clients and others to enroll in health insurance and to connect clients to health care services. The program ended due to statewide budget cuts in May 2020. Services offered through the TCHD Healthy Communities program included, enrollment assistance with Medicaid, CHP+, and Connect for Health Colorado applications; troubleshooting enrollment issues with Medicaid

and CHP+; reporting changes in household information affecting enrollment; and completing paper or PEAK applications by phone or by video using Zoom.

Throughout the pandemic, TCHD maintained designation as a Certified Application Assistance Site (CAAS) with authority to provide Presumptive Eligibility enrollment assistance to community members through the Colorado Department of Healthcare Policy and Financing. This designation allowed TCHD to provide immediate temporary coverage to pregnant women and children with a focus on serving immigrant, refugee, and asylee families who often struggle with accessing coverage through the online PEAK portal. Anticipated enrollment assistance to Afghan refugees is prioritized work in the 2022 work plan.

Due to the rise in unemployment and the 'freeze' on dis-enrolling individuals from Medicaid/CHP+ during the pandemic, September 2021 figures from the Colorado Department of Health Care Policy and Financing estimate 488,000 Coloradans will need to take action to be renewed under continuous coverage requirements at the end of the Public Health Emergency or lose coverage. TCHD plans to continue providing enrollment services so individuals can maintain their coverage when the federal public health emergency ends (anticipated date January 2022).[1]

Performance Measures	2018	2019	2020	2021 Q1-Q2
Number of clients enrolled into Medicaid or CHP+	1,288	1,204	645	508

Key Accomplishments

- Expanded co-location of enrollment assistance to include the Aurora clinic location within the Every Child Pediatrics Network for a total of 2 co-location sites.
- Transitioned from the state-funded Healthy Communities program to the TCHD-funded Health Enrollment Team, retaining TCHD's ability to focus on new enrollments and maintaining coverage for residents of Adams, Arapahoe, and Douglas Counties.
- Added Connect for Health enrollment assistance in a virtual co-location with Connect Aurora.
- Improved how clients access services during the COVID-19 pandemic, including implementing a new workflow to receive incoming calls directly instead of routing through the TCHD Nursing Division call center, allowing immediate access to staff by incoming callers, and establishing a process for virtual appointments and electronic signatures.

[1] Colorado Public Health Emergency Unwind and FMAP Continuation. (2021) Colorado Department of Health Care Policy & Financing. Accessed November 2, 2021 at https://hcpf.colorado.gov/sites/hcpf/files/Colorado%20PHE%20Unwind%20and%20FMAP%20Continuation%209-21-2021.pdf

Goal 1: Increase the proportion of persons who are insured

Objective 2: Engage with consumers and partner organizations to understand and address enrollment barriers in Medicaid and CHP+

The state and federal landscape related to health insurance is ever-evolving, even more so during presidential and gubernatorial administration changes. In order to deliver quality enrollment services, TCHD engages with partners from all sectors to gather information about barriers to health insurance enrollment and provides feedback to those with decision-making authority. TCHD engagement includes, but is not limited to:

- Attending in-person outreach events to increase awareness of Medicaid, CHP+, and Connect for Health.
- Engaging in systems-level project work to identify and address administrative barriers in access.
- Engaging in policy and advocacy efforts to influence local, state, and national policy directed at medical assistance programs.

Significant staff capacity and associated work was driven by data emerging in 2019, which revealed troubling trends, especially for many members of the TCHD community:

- Enrollment data from 2019 showed a concerning decline in Medicaid coverage (Hispanic/Latinx children who were EBNE in Medicaid in 2019 went from 56.3% in 2018 to 50.7% in 2019[1]), with the rate of decline more than threefold the national average and most notable in children who are Hispanic.
- Individuals eligible but not enrolled in Medicaid, CHP+, or advance premium tax credits (APTC) increased for the first time since 2015, from 229,238 (14.4%) in 2017 to 239,143 (15.4%) in 2018.[1]
- Children with parents who are noncitizens make up over one-third (35%) of the EBNE population at approximately 11,900 Coloradans.[1]

To combat these trends:

- TCHD enrollment staff co-located with 2 primary care clinics to serve as a trusted and knowledgeable partner to help uninsured families enroll in health insurance and to answer their questions. While in-person, co-location was paused during the pandemic, TCHD staff remained available to assist clients and providers by phone.
- TCHD designed a project to assess the "churn," or turnover rate, of families who enrolled in Medicaid at TCHD, and/or visited TCHD for clinical services, and had Medicaid. These were previously-insured families that were now forgoing health insurance due to concerns about the public charge rule. Project data was shared with the Colorado Health Institute to inform a project developed in partnership with safety-net clinics to reinforce the observation that previously insured families were now forgoing enrollment insurance due to concerns about the "Public Charge Rule."

TCHD discontinued outreach to community members, partner organizations, and health care provider offices through individual calls and outreach events when the grant-funded Healthy Communities program ended in June 2020. However, significant advocacy and policy wins were accomplished based on lessons learned from community members and enrollment assistance programs. TCHD's participation in policy and advocacy groups was an important factor in advocating for these policy changes, such as approval by the Colorado Department of Health Care Policy and Financing (HCPF) for verbal acknowledgements to be used in lieu of a physical signature on Medicaid and CHP+ applications in January 2021, which lessened administrative barriers to enrollment caused by the COVID-19 pandemic.

[1] Eligible but Not Enrolled 2019: Continuing an Upward Trend. (2021) Colorado Health Institute. Accessed November 2, 2021 at https://www.coloradohealthinstitute.org/research/eligible-not-enrolled-2019

Priority Area One: Access to Care

Performance Measures	07/18 - 06/19	07/19 - 06/20	07/20 - 06/21	07/21 - 10/21
Advise on improved Medicaid policy by serving in advisory roles through engagement with the Colorado Department of Health Care Policy and Financing (state and federal) and Colorado Access (local); # of advisory meetings attended	11	14	15	3
Advocate for policy and system improvements to enrollment through engagement in Covering Kids and Families; # of advocacy meetings attended	12	48	48	9

Key Accomplishments

- TCHD co-facilitated the People-Centered Transportation Coalition which helped pass HB1321 to support efficient administration of Medicaid's non-emergency medical transportation (NEMT) benefit through education and support of local legislators in the metro area. In addition, the coalition proposed recommendations to the Colorado Department of Health Care Policy and Financing (HCPF) informing the Request for Information (RFI) that would eventually lead to the selection of a new Medicaid transportation vendor.
- TCHD commented on HCPF's 2019 Access Monitoring Review Plan, drawing particular attention to access issues in two priority populations: women of color with high risk pregnancies accessing care and children with disabilities as they transition to adulthood. HCPF has robust stakeholder engagement efforts currently in place to address barriers to access for these populations.
- Completed a retrospective review of the "churn" of families who enrolled in Medicaid at TCHD; findings shared with the Colorado Health Institute for consideration of inclusion in a large statewide report on the churn in Medicaid.[1]
- Obtained funding for community engagement project on perceptions of health care coverage.
- As early as March 2020, TCHD submitted multiple requests to HCPF to authorize application assistance sites to accept a verbal signature in lieu of a physical signature for Medicaid and CHP+ applications; HCPF submitted the request to the US Centers for Medicare and Medicaid Services (CMS) and a waiver was granted in January 2021, which remains in effect through the end of the federal public health emergency for the COVID-19 pandemic.
- Feedback submitted to Covering Kids & Families on HCPF's Emergency Medicaid coverage, which resulted in new policies for providers to bill HCPF that make it easier for clients to get covered and a new public-facing website about Emergency Medicaid so people know this coverage is available to them.
- Feedback submitted to Covering Kids & Families on PEAK modernization project, which will inform the development of a new interface that is more customer-friendly, to be introduced in 2021.
- Feedback submitted to Covering Kids & Families to make changes to renewal packets that will be sent to Medicaid members at the end of the federal public health emergency.
- In the first quarter of 2021, TCHD has engaged in 16 specific policy and/or advocacy opportunities. Moving forward, these activities will be tracked and reported in TCHD's Partnership Tracking Tool and are a major component of the 2022 work plan.

[1] Covering Colorado's Kids Blog. (February 11, 2020) Colorado Health Institute. Accessed on November 1, 2021 at https://www.coloradohealthinstitute.org/blog/covering-colorados-kids

Goal 2: Increase the proportion of children who saw a doctor, nurse, or other health provider for preventative medical care, such as physical exam or well-child checkup 1+ times in past 12 months; increase the proportion of adults who had a visit for a check-up, physical examination or other preventive care in the past 12 months.

Objective 1: Reduce barriers to accessing physical and mental health care in four priority populations.

The four priority populations include: children and youth with special health care needs (CYSHCN), children and pregnant women enrolled in Medicaid, the perinatal population, and individuals seeking treatment for substance use. The activities carried out across the four priority populations were aligned and included: mapping and/or assessing the system to identify and understand barriers and/or strengths, engaging with community members and partner organizations, and collaborative prioritization of system level strategies to address barriers in accessing physical and mental health services. A short summary of each priority population is included below.

Priority Population One: Children and Youth with Special Health Care Needs

TCHD used a strengths-based assessment process that incorporated an asset-based community development approach, including three levels of data collection. TCHD identified three key areas of strength: support and connectedness, resiliency, and advocacy. Through a collaborative process, TCHD worked with partners knowledgeable about the CYSHCN community across the metro area to increase engagement with families. A strategy focused on strengthening connectedness and support through parent-to-parent support and family support groups was prioritized for addressing barriers in access.

Priority Population Two: Children and Pregnant Women Enrolled in Medicaid

In partnership with Colorado Access, a mapping project focusing on the Medicaid member experience was in process when statewide program cuts, due to COVID-19, resulted in a sunset of the Healthy Communities Program; the project was terminated early in June 2020. TCHD continues to work with Colorado Access in multiple areas of aligned work and on barriers to access for this priority population, such as Presumptive Eligibility and other work described above.

Priority Population Three: Perinatal Population

TCHD actively participates in the Metro-Denver Perinatal Action Network (PAN), a network of metro-Denver partners with a passion for improving perinatal mental health; the group is convened by Maternal and Child Health Programs at Denver Public Health and TCHD. The PAN conducted a systems mapping project that resulted in completion of the Perinatal Continuum of Care framework, which focused on mental health during the perinatal period. The collaborative process included engagement with TCHD, community members, partner organizations, health care providers, community systems, and PAN members are now working with partners to disseminate and implement the framework as a means to improve perinatal mental health supports.

Priority Population Four: Individuals in Need of Substance Use and Behavioral Health Treatment Services

TCHD participated in a local and statewide collaboration, which conducted a mapping process to identify treatment and recovery services for substance use and behavioral health treatment services. This collaborative process resulted in the creation, by TCHD's CHP and PIM Divisions, of a community-facing recovery map with information on recovery services and sober-supported activities in the Denver Metro area as a prioritized strategy for improving access.

Key Accomplishments
- The Metro-Denver Perinatal Action Network completed the Perinatal Continuum of Care framework. TCHD participated in the development of this framework. - The Association of Maternal Child Health Policy (AMCHP) accepted the Perinatal Continuum of Care framework as a cutting-edge practice, including featuring the program online in the AMCHP Innovation Hub. The Continuum of Care framework was presented at the National Association of City and County Health Officials (NACCHO) and AMCHP conferences in 2020. - Completed the CYSHCN Strengths Assessment. - Map was created for the community including recovery services and sober supported activities in the Denver metro area. - Promoted virtual parent support groups for the CYSHCN community in response to the COVID-19 pandemic. - The Perinatal Continuum of Care tool continues to be disseminated by PAN leadership and partners, including TCHD. A toolkit for the Continuum of Care has been developed and technical assistance will be provided to support prioritization and implementation of provider, organizational, and community system-level strategies.

Goal 2: Increase the proportion of children who saw a doctor, nurse, or other health provider for preventative medical care, such as physical exam or well-child checkup 1+ times in past 12 months; increase the proportion of adults who had a visit for a check-up, physical examination or other preventive care in the past 12 months.

Objective 2: Increase provider uptake of screening and referral to three prioritized community programs or services.

Provider-focused efforts were conducted to increase provider screenings and referrals to the following community programs:

- Increased depression screenings and referrals to treatment of parents in pediatric settings through the dissemination of a provider toolkit.
- Increased screenings of first-time pregnant women for referral to Nurse Family Partnership (NFP).
- Increased screenings of individuals seeking opioids for alternative options to treating pain through referral to a community pharmacist.
- Provided provider education to screen and administer the Human Papillomavirus Virus (HPV) vaccine.

TCHD's provider-focused work was significantly impacted by the COVID-19 pandemic in a number of ways:

- Depression screenings and referrals: dissemination of provider toolkits limited to virtual outreach via emails and newsletters.
- Screenings and referrals to Nurse Family Partnership: an outreach strategy and materials were developed and shared with the statewide office, Invest in Kids, but continued engagement with Invest in Kids specific to implementation did not occur.
- Screenings and referrals to a community pharmacist: project completed prior to the COVID-19 pandemic.
- Provider education to screen and administer the Human Papillomavirus Virus (HPV) vaccine: discontinued activities.

In addition to provider-focused efforts, TCHD provided support to hospitals to demonstrate meaningful community engagement as part of the State of Colorado's Hospital Transformation Program (HTP), through the convergence of three local health alliances, including Adams County Health Alliance, Aurora Health Alliance and Douglas County Health Alliance. Time was allocated during health alliance meetings for hospitals to engage with community partners. Health alliances disseminated information on behalf of hospital partners through robust alliance list-

serves. This work continued during the COVID-19 pandemic and throughout the Community and Health Neighborhood Engagement (CHNE) process of the HTP.

Performance Measures	07/18 - 06/19	07/19 - 06/20	07/20 - 06/21	07/21 - 10/21
# Health alliance meetings TCHD convened: Douglas County	12	12	12	4
# Health alliance meetings TCHD convened: Adams County	12	12	12	4

Key Accomplishments

- TCHD's Regional Health Connector Team launched the Community Pharmacist Pilot Project with referral workflows in place to provide pharmacy consultation to providers at 3 primary care practices and provide opioid use medication therapy management (MTM) to referred patients. The Tri County Overdose Prevention Partnership served in an advisory role and The University of Colorado School of Pharmacy was contracted for pharmacy consultation and MTM services.
- TCHD's Regional Health Connector Team, in partnership with TCHD's PIM team, conducted a comprehensive evaluation on the Community Pharmacist Pilot Project, with findings and implications for practice shared with HCPF, Colorado Access, Colorado Hospital Association, SIGNAL Behavioral Health, Skaggs School of Pharmacy, Centura and Colorado Consortium for Prescription Drug Abuse Prevention. The project was also selected for a 2020 NACCHO presentation session.
- TCHD's Access to Care team developed and presented an innovative NFP provider engagement strategy, including a needs assessment and provider toolkit, to Invest in Kids, for statewide consideration.
- TCHD's Access to Care team developed a novel proposal and successfully engaged Colorado Access and STRIDE to work across the health care system to successfully increase adolescent well visits, including HPV vaccination. While the project was not completed due to COVID and the rapid decline of in person well visits, the alignment and planning across health care sectors positions partners for similar work in the future.
- TCHD's Maternal Child Health Team disseminated Pregnancy-Related Depression (PRD) and marijuana materials for pregnant and breastfeeding women to 8 organizations.
- In response to the COVID-19 pandemic, significant staff capacity was redirected to support providers. TCHD's Access to Care staff provided education and technical assistance to providers related to isolation and quarantine, testing, vaccines, as well as access to COVID-19 funding and treatment.

Goal 2: Increase the proportion of children who saw a doctor, nurse, or other health provider for preventative medical care, such as physical exam or well-child checkup 1+ times in past 12 months; increase the proportion of adults who had a visit for a check-up, physical examination or other preventive care in the past 12 months.

Objective 3: Implement and evaluate 3-6 co-location initiatives that increase access to physical and mental health care and substance use services in priority populations.

TCHD's co-location efforts focused on increasing access to physical and mental health care and substance use services in priority populations. The general activities carried out across the various co-location efforts were aligned and included: formalizing co-location relationships through contractual agreements, developing workflows, and target setting with co-locating partners. Co-location initiatives included:

- Co-location of behavioral health services in TCHD's WIC clinics or 'Warm Connections'.
- Co-location of a community pharmacist in primary care clinics to support patients with alternatives to opioid treatment options for managing pain.
- Co-location of medical services in community settings where community members are accessing non-medical services, including a medical clinic co-located in a church food pantry in Douglas County and health screenings in Adams County at two Anythink Library Healthy Farmers Markets (Huron and Wright Farms Library locations).
- Co-location of TCHD health enrollment assistance staff in primary care clinics.

- Co-location of Connect for Health enrollment staff, Medicaid/CHP enrollment staff and Human Services enrollment staff.
- Planning efforts for a community hub model in Commerce City inclusive of multiple services and supports for families with children in early childhood.

The co-location work outlined above was significantly impacted by the COVID-19 pandemic. TCHD staff activation to support the pandemic response, combined with community access to public buildings and spaces, resulted in the following impacts:

- Co-location of behavioral health services in TCHD's WIC clinics: services were delivered via telehealth during office closure times.
- Co-location of medical services in community settings where community members are accessing non-medical services: pause in operations without a re-opening of the Douglas County location to-date and the re-openings of both Anythink Library Huron and Wright Farms' Healthy Farmer's Market locations in July 2021.
- Co-location of TCHD health enrollment assistance staff in primary care clinics: on-site services discontinued, and a referral workflow was established to support patients with accessing virtual enrollment assistant through TCHD.
- Co-location of Connect for Health enrollment staff, Medicaid/CHP+ enrollment staff and Human Services enrollment staff: transitioned to a virtual co-location team.

Key Accomplishments

- Warm Connections launched and continues in two TCHD WIC clinic locations.
- TCHD's Access to Care team worked with community based organizations and a local physician to launch a monthly Youth Health Clinic in Castle Rock, and a free and volunteer-led medical clinic co-located with the St. Francis of Assisi Church's food pantry.
- The Community Pharmacist Pilot Project launched with co-location agreements in place to provide pharmacy consultation to providers at 3 primary care practices and opioid use medication therapy management (MTM) to referred patients.
- TCHD joined forces with the City of Thornton, community members, Anythink Libraries, the American Heart Association (AHA) and Lulu's Farm to stand up the Healthy Farmer's Market at the Anythink Huron Street Library. The Healthy Farmer's Market included co-located health services.
- The Healthy Farmer's Market program, including co-located health services, was replicated in its second year by expanding to a second location.
- TCHD created this Commerce City and Resource Gaps and Health Needs Story Map to assist with data story telling as part of the planning efforts for a community hub model in Commerce City.
- The Healthy Farmer's Market received NACCHO's Model Practice Award in 2021.
- TCHD's Regional Health Connector participates in the Commerce City Alignment group for continued support of a community hub model at South Platte Crossing, in Commerce City. TCHD, along with Adams County, City of Commerce City, Early Childhood Partnership of Adams County (ECPAC), Kids First Healthcare, Kids in Need of Dentistry (KIND), Colorado Access, ACCESS Housing, Urban Land Conservancy, Maria Droste Counseling, Front Range Clinic, Colorado Orthodontic Foundation, Creative Treatment Options and other emerging partners and tenants of the building have generated letters of support for grant funding for two partner organizations and two additional letters of support directed at securing the government building space. To date, ECPAC has already moved services into the building and is pursuing grant funding to support proposal to modernize the shared spaces and make the building more culturally appropriate and welcoming for families. Kids First and KIND prepare for their move-in in Spring 2022. TCHD's Commerce City WIC office will be moving into the space in Spring 2022 as well. The goal of the Commerce City Community Campus (C4) is to C4 is centralize health and social services, bringing services together, and to empower families.

Goal 2: Increase the proportion of children who saw a doctor, nurse, or other health provider for preventative medical care, such as physical exam or well-child checkup 1+ times in past 12 months; increase the proportion of adults who had a visit for a check-up, physical examination or other preventive care in the past 12 months.

Objective 4: Expand provider screenings and referrals for social determinants of health (SDOH).

TCHD supports the integration of social care into health care delivery through fundamental activities such as screening and referral for SDoH. TCHD efforts to support the integration of social care into the delivery of health care include:

- Support the development of interoperable Social Health Information Exchange (S-HIE) ecosystem through active workgroup participation across multiple initiatives including the Colorado Office of eHealth Innovation, Metro Denver Partnership for Health (MDPH) S-HIE Steering Committee, statewide SDoH learning collaborative, and robust information sharing with partners through convening of local health alliances.
- Implement an SDoH screening tool and a referral process in 1-2 TCHD programs.
- Build capacity to standardize screening and referral for SDoH in TCHD's new electronic health record system.
- Engage with primary care practices and health system partners to identify gaps in and/or barriers to care, and link practices and partners to social care resources in their communities through one-to-one practice support and through convening of local health alliances, including workgroups.

The work outlined above is robust and continues, with a few exceptions:

- TCHD was awarded grant funding to implement an SDoH screening and referral program across two TCHD divisions and four programs. Initially, both the Nutrition and Nursing Divisions partnered to implement in WIC, Nurse Support Program, HCP-A Program for Children and Youth with Special Healthcare Needs, and Healthy Communities. As a result of the COVID-19 pandemic, implementation did not occur in the Nursing programs. Successful implementation in WIC is informing future agency activities for SDoH screening and referral.
- The activities planned for incorporation of SDoH screening and referral into TCHD's new electronic health record system has been adjusted to align with the revised agency timeline for system implementation, and is work that is expected to take place in the coming months/year.

Priority Area One: Access to Care

Performance Measures	07/18 - 06/19	07/19 - 06/20	07/20 - 06/21	07/21 - 10/21
Practice engagement: # Primary care practices	N/A	16	28	30
# Health alliance meetings TCHD convened: Douglas County	12	12	12	4
# Health alliance meetings TCHD convened: Adams County	12	12	12	4
# Aurora Health Alliance, SDoH workgroup meetings TCHD convened	2	5	3	1
# Aurora Health Alliance, Kids Access meetings convened	N/A	8	8	2

Key Accomplishments

- Aurora Health Alliance launched a new workgroup focused on the SDoH. TCHD assumed a leadership role as convener of the workgroup.
- TCHD received grant funding from the University of Colorado School of Medicine for the Regional Health Connector (RHC) Program to support successful interventions for social determinants of health through partnerships between primary care and community health organizations.
- TCHD assumed the convening role for Aurora Health Alliance Kids Workgroup, including social care and supports for children.
- TCHD received continuation funding for the RHC work with primary care practices.

Priority Area Two: Mental Health

Summary

In a healthy community, positive mental health and social connections allow people to have the mental and physical energy, vitality, and resilience to live joyfully and cope with the stresses of life, work productively, and make meaningful community contributions. Mental health includes emotional, psychological, and social well-being, and is important at every stage of life.

Goal 1 of the Mental Health PHIP aims to optimize mental health and promote emotional wellbeing by addressing the determinants of mental health through the creation of environments and relationships that support emotional wellbeing and build individual and community resilience when faced with adverse events. Goal 2 aims to prevent and reduce negative health outcomes associated with mental health and substance use disorders by increasing protective factors and mitigating risk factors.

The information presented in this report includes some (but not all) of the numerous mental health activities conducted by TCHD through September 2021. It is important to note that many of the staff carrying out the work outlined in this section were activated in the COVID-19 response, beginning in March 2020 through July 2021. Despite significant redirection of staff to pandemic response, work on the Mental Health PHIP remained a primary focus at all times. Progress was made across all PHIP objectives and new, customized strategies were deployed as part of the pandemic response. The development of a dedicated mental health promotion staff position and mental health and suicide prevention frameworks - informed by partner engagement and a regional assessment of assets and gaps - will provide a solid, shared foundation for ongoing and future efforts.

Population Health Measures	2017	2018	2019	2020	2024 Target
Proportion of adults who report having good or better mental health (Having 0 to 13 Poor Mental Health Days in the Past Month) [1]					
Adams	87.7	86.1	64.1	N/A	**91.6**
Arapahoe	86.4	86.0	71.5	N/A	**93.6**
Douglas	89.9	90.1	78.3	N/A	**94.3**
Proportion of adolescents who report having an adult in their lives with whom they can talk about serious problem [2]					
Adams	71.9	N/A	70.0	N/A	**77.2**
Arapahoe	73.5	N/A	70.8	N/A	**79.8**
Douglas	76.3	N/A	76.2	N/A	**88.0**
Proportion of adolescents who report participating in extracurricular and/or out-of-school activities [2]					
Adams	57.9	N/A	52.3	N/A	**62.5**
Arapahoe	66.9	N/A	64.2	N/A	**70.7**
Douglas	71.3	N/A	66.6	N/A	**72.7**
Percentage of students who actually attempted suicide one or more times during the past 12 months [2]					
Adams	10.4	N/A	8	N/A	**7.2**
Arapahoe	7.9	N/A	8.1	N/A	**5.1**
Douglas	5.5	N/A	5.3	N/A	**5.2**

Population Health Measures	2017	2018	2019	2020	2024 Target
Suicide death rate (adults, 19+) per 100,000[3]					
Adams	27.0	25.3	25.1	26.9	**15.3**
Arapahoe	21.6	21.1	20.7	21.7	**20.2**
Douglas	17.9	20.7	18.5	12.4	**15.4**
Drug poisoning death rate per 100,000[3]					
Adams	22.7	20.6	17.3	24.1	**15.3**
Arapahoe	14.2	17.0	16.1	21.3	**12.9**
Douglas	8.3	7.7	9.2	13.5	**5.2**

[1]Behavior Risk Factor Surveillance System (BRFSS), Colorado Department of Public Health and Environment. 2020 data not yet available.
[2]Healthy Kids Colorado Survey, Colorado Department of Public Health and Environment (surveys conducted every two years, in 2017 and 2019)
[3]Vital Statistics, Colorado Department of Public Health and Environment

Goals 1 & 2: Mental Health and Suicide Prevention Frameworks (Cross-Cutting)

Cross-Cutting Objective: By 2022, a broad coalition of TCHD partners will be engaged in a collective impact approach to implement shared, evidence-based frameworks outlining actionable recommendations for improving mental health and preventing suicide.

TCHD partnered with a public health research and consulting firm to conduct an assets and gaps assessment, and to collaboratively develop a set of structural frameworks with actionable recommendations for improving mental health and preventing suicide in Adams and Arapahoe counties. A similar assessment of mental health in Douglas County was conducted in 2018 to inform the development of a blueprint for the Douglas County Mental Health Initiative (DCMHI). As part of this work, TCHD and our partners sought to define the optimal public health role in mental health promotion and suicide prevention across the life course. The mental health and suicide prevention frameworks are important components to guiding meaningful public health improvements related to mental health and suicide.

The frameworks serve as a clarifying catalyst for implementation of shared strategies and provide effective language to convey the unique role public health plays in improving mental health and reducing suicide. The mental health framework describes components of the mental health continuum from promoting positive mental health, preventing the onset or progression of mental and substance use disorders or poor mental health, to treatment interventions and recovery from disorders or poor mental health and reclamation of good mental health.

Within the suicide prevention framework, the continuum remains the same regarding mental health and wellness promotion and clinical and support services. In place of recovery and reclamation found in the mental health framework, the suicide prevention framework refers to postvention and recovery. During postvention efforts, an organized response is conducted to facilitate healing and mitigate subsequent negative effects of exposure.

Because the mental health and suicide prevention frameworks address mental health and suicide prevention across the continuum, the development and implementation of the frameworks apply to both Goals 1 and 2 of the Mental Health PHIP work plan. The frameworks also apply to Goal 2 of the Access to Physical and Behavioral Health Care PHIP. Going forward, the frameworks will be utilized to revise and further prioritize PHIP objectives and activities across the continuum.

Key Accomplishments
- TCHD and its contractor engaged community partners in the development of the Mental Health and Suicide Prevention Frameworks through targeted key informant interviews (with 35 people interviewed), community webinars (with more than 60 participants), and a series of 3 partner surveys with 91 responses completed. - The TCHD Mental Health and Suicide Prevention Frameworks were finalized and launched in 2020, along with a comprehensive report. - 34 TCHD staff were trained to ensure awareness of assessment findings, frameworks, pandemic implications, and current burden data. - Implementation strategies were shared at four community engagement town halls with 77 registrants, and through other community partner engagement channels, including online and community presentations. - TCHD actively participated in supporting and enhancing the Douglas County mental health system, including serving as steering committee and work group participants of the Douglas County Mental Health Initiative. Opportunities were routinely sought and leveraged for alignment and shared learning.

Goal 1: Improve mental and behavioral health through advocacy, policy development and implementation, and shared performance measures

The Objectives under Goal 1 are intended to optimize mental health and promote emotional wellbeing by addressing the determinants of mental health through the creation of environments and relationships that support emotional wellbeing and build individual and community resilience when faced with adverse events. The determinants of poor mental health include discrimination and social exclusion, poor education, unemployment or underemployment, lack of job security, poverty, food insecurity, lack of quality or affordable housing, lack of access to healthcare, and adverse childhood experiences.[1] As many mental health disorders are biologically based, addressing determinants of mental health can help those with these conditions to experience positive mental health. Policy and systems change strategies to address determinants of mental health are driven by the concept of health in all policies to ensure sustainability of efforts. Additionally, communications and training strategies are designed to increase knowledge about mental health, promote mental wellness behaviors, reduce stigma, and increase help-seeking.

Goal 1: Improve mental and behavioral health through advocacy, policy development and implementation, and shared performance measures

Objective 1: By 2020, strengths and gaps in current mental health promotion resources and initiatives will be confirmed and/or identified through the completion, analysis, and dissemination of an environmental asset scan.

TCHD sought to assess and describe the behavioral health assets/activities and gaps in Adams and Arapahoe Counties, as well as community assets related to community-based risk and protective factors for youth mental health and substance use in Adams County and Aurora. These assessments, together with an assessment previously completed in Douglas County for the Douglas County Mental Health Initiative (DCMHI) and findings from a statewide needs assessment conducted for the Colorado Department of Human Services (CDHS) Office of Behavioral Health (OBH), were used to inform the development of a collaborative, data-driven suicide prevention framework and a broader mental health framework within which the suicide prevention framework is embedded.

[1] Social Determinants of Mental Health. (2014) World Health Organization. Accessed November 2, 2021 at https://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf

Performance Measures	07/18 - 06/19	07/19 - 06/20	07/20 - 06/21	07/21 - 10/21
# Community partners engaged in assessment	N/A	35	60	N/A

Key Accomplishments

- TCHD conducted an environmental assessment in 2020 to describe the behavioral health assets/activities and gaps in Adams and Arapahoe County.
- TCHD assessed community assets related to risk and protective factors for youth mental health and substance use in Adams County and Aurora.
- Also see key related accomplishments under Goal 2, Objective 1 regarding ongoing
- Training for 34 TCHD staff was provided to ensure broad awareness and leveraging of the most recent information associated with TCHD-area assets and gaps, surveillance data, pandemic implications, recommended strategies, and shared frameworks for a coordinated, jurisdiction-wide response.

Goal 1: Improve mental and behavioral health through advocacy, policy development and implementation, and shared performance measures

Objective 2: By 2020, develop, disseminate, and evaluate appropriate and consistent framing and language for mental health promotion in areas such as stigma reduction, adverse childhood experiences (ACEs), risk and protective factors, assets, and trauma-informed care.

TCHD has a significant role in reducing stigma and increasing the awareness that physical health and mental health are not separate. TCHD educates the public about mental health and substance use conditions, the effectiveness of treatment, and the hope of recovery. TCHD seeks to incorporate mental health into chronic disease management and prevention, and TCHD uses evidence-based communication strategies to raise awareness, promote help-seeking behaviors, and reduce stigma.

It is important to note that the unprecedented impact of the COVID-19 pandemic on public health and the behavioral health (mental health and substance use) system, as well as on health disparities, is unparalleled. It became clear at the onset of the pandemic that the impact on the mental health of citizens in the Tri-County area, including our staff, would be significant. Additionally, this work took place amidst nationwide protests in the wake of current and historical acts of violence perpetrated against Black Americans and long-standing systemic racism. Many of the communication strategies under this Objective were initiated or adapted to be responsive to current events. Efforts were fast-tracked to promote and increase mental health support for public health staff and to build needed stigma reduction and resource navigation tools, such as Parents Thrive Colorado, for the public. TCHD's established regional and state partnerships enabled rapid tailoring to incorporate pandemic-relevant messaging on social connections and coping with stress and anxiety into the Tobacco-Free 303, Let's Talk Colorado, Pregnancy-Related Depression and Below the Surface campaigns.

Priority Area Two: Mental Health

Key Accomplishments

- From February 2019 to June 2020 TCHD estimates 6,045,827 media impressions were garnered through promotion of the Let's Talk Colorado campaign through paid and earned media including pandemic-customized releases, print, online, and TV.
- From July 2020 to June 2021 TCHD estimates 4,713,568 impressions were generated through regional promotion of the Let's Talk Colorado Campaign via paid and earned media.
- TCHD's Tobacco-Free 303 Campaign launched a mass media campaign focused on alternative stress coping mechanisms for young people. TCHD engaged young people in Adams and Douglas Counties to create and film a series of videos using the tagline "Vape's No Escape."
- The Douglas County Healthy Youth Coalition leveraged grant funds obtained by TCHD to increase local saturation of the statewide Speak Now campaign, encouraging parents to engage in conversations with kids about substances.
- Messaging and dissemination plans were redesigned for the Tobacco-Free 303, Let's Talk Colorado and Pregnancy-Related Depression campaigns, including pandemic-relevant messaging on social connections and coping with stress and anxiety.
- Mental Health Month was promoted for TCHD staff, amplifying Mental Health America messages, including provision of online classes on Food and Mood, Taking Care of YourSELF, Emotional Well-Being, and Finding More Margin in Your Day; facilitated stretching breaks offered weekly by a local yoga instructor; and executive leadership, agency-wide emails, and break room fliers widely promoting the mental health assessments, community mental health resources, and the Employee Assistance Program (EAP).
- Training for staff was provided to address and support behavioral health in pandemic response activities:
    - TCHD engaged EAP to host three sessions with all COVID-19 Incident Management Structure and Response staff. 38 sessions were conducted with a Critical Incident Therapist to normalize and integrate behavioral health for staff working on pandemic response and 651 individuals participated, including TCHD staff, contracted staff, and volunteers.
    - Training and support sessions were conducted on topics including stress management, resources and support, navigating change, resiliency, compassion fatigue, establishing professional boundaries, and suicide assessment and prevention for COVID-19 Case Investigators.
    - TCHD partnered with the Colorado Spirit Program to provide trainings to staff and contracted workers, including six sessions of Psychological First Aid and four sessions on de-escalation and self-preservation, burnout, and transition.
- Integrated behavioral health and wellness activities and supports for staff were promoted. For example:
    - Six, 90-minutes evidenced-based mindfulness stress reduction sessions were provided remotely in April and May of 2020.
    - Two, 8-hour sessions of Stress Management and Relaxation Techniques in Education (SMART) courses for home visitation nurses within the nursing division were hosted. 24 nurses participated.
    - 20-minute, facilitated mindfulness sessions through Passage Works Institute were offered weekly with over 60 staff on average in attendance per session. From February 2021 to May 2021 on Tuesday/Thursdays, 15-minute virtual mindfulness sessions were facilitated using "Calm App" meditations with over 70 sessions and over 880 staff attending. TCHD staff continue to have free access to the Calm App through Kaiser Permanente.
- Parents Thrive Colorado, a mental health resource navigation and stigma reduction tool for pregnant and postpartum parents, was launched January 2021, with over 9,000 unique website views between February and September 2021.
- Promotion of the Below the Surface campaign was supported through a paid media buy utilizing social and digital media channels. Between July and September 2021, the campaign generated 3,186,784 impressions, 1,105,220 video completions and 3,156 unique website views.

Goal 1: Improve mental and behavioral health through advocacy, policy development and implementation, and shared performance measures

Objective 3: By 2024, 20 schools will implement restorative justice policies and practices (such as policies that offer alternatives to school expulsions).

The use of exclusionary discipline measures such as out-of-school suspension and expulsion is counter to the protective factors that reinforce positive health behaviors, build resiliency, and improve mental health outcomes for young people. Protective factors such as connectedness to school and belonging, having trusted adult relationships, and pro-social activities are most easily built in the school environment. The use of out-of-school suspension and expulsion reduces access to positive relationships that are critical to youth mental health and also impact educational outcomes by limiting a student's in-class time. Exclusionary discipline is also disproportionately used among students of color, students with disabilities, and low-income students.[1] TCHD works with partners and community coalitions to educate and train school partners on restorative practices and the shared risk and protective factor approach to substance use prevention and mental health promotion and provide technical assistance and evaluation services to schools. Unfortunately, much of this work was paused due to the COVID-19 pandemic and a lack of in-person instruction and discipline.

Key Accomplishments

- TCHD worked with the Douglas County Healthy Youth Coalition (DCHYC) and Douglas County School District (DCSD) staff to promote policy change language in support of restorative discipline practices. DCSD school board adopted the language change in 2019.
- A scan of alternative-to-suspension and restorative disciplinary practices was completed in 2020. Next steps were paused due to the COVID-19 pandemic.

Goal 1: Improve mental and behavioral health through advocacy, policy development and implementation, and shared performance measures

Objective 4: By 2022, using the Strengthening Families Framework, implement activities to build family resiliency and reduce the impact of trauma.

Children are more likely to thrive when their families have the support they need. The Strengthening Families Framework is a research-informed approach to increase family strengths, enhance child development, and reduce the likelihood of child abuse and neglect. In this Objective, TCHD works to engage families, programs, and communities in building the five protective factors (parental resilience, social connections, knowledge of parenting and child development, concrete supports in times of need and social and emotional competence of children) and apply the Strengthening Families approach in early childhood, child welfare, child abuse prevention, and other child- and family-serving systems. TCHD engages in ongoing training, technical assistance and quality improvement efforts to increase knowledge, change behaviors and increase referrals for family support. Activities include facilitation and leadership support for community coalitions, targeted health systems change and education for providers and community partners on frameworks and best practices to support and strengthen families.

TCHD continues to adopt and adapt the SFF into the work of Nurse Support Program (NSP), Not One More Child, Child Fatality Review Teams and the Adams County Strengthening Family Initiative to address child maltreatment prevention strategies at the direct service level and community level. The Nurse Support Program has fully integrated SFF as the program's foundational framework for working with families. TCHD staff along with Denver Public Health continue to lead the Denver-Metro Perinatal Mental Health Action Network (PAN) for local coordination on referral systems for pregnant and postpartum parents.

Priority Area Two: Mental Health

Performance Measures	07/18 - 06/19	07/19 - 06/20	07/20 - 06/21	07/21 - 10/21
# People trained on maternal mental health promotion and resources	24	95	34	N/A
# Community Mental Health Centers referrals received supporting maternal mental health of TCHD clients	132	78	50	26
# Childcare centers with policy change aligned with developmental screening and referral standards	5	6	3	N/A
# Childcare centers that receive ABCD Developmental Screening and Referral Standards Technical Assistance	15	6	3	N/A

Key Accomplishments

- Implemented and integrated The Neuroscience, Epigenetics, Adverse Childhood Experiences, and Resiliency NEAR @ Home model was into the NSP practice with clients who receive ongoing services. Evaluation was completed in 2019.
- Evaluation survey was completed and documented the results in the 2019 NEAR Report. Results are being used to address hesitancy and to improve proficiency in providing NEAR visits for NSP clients.
- Training and technical assistance was provided to childcare center staff and early childhood system partners.
    - In 2021, three developmental screening and referral trainings were provided to childcare programs, one in Douglas County and two in Arapahoe County. A total of 18 educators among the three programs participated.
    - An Ages and Stages Questionnaire training was provided for Nurse Family Partnership and Nurse Support Program in 2021.
- Training was provided to TCHD WIC and Nursing Division staff on infant and maternal mental health in partnership with the Warm Connections project staff.
    - The Warm Connections team provided a series of three trainings on toxic stress and resiliency to TCHD WIC staff.
- Quality improvement (QI) recommendations were provided to enhance reach and use of the NEAR @ Home model and results were used to recommend strategies that would improve staff confidence and knowledge about ACES and increase likelihood of providing the intervention to NSP clients
- The NSP staff continue to receive relevant training and education to inform the practice of providing NEAR home visits. In collaboration with the Maternal Child Health Title V team, the NSP staff hosted a Benevolent Childhood Experiences Training for home visitation and MCH staff in August 2021.
- TCHD is currently developing a shared Strengthening Families Plan to align current efforts of the Early Childhood Partnership of Adams County (ECPAC) Child Maltreatment Prevention plan, TCHD's Title V Maternal Child Health plan, and Adams County's Human Services prevention efforts (as related to the Families First Act) to help prevent child abuse and neglect. The project is supported through the Colorado Partnership for Thriving Families and Federal Family First Prevention Services Act funding.

Goal 2: Reduce poor health outcomes related to mental health

The Objectives under Goal 2 are intended to prevent and reduce negative health outcomes associated with mental health and substance use disorders through mitigation of risk factors and increasing protective factors. Health outcomes for individuals, families and communities are driven by complex interactions of experiences and biology. In order to maximize the impact of public health prevention programming, TCHD aims to recognize and address the shared nature of root causal influences on health.

Goal 2: Reduce poor health outcomes related to mental health

Objective 1: By 2020, localized mental and behavioral health data and resource mapping and analysis will be enhanced to inform the efforts of staff, partners, and community members.

TCHD strives to provide timely, innovative and high-quality public health data collection, analysis and reporting services to drive evidence-based decisions, translate data into action and support policy development to improve mental health and wellness and reduce poor health outcomes related to mental health. Additionally, demands for mapping resources and navigation supports for mental health and wellness resources are ongoing in an ever-changing landscape, and efforts to eliminate barriers to supports and resources are essential to addressing determinants of mental health.

Key Accomplishments

- A community-level data report on substance misuse among women of reproductive age with a focus on pregnant/postpartum women was updated and disseminated to 18 community partners and providers.
- The TCHD Syndromic Surveillance program received grant funding in 2019 specifically focused on increased surveillance related to suicide and substance use. This led to increased data availability for decision-making and stronger partnerships between the Syndromic Surveillance team and other program teams across the agency addressing substance use, suicide, mental health, and violence.
- Parents Thrive Colorado and the Perinatal Continuum of Care tools were updated and leveraged for cross-promotion with Postpartum Support International, 211, and Colorado Access information.
- Local data from the Health eMoms surveillance system on barriers to accessing resources for perinatal mental health informed the development of Parents Thrive Colorado. Additionally, the Perinatal Continuum of Care toolkit features assistance on how to use local Health eMoms data to prioritize action for practice or systems change.
- In support of the Hospital Transformation Project (HTP), TCHD staff provided input on local health system partner applications and identified opportunities for collaboration (e.g., identifying methods by which the Tri-County Overdose Prevention Partnership [TCOPP] can utilize HTP substance related data to enhance targeted work).
- The TCHD Community Services Branch (CSB) created a database of behavioral health resources for individuals served by the CSB.
- PAN collaborated on the development of a pandemic resource list for perinatal parents and serving partners, along with an equity toolkit for maternal mental health and wellness.
- Substance use partners were consulted for upcoming improvements to TCHD's Substance Use data website/dashboard.
- Parents Thrive Colorado resources and content are routinely updated and added through the Content Advisory Board, which includes parents with lived experience. More than 40 community partners received targeted outreach for inclusion in Parents Thrive.

Goal 2: Reduce poor health outcomes related to mental health

Objective 2: By 2022, implement a community-wide suicide prevention framework based upon evidence-based and evidence-informed strategies across the lifespan.

Suicide prevention aims to reduce the incidence, prevalence and recurrence of suicidal ideation and behavior. Suicide prevention strategies focus on mitigating those risk and increasing those protective factors found to be associated with suicide. Population strategies such as the prevention recommendations from the Maternal Mortality Review Committee and Child Fatality Review Teams are used to bring awareness to TCHD home visitation teams. Ongoing collaboration between direct service and population health continues to build capacity for integrating relevant suicide prevention practices.

Collaboration with schools to support mental health needs, including protective or safety factors associated with bullying and suicide, are ongoing. Partnership is also ongoing with Partners for Children's Mental Health (PCMH) and their School Community of Practice, which includes the Colorado School Safety Resource Center, to address risk, protective, or safety factors associated with bullying and suicide.

Key Accomplishments

- TCHD completed a county asset map cataloging bullying and suicide prevention resources within schools and communities in August 2019.
- The TCHD Suicide Prevention Framework was finalized and launched.
- TCHD hosted a "Behavioral Health Support for Youth in Crisis" webinar for school staff in September 2021, modeled after COVID-19 webinar series. The presentation featured Colorado Crisis Services and Below the Surface campaign promotion, and 53 registrants participated.
- Internal collaboration with MCH, Syndromic Surveillance Data Team, and Child Fatality Review Teams is ongoing to inform how to best share syndromic surveillance data with school partners.
- TCHD held meetings with key school mental health and crisis response staff from Adams 12, Cherry Creek, Douglas and Littleton school districts to share suicide and violence prevention syndromic surveillance data. Staff are currently working with two school districts to build syndromic surveillance data alerts specific to the zip codes within their school districts.

Goal 2: Reduce poor health outcomes related to mental health

Objective 3: By 2024, cross-sector partnerships will support the reduction of prescription drug misuse and overdose deaths by 2 percent.

TCHD continues to build partnerships through multiple public health and community collaborations to strengthen and improve efforts to reduce drug overdoses. These partnerships allow for effective implementation of programs and help advance promising strategies that address the overdose epidemic. This Objective includes unique opportunities to enhance programs and policies to support the needs of those at risk of overdose, and bridge knowledge, data, and service gaps that impact the success of community-wide overdose prevention efforts.

Priority Area Two: Mental Health

Performance Measures	07/18 - 06/19	07/19 - 06/20	07/20 - 06/21	07/21 - 10/21
# Providers trained on substance use prevention and referral	155	152	60	N/A
# Trainings provided on substance use prevention and referral	4	3	4	N/A

Key Accomplishments

- TCHD successfully pursued and received new competitive funding to facilitate a substance use prevention coalition, the Douglas County Healthy Youth Coalition, in partnership with Douglas County School District.
- TCHD hosted and facilitated two provider education events entitled "Trauma and Integrated Care: Best Practices for Treating Pain and Substance Use," which took place in August 2019 (one in Lone Tree and one in Thornton). These events were marketed to all types of medical providers including primary care providers and OBGYNs who serve women of reproductive age. A total of 80 participants attended.
- TCHD provided healthcare education and technical assistance on perinatal substance use prevention, screening, and referral, and treatment best practices via a new Perinatal Substance Use Provider Toolkit with Colorado Access, Community Reach Center, Mental Health Center of Aurora, AllHealth Network, and SCL Health Neonatal Intensive Care Unit providers.
- TCHD contracted with a public health research and consulting firm to conduct a community and resources assessment related to substance use, violence, bullying, and suicide among young people for Adams County and Aurora in summer 2020.
- TCHD applied for two competitive grants to augment work occurring in Adams County in 2019 that were not funded, and one to expand efforts in Aurora, which was funded.
    - TCOPP hosted its first virtual International Overdose Awareness Day event in August 2020 with nearly 100 attendees and 50 boxes of naloxone distributed.
    - TCOPP worked with a contractor to conduct focus groups among individuals in recovery and affected family members to understand drivers and barriers to treatment. Learnings were used to guide development of the TCOPP action plan.
- TCHD successfully pursued and received new competitive federal funding to facilitate a substance use prevention coalition, the Aurora Partners for Thriving Youth, serving the Aurora Public Schools service area.
- TCHD successfully pursued and received competitive state funding to continue facilitation of the Communities that Care substance use prevention coalition, with communities along the I-70 in partnership with Bennett Parks and Recreation District.
- TCOPP partnered with a local sobriety-promoting non-profit organization to host a public awareness event featuring naloxone distribution in honor of International Overdose Awareness Day.

Summary

Access to healthy food and food insecurity are Social Determinants of Health (SDoH). Food insecurity is more commonly experienced by children, seniors, people of color, immigrants, low-income communities, and people with disabilities. Food insecurity is associated with chronic diseases such as overweight and obesity, cardiovascular disease, hypertension, stroke, diabetes, and some cancers. In addition to health outcomes, food insecurity can negatively impact educational and economic outcomes for children and adults. There are federal nutrition programs such as WIC and SNAP to help with food insecurity but, unfortunately, not all who are eligible participate due to many reasons, including awareness and stigma.

Population Health Measures	2017	2018	2019	2020	2024 Target
Proportion of pregnant women reporting food insecurity (3-year estimate)[1]					
Adams	9.3	N/A	8.6	N/A	**7.8**
Arapahoe	9.2	N/A	8.2	N/A	**8.3**
Douglas	1.4	N/A	2.3	N/A	**0.0**
Proportion of high school students reporting food insecurity[3]					
Adams	N/A	N/A	12.8	N/A	**16.5**
Arapahoe	17.1	N/A	18.3	N/A	**15.0**
Douglas	12.5	N/A	12.3	N/A	**12.5**
Proportion of those eligible but not enrolled in SNAP[4]					
Adams	35.5	N/A	N/A	N/A	**32.0**
Arapahoe	28.1	N/A	N/A	N/A	**22.5**
Douglas	68.3	N/A	N/A	N/A	**46.5**
Proportion of those eligible but not enrolled in WIC[4]					
Adams	43.0	N/A	N/A	N/A	**37.5**
Arapahoe	46.0	N/A	N/A	N/A	**43.6**
Douglas	61.0	N/A	N/A	N/A	**50.6**
Proportion of children ages 5-14 who are overweight or obese[5]					
Adams	33.4	N/A	N/A	N/A	**19.6**
Arapahoe	18.1	N/A	N/A	N/A	**17.0**
Douglas	7.4	N/A	N/A	N/A	**6.5**

[1]Pregnancy Risk Assessment Management System (PRAMS)

[2]Child Health Survey (discontinued)

[3]Healthy Kids Colorado (bi-annual survey; Adams County did not participate in 2017)

[4]Colorado State WIC Program (these data have not been updated since 2017)

Population Health Measures	2017	2018	2019	2020	2024 Target
Proportion of high school students who are overweight or obese[3]					
Adams	27.1	N/A	26.5	N/A	**17.9**
Arapahoe	21.7	N/A	22.8	N/A	**18.8**
Douglas	14.6	N/A	13.1	N/A	**11.9**
Proportion of adults who are overweight or obese[5]					
Adams	68.8	66.0	69.2	N/A	**57.3**
Arapahoe	58.9	58.8	61.7	N/A	**55.0**
Douglas	55.4	56.5	57.1	N/A	**51.0**
Proportion of children ages 2-4 enrolled in WIC who are overweight or obese[4]					
Adams	23.3	21.1	20.9	N/A	**20.2**
Arapahoe	16.4	17.4	20.0	N/A	**13.6**
Douglas	16.0	15.1	17.2	N/A	**14.4**

[3]Healthy Kids Colorado (bi-annual survey; Adams County did not participate in 2017)

[4]Colorado State WIC Program (these data have not been updated since 2017)

[5]Behavioral Risk Factor Surveillance System (BRFSS), Colorado Dept. of Public Health and Environment, 2020 data are not available

Goal 1: Increase access to safe, nutritious, affordable and culturally relevant food, especially in communities with limited resources and communities of color

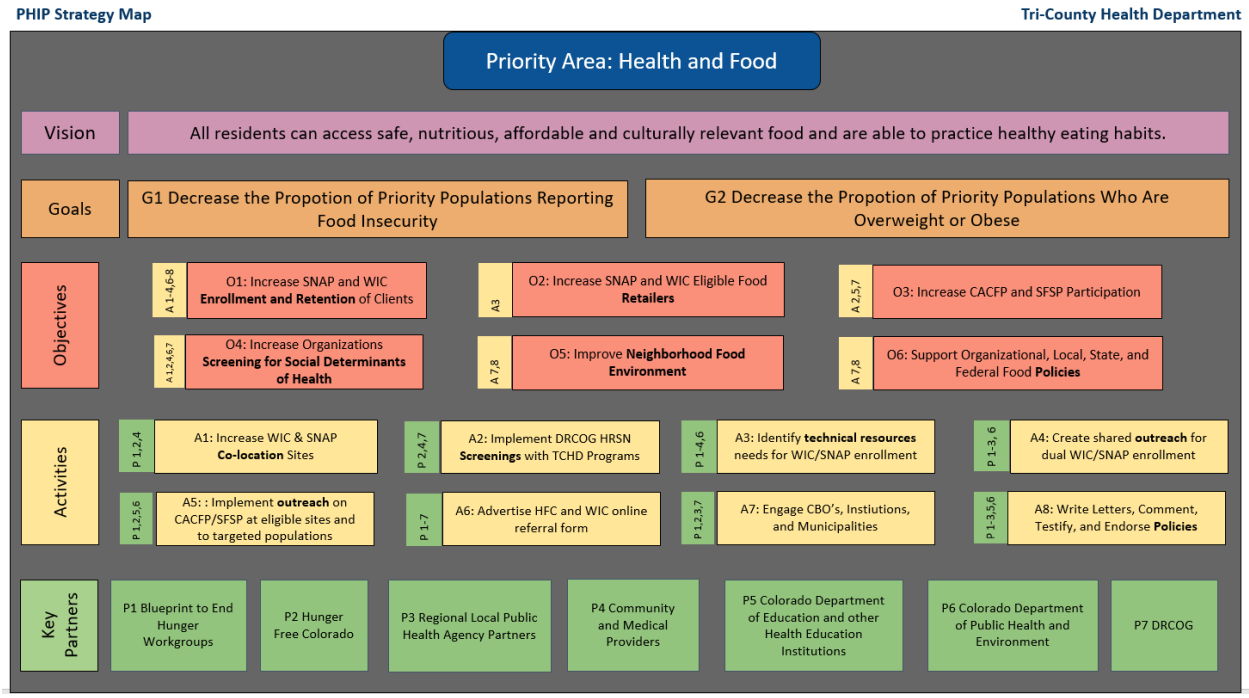
Multiple divisions provide programs and collaborate with partners and community-based organizations to address food security through programs, technical assistance and alignment of key strategies and promotion efforts in TCHD communities. Federal Nutrition programs are one key to providing access to nutritious foods across the lifespan including WIC, School Nutrition Programs and SNAP; unfortunately, not all who are eligible participate due to many reasons, including awareness and stigma. Community nutrition programs and community-based organizations also play a key role in providing access to food through initiatives and programs such as gardens, markets and pantries.

Goal 1: Increase access to safe, nutritious, affordable and culturally relevant food, especially in communities with limited resources and communities of color

Objective 1: By the end of 2019, and annually thereafter, develop a strategy map reflecting interrelated systems-level work, including food, housing, transportation, and employment, which identifies gaps and areas for collaboration with partners and community organizations

In 2019, the TCHD Dietetic Internship class completed a literature review of strategy maps and frameworks to assist TCHD in its strategy mapping efforts to describe the complex, interrelated systems affecting SDoH. Ultimately, the purpose of this strategic mapping framework was to provide key TCHD staff with a tangible resource to understand how TCHD's PHIP will be implemented to meet defined goals within specific priority areas while also identifying existing partnerships and potential linkages among efforts. The following strategy map template was utilized and the Health and Food Model is below. This specific objective was not continued into the second year of the PHIP (July 2020 to June 2021).

Priority Area Three: Health and Food



Goal 1: Increase access to safe, nutritious, affordable and culturally relevant food, especially in communities with limited resources and communities of color

Objective 2: By the end of 2021, provide technical assistance and capacity building support to 10 organizations, agencies, and community leaders implementing community-based food projects, food assistance, and/or food systems environment or policy changes in two focus areas in the Tri-County jurisdiction.

Food in Communities (FIC) is a regional collaborative that uses community-based participatory approaches to address food insecurity and increase access to healthy, affordable, and culturally important foods. TCHD, Denver Department of Public Health and Environment, and Jefferson County Public Health convene and facilitate FIC in their respective jurisdictions using approaches that are rooted in equitable partnership. In Adams County, the TCHD FIC team works in two focus areas: Northwest Aurora and Southwest Adams County.

The TCHD FIC team works with community members, organizations, institutions, and public agencies to collectively cultivate and sustain neighborhood and regional food policy, system, and environment (PSE) changes. Community-driven priorities guide FIC's work, and FIC aims to build capacity among community leaders and organizations to strengthen the local and regional food system. In collaboration with community partners, the TCHD FIC team drafted guiding documents in 2019-2020. For each focus area, these guiding documents include: 1. Criteria for a complete neighborhood food environment with discussion of the current state of the food environment as well as potential strategies for food PSE changes, and 2. An action plan for implementing food PSE changes.

From July 2020 through June 2021, the TCHD FIC team provided technical assistance to over 30 organizations, institutions, and public agencies implementing community-based food projects, food assistance, and/or food systems environment or policy changes. This included trainings with participation from multiple partners, as well as individual technical assistance. Group trainings included racial equity training, foundations in data equity, and municipal food policy training. Individual technical assistance included grant writing support, subject matter research and presentations, meeting facilitation, strategic thought partnership, participation on community advisory groups, site visits, and other technical assistance.

In 2021, the TCHD FIC team also hosted a Municipal Food Policy Training with representatives from the Adams County government and seven municipal governments. The training focused on how municipal and county policies can be used as tools to increase access to healthy, affordable, and culturally important food. The national-level facilitator also met with each jurisdiction to offer relevant local food policy case studies with respect to current and forthcoming planning and policy processes.

Additionally, in 2020 and 2021, the TCHD FIC team not only supported community partners with implementation funding from FIC's Cancer, Cardiovascular, and Pulmonary Disease Grants Program budget from CDPHE but also engaged other funders and leveraged over $710,000 from public and private sources for community partners to implement strategies in Adams County and Aurora.

Performance Measures	07/18 - 06/19	07/19 - 06/20	07/20 - 06/21	07/21 - 10/21
# Organizations assisted	6	23	33	11
# Criteria and action plan for complete neighborhood food environment	N/A	2	N/A	N/A

Key Accomplishments

- Drafted action plans in two focus areas (Northwest Aurora and Southwest Adams County)
- Provided technical assistance to over 20 organizations
- Provided FIC grants to 8 partners to implement action plan strategies in Adams County
- Leveraged over $280,000 from public and private sources to support partners
- Provided technical assistance to over 30 organizations
- Provided 10 FIC grants to partners to implement action plan strategies in Adams County
- Leveraged over $430,000 from public and private sources to support partners

Goal 1: Increase access to safe, nutritious, affordable and culturally relevant food, especially in communities with limited resources and communities of color

Objective 3: By the end of 2021, increase the number of medical providers and community organizations that screen for food insecurity and refer to federal nutrition programs and community-based nutrition programs by 20 medical/community organizations in the Tri-County jurisdiction.

Between July 2018 and July 2019, three medical providers completed contracts to add food insecurity screening (FIS) to their electronic medical records and workflows and began referring clients to food resources. In addition, one pediatric dental office implemented FIS; however, did not add the questions to their electronic medical record. Two additional providers were interested in the sub grant; however, limited staff capacity and ability to change electronic medical records were barriers. Providers who implemented FIS provided positive feedback, indicating overall satisfaction with the ability to screen and connect their patients to food resources. Data collection from practices was challenging due to limited electronic medical record capability and staff turnover. This objective was not continued 2020-2021 due to loss of grant funding for staff capacity and provider sub grants to implement screening questions into electronic health records or into process workflows.

Performance Measures	07/18 - 06/19	07/19 - 06/20	07/20 - 06/21	07/21 - 10/21
Number of Medical Providers Assisted to Implement Screening	2	2	N/A	N/A

Key Accomplishments

- Three medical practices completed sub grants to add food insecurity screening to their electronic medical records and one pediatric dental clinic added food insecurity screening to their workflow.
- This objective was not continued 2020-2021 due to loss of grant funding for staff capacity and provider sub grants to implement screening questions into electronic health records.

Goal 1: Increase access to safe, nutritious, affordable and culturally relevant food, especially in communities with limited resources and communities of color

Objective 4: Increase WIC caseload by 2% through enrollment and retention efforts by 12/31/21; Increase SNAP participation by 3% by 12/31/21

In 2019, TCHD began a partnership with Hunger Free Colorado to become a "SNAP PEA" or Partner Engaging in Application Assistance. The goal was to complete dual enrollment of WIC participants into the Supplemental Nutrition Assistance Program (SNAP) and increase the number of WIC families who were enrolled in both programs. WIC staff completing appointments with participants identify those who are not enrolled in SNAP and make a referral to one of our Food Assistance Navigators. This is a successful model as participants are getting a referral from a trusted resource and navigators are also trained WIC staff. The navigators not only help with the SNAP application process, but also upload documents as well as check on status and needed documents to ensure success in client applications. The navigators not only help with the SNAP application process, but also upload documents as well as check on status and needed documents to ensure success in client applications. TCHD exceeded the grant goal number of applications during both of the grant cycles. In year one (2019-2020) of the PHIP, 436 applications were completed; in year two (2020-2021) 1141 applications were completed. To date in year 3, 411 applications have been completed.

The Nutrition Division recently expanded its food access efforts to address food insecurity in Adams County with a fulltime Food Security Specialist position. Starting fall of 2020, regular outreach events took place to reach families, seniors, and college students at local events and food pantries. In partnership with Adams County Human Services, the Food Assistance Navigators are able to complete SNAP applications and provide a county interview all in one day. This style of outreach is especially helpful for those experiencing homelessness, those who may not have a phone, or may not be able to travel to the Human Services Office. New sites include local food pantries, farmers markets, and a community college. In addition, programs within TCHD are now referring clients to the SNAP program. These programs include Nurse Family Partnership, Harm Reduction & HIV Prevention Program and the Diabetes Education Program.

TCHD WIC increased targeted outreach to medical providers through WIC 101 presentations and directly to WIC clients. TCHD's WIC social media presence increased due to informational weekly posts, videos, highlights, and stories. New video reels have reached an average of 1,000 people per video and program social media following has increased. TCHD WIC Program is also participating in the WIC Central Referral Pilot with CDPHE to help increase the number of enrollment from those entered through Colorado PEAK and the on-line referral system. This includes a process of engagement and testing a two-way texting platform. The pilot has been extended into a second year to continue to evaluate and develop a plan for statewide implementation on follow-up of referrals through the on-line platforms.

Performance Measures	07/18 - 06/19	07/19 - 06/20	07/20 - 06/21	07/21 - 10/21
Monthly Average WIC Caseload	21,382	20,692	20,537	20,777
SNAP WIC Dual Enrollments	N/A	436	1,141	411

Key Accomplishments

- Partnered with Hunger Free Colorado to assist WIC clients in applying for SNAP. Completing 436 applications in PHIP year one.
- Implemented targeted WIC outreach to medical providers
- Began WIC Central Referral Pilot with Colorado Department of Public Health and Environment to increase the number of enrollments through Colorado PEAK and the online referral system with two-way texting.
- Completed 1,141 SNAP applications for WIC clients in PHIP year two
- Targeted WIC/SNAP outreach via social media and outreach at food pantries, Farmers' Markets, and a Community College.
- Began receiving referrals for SNAP application assistance from additional internal TCHD programs (Nurse Family Partnership, Harm Reduction & HIV Prevention Program and the Diabetes Education Program.)
- Received extension of the WIC Central Referral Pilot to continue for an additional year.

Goal 1: Increase access to safe, nutritious, affordable and culturally relevant food, especially in communities with limited resources and communities of color

Objective 5: Expand access to quality nutrition for underserved or vulnerable children in the SFSP. Expand access to quality nutrition for underserved or vulnerable children in the Early Care and Education System.

The Office of Early Childhood's Preschool Development Grant (PDG), Quality Nutrition in Early Care and Education (ECE) Strategy workgroup convenes regularly with TCHD representation. The goal of this workgroup is to expand access to quality nutrition to underserved or vulnerable children in the ECE system. Components of this work include data sharing and outreach strategies. In 2020, data sharing was strengthened to better analyze utilization of the Child and Adult Care Food Program (CACFP) by ECE programs. Additionally, a family childcare home outreach brochure was created and distributed. In 2021, a statewide Geographic Information System map reporting CACFP utilization was published and cost-benefit calculators for both childcare homes and centers were updated. Notably, the pandemic-related federal waivers to allow flexibilities with child nutrition programs including CACFP are believed to be greatly assisting with outreach and participation. TCHD utilizes a childcare newsletter and training sessions to distribute outreach and education.

In 2019-2020, TCHD promoted the Summer Food Service Program (SFSP) to WIC clients through newsletters and social media outlets. The agency also explored opportunities to become SFSP meal sites as it had done in the past at our Aurora West WIC clinic. Due to the COVID-19 pandemic, the SFSP changed greatly with the ability to pick up food "to go." TCHD's new School Policy and Prevention Coordinator was activated into the pandemic response, yet continued work with school partners on how to engage with them on food access. The SFSP was continually highlighted in regular WIC newsletters and through social media platforms. In July 2021, summer meal sites were included on the TCHD Equity and Assets Dashboard (map layer) and this planning tool was shared with many county, city, and community partners.

Performance Measures	07/18 - 06/19	07/19 - 06/20	07/20 - 06/21	07/21 - 10/21
Summer Food Service Program Participants: Adams (All SFSP data from Colorado Department of Education; data not yet available for July-Oct 2021)	118,040	N/A	N/A	N/A
Summer Food Service Program Meals Served: Adams	169,390	3,027,542	6,759,237	N/A
Summer Food Service Program Participants: Arapahoe	62,819	N/A	N/A	N/A
Summer Food Service Program Meals Served: Arapahoe	112,869	2,801,816	8,246,463	N/A
Summer Food Service Program Participants: Douglas	44,324	N/A	N/A	N/A
Summer Food Service Program Meals Served: Douglas	44,324	1,155,030	4,079,522	N/A
# CACFP Sites/Locations in TCHD Jurisdiction includes Childcare, Head Start and After School programs. Data pulled annually in September by CO CACFP.	N/A	129	203	270

Key Accomplishments

- Began receiving data from CO CACFP regarding participation in the TCHD jurisdiction
- Began Preschool Development Grant workgroup meetings with the Office of Early Childhood
- Promoted pick up locations for SFSP
- CACFP outreach brochures and cost-benefit tools published and shared with partners
- CACFP story map published and shared with partners

Goal 1: Increase access to safe, nutritious, affordable and culturally relevant food, especially in communities with limited resources and communities of color

Objective 6: Increase access to locally grown produce to community members by December 2021.

The original goal of increasing food retailers to accept WIC and SNAP was delayed and then later changed in Year 2 due to the COVID-19 pandemic and outreach capacity.

From July -October 2020, the Healthy Farmers Markets program operated to provide food assistance to the communities in and around the City of Thornton. COVID CARES Act funding through the City of Thornton was able to provide a $25 produce voucher to Thornton residents who receive WIC/SNAP or who were over the age of 55. To establish equitable opportunities, funding through the American Heart Association (AHA) was able to match the value of this voucher to provide the same incentive for non-Thornton residents who also receive WIC and/or SNAP or were over the age of 55. In order to receive these vouchers, participants who met eligibility criteria, were asked to complete a short survey. Since the farmers markets had never collected baseline data on participants, these vouchers were an opportunity to determine our geographic reach within TCHD communities as well as identify which marketing strategies yielded higher levels of engagement. Produce voucher information was entered into a GIS survey tracking system and highlighted in a farmer's market data dashboard throughout the market season. AHA created a Healthy Farmers Market video to highlight the efforts of the partner organizations to increase food access in these areas to use for future marketing, to solicit funding/sponsorships and to share with interested partners (which won a 2021 NACCHO Model Practice Award). Program and sustainability planning will continue to expand this model into other TCHD jurisdictions.

In May 2020, TCHD continued with two WIC community gardens to provide access to freshly grown produce and nutrition education to WIC clients who participated. The 27J Community Garden in Brighton and the Amazing Meadows Community Garden in Thornton produced 384 and 281 pounds of produce respectively, and donated 434 pounds of produce to local food pantries. Future steps of the community gardens are to improve efforts aimed at increasing participation of TCHD WIC clients.

The Community Supported Agriculture (CSA) Box Pilot program started in August 2020. Nourish, a Colorado non-profit, was able to provide funds for summer 2020, winter 2020, spring 2021, and summer 2021, and has provided food box deliveries for an average of 50 families per season. A total of $82,175 has been given to the East Denver Food Hub in order to provide locally grown produce. Traditionally, CSA Box Programs require members to pick-up the food at a specified location. This innovative model allows for foods from local farms to be delivered directly to WIC families that are served out of the North Broadway office. All partners are looking for sustainable funding so that program can be expanded to additional clinics in TCHD jurisdiction.

Priority Area Three: Health and Food

Performance Measures	07/18 - 06/19	07/19 - 06/20	07/20 - 06/21	07/21 - 10/21
Number of WIC Authorized Grocery Stores	N/A	113	112	112
Number of SNAP Authorized Stores/Retailers	N/A	652	N/A	698
Number of Vouchers Provided	N/A	294	2,528	1,956
Number of Participants at Farmer's Market	N/A	2,600	3,955	5,290
# CSA Produce Boxes Provided	N/A	N/A	1,836	1,764
# Families receiving CSA boxes	N/A	N/A	103	147
# Pounds of produce harvested, WIC gardens	N/A	1,403	605	678

Key Accomplishments

- The Healthy Farmer's Market Coalition was in its second year in 2019 at Anythink Library at Huron where $10 vouchers were provided to WIC and SNAP participants. A second location at the Anythink Wright Farms library was initiated. Funding was provided through American Heart Association with support from the City of Thornton, Anythink Libraries, and TCHD.
- The three WIC community gardens, all in Adams County, had a good year with many WIC families and community members participating in the gardens. The gardens served 104 WIC families who were educated in planting, maintaining, and harvesting the produce. Additionally, college students who are majoring in nutrition came to volunteer. The gardens are supported by community organizations or cities.
- The COVID-19 pandemic changed the markets as only food-related vendors were allowed. With additional funds through CARES act and City of Thornton, the markets were able to provide $25 vouchers to WIC/SNAP participants and senior citizens from Thornton.
- With the COVID-19 pandemic, the participation in the gardens dropped. Stonehocker garden collaboration was ended and the Commerce City garden moved to a church location. 27J continues to collaborate with the 27J schools. The 27 J garden divided into 17 private beds and 16 community beds. 42 WIC families participated. College students continue to volunteer.
- The CSA Pilot Program was implemented. TCHD partnered with local farmer East Denver Food Hub and Bondadosa, a social enterprise, to deliver boxes of locally grown produce to WIC families
- The Healthy Farmers Markets significantly increased vendors this year and brought a greater variety of community members. TCHD continued to support the two locations with funding and additional support provided by the American Heart Association, the Anythink Libraries, and the City of Thornton. Participation was steady at 5,290 participants.
- The Commerce City garden moved to the Anythink Commerce City Library location in order to better benefit the needs in Commerce City and create the opportunity for families to walk to the garden. 44 community members participated. College students volunteered and Master Gardeners came to the Commerce City location.
- The CSA program increased number of families from 30 to 51 per season
- A total of $82,175 has been given to local farmers in Adams County through the CSA program

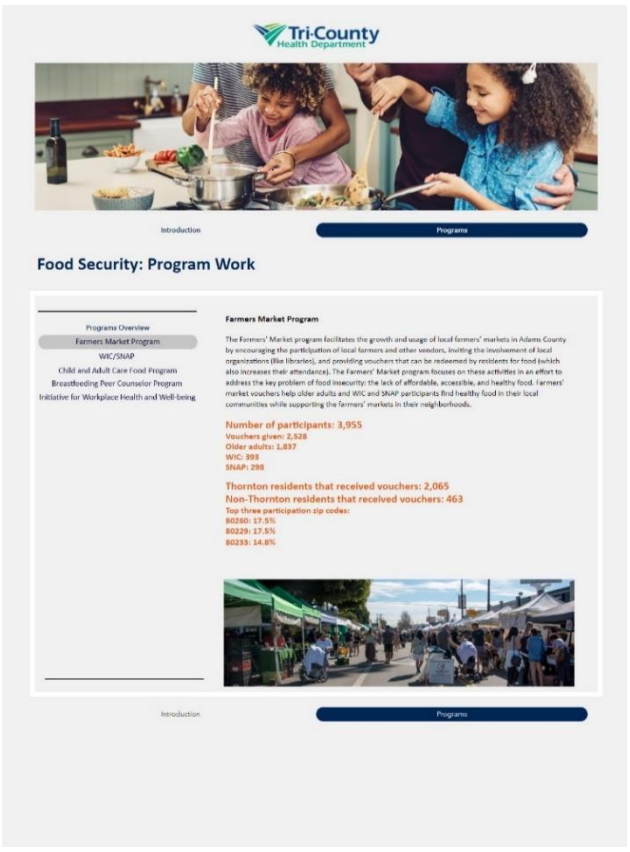
Goal 2: Promote food security and healthy eating habits through messaging, education, advocacy, and policy development

Multiple programs across TCHD divisions influence policy, systems, and environmental changes that increase access to healthy food and make healthy food and beverage choices easier. At the same time, efforts to increase awareness and skills to utilize healthy food resources and to make individual behavior changes towards health are critical to preventing chronic disease within the community.

Goal 2: Promote food security and healthy eating habits through messaging, education, advocacy, and policy development

Objective 1: By the end of 2020, develop a web-based story map site to highlight data related to food insecurity, food safety and related health outcomes

The TCHD Health and Food web-based story board will highlight topic area population health metrics and program work to address the PHIP goals. There will be data describing issues around food security across the three counties. Programs addressing food security will be highlighted with a program description and performance metrics to gauge how the programs are addressing the topic. The Health and Food story board is in process to be completed end of 2021 or early 2022 followed by completion of the other PHIP Priority Areas. Below are snapshots of the Health and Food Story board.



Goal 2: Promote food security and healthy eating habits through messaging, education, advocacy, and policy development

Objective 2: Complete comments and sign-on letters to support food security efforts at local, state and national levels.

Health and Food staff worked with the Policy and Intergovernmental Affairs Manager to pilot a state and federal policy tracker and then helped to draft an online form for TCHD staff to submit requests for TCHD to engage in policy activities. The form was implemented and the policy manager is now tracking policy requests and activities through the form.

Performance Measures	07/18 - 06/19	07/19 - 06/20	07/20 - 06/21	07/21 - 10/21
Number of Sign on Letters	N/A	7	2	N/A
Number of State Legislative Bills Supported in Health and Food	N/A	1	2	N/A
Number of Health and Food regulatory processes influenced through comment submission	N/A	N/A	N/A	1

Key Accomplishments

- Developed a state and federal policy tracker for TCHD staff
- Developed an on-line form for TCHD staff to submit requests for policy engagement (e.g., letter of support, sign on letter, public comment)

Goal 2: Promote food security and healthy eating habits through messaging, education, advocacy, and policy development

Objective 3: By the end of 2020, develop appropriate framing and language for food access, food security, and healthy eating habits with system partners and community members

This objective occurred during Year 1 only. The Health and Food Workgroup aligned with Goal 1 from the Blueprint to End Hunger and activities towards public will building. Staff also utilized the Frameworks Institute's Message Banks to inform language in discussing programs that promote food security. Hunger Free Colorado also received funding to increase WIC participation and formed a WIC Coalition that included state and local WIC and SNAP partners, providers, and participants to determine what program and communication changes could benefit or increase participation in WIC Hunger Free Colorado hosted listening sessions at the beginning of the pandemic. Through these sessions, community members consistently reported about eight issues WIC should address: the food package, the shopping experience, administrative churn and communication challenges, time and hassle relative to benefit from the program, stigma and perception of limited resources, outdated perceptions of WIC, lack of WIC presence in communities, and fear about immigration status and data use (HFC Report). This goal was not specifically continued into Year 2 and 3, but staff continue to engage in work related to advocacy, communications and framing to best engage clients and community members.

Key Accomplishments

- Partnership and participation with the Hunger Free Colorado WIC Coalition

Goal 2: Promote food security and healthy eating habits through messaging, education, advocacy, and policy development

Objective 4: By the end of July 2020, catalogue educational opportunities to increase healthy eating behaviors for residents focused on food skills, nutrition, and food safety

The Health and Food workgroup identified that it would be helpful to have a catalogue of educational opportunities to refer clients and community members to for those who are interested in healthy eating behaviors and skills and resources to do so. Many programs within TCHD provide education on this and have community referrals for each program to refer to (e.g., WIC and Diabetes Program), but the agency did not have one comprehensive place or resource list specific to food skills, nutrition. Many community organizations do provide classes including Cooking Matters and County Extension Offices. Due to capacity and staffing, this objective was not able to be completed. One example of success was the Douglas County Regional Health Connector's work, where the staff member worked with a coalition and put together a "menu" of healthy eating and active living resources.

Goal 2: Promote food security and healthy eating habits through messaging, education, advocacy, and policy development

Objective 5: By the end of 2021, establish 20 new organizational (e.g. schools, worksites) and municipal policies to promote healthy food and beverage consumption

The Advancing Breastfeeding in Colorado (ABC) project seeks to reduce health disparities and improve overall health across the state by creating a seamless system of breastfeeding support for parents and families in child care settings, medical offices, and in their communities. The ABC grant provides outreach, technical assistance and grant support for creation and enhancement of lactation spaces in child cares and medical offices as well as adoption of organizational policies supportive of breastfeeding. The project outcomes also include sites being certified as Breastfeeding Friendly.

The Initiative for Workplace Health and Wellbeing brings together organizations of all sizes with the end goal of improving the health of Colorado's workforce. The project includes technical assistance for creating healthy food and beverage environments and lactation support in the workplace. Although grant funding specific to these two strategies ended in June 2021, five employer coalitions continue to work on them as identified priorities within comprehensive workplace wellbeing. Over the course of the last six years, the Initiative for Workplace Health and Wellbeing grew to 88 participating employers (reaching approximately 104,000 employees) who were provided with healthy food/beverage and breastfeeding-friendly education, technical assistance and support for their workplace policies.

As part of TCHD's health promotion in childcare efforts, childcare providers are encouraged to complete a Healthy Eating and Active Living (HEAL) self-assessment during training and outreach events. This tool has been used regionally and pilot-tested along with an accompanying toolkit that will be published for statewide use. The assessment allows childcare programs to identify strengths and growth areas to assist with local level action planning regarding their policies and environment. For example, one center installed a touchless water refill station because of participation with the assessment and action-planning tools.

Healthy beverage grant work shifted to municipal policy strategy beginning in July 2018. Based on partner interest and the potential for substantial impact on children's health, a campaign was launched for a healthy drinks in kids' meal ordinance in Aurora. Through community engagement at grassroots and grasstops levels, including the restaurant sector, the policy work progressed through a positive first reading and vote just prior to the start of the COVID-19 pandemic. The second reading on the Healthy Kids' Meal Drinks ordinance in Aurora was delayed multiple times due to the COVID-19 pandemic, and ultimately postponed indefinitely in June 2021 due to insufficient political will. The healthy beverage team completed a readiness assessment to determine which other

municipalities could potentially have interest in and support a healthy kids meal drink ordinance or other policy strategy to address sugary drink consumption as a primary driver of chronic disease. The team is now pursuing support and beginning community engagement on this topic in Northglenn.

Performance Measures	07/18 - 06/19	07/19 - 06/20	07/20 - 06/21	07/21 - 10/21
# New child care and primary care providers connected with breastfeeding friendly grant resources	32	19	4	18
# Employers provided with education, TA and support for HFB and BFF workplace policies	65	78	86	88
# Child care programs with completed HEAL self-assessment	19	27	2	1
# Child care locations adopting or updating program policies, systems, or environments that support healthy eating and active living (HEAL)	N/A	0	1	0
# Municipal-level healthy beverage policies adopted	N/A	0	0	N/A
# New community members or community organizations engaged in policy campaign (new indicator)	N/A	N/A	N/A	5
# Decision-maker consultations related to healthy beverage policy strategy	N/A	7	17	2

Key Accomplishments

- 5 childcares achieved Breastfeeding Friendly certification.
- 13 employers achieved Breastfeeding Friendly certification and 12 employers adopted a health food/beverage policy.
- Statewide Healthy Eating and Active Lifestyle in childcare toolkit writing workgroup began.
- Core team and coalition formed for Aurora healthy drinks in kids' meal campaign following community listening sessions.
- 8 childcares achieved Breastfeeding Friendly certification
- 10 employers achieved Breastfeeding Friendly certification and among these 10 organizations, a total of 39 new lactation spaces were created.
- 6 employers adopted a healthy food/beverage policy.
- Draft of Healthy Eating and Active Lifestyle in childcare toolkit completed.
- Multiple presentations and connection with Aurora city staff and councilmembers along with community support led to successful first reading of Aurora healthy drinks in kids' meals ordinance in early March 2020.
- 1 primary care provider with 2 sites achieved Breastfeeding Friendly medical office certification, 9 childcare providers completed their annual re-assessment process, 6 employers achieved Breastfeeding Friendly certification, and 6 employers adopted a healthy food/beverage policy.
- Healthy Eating and Active Lifestyle toolkit pilot-testing completed and revisions began.
- Additional grant funding secured to support a part-time community organizer for healthy beverage policy efforts. Youth coalition established in Aurora.

Summary

When housing emerged as a priority area for TCHD's Public Health Improvement Plan, the Board of Health intentionally identified it as a developmental area to allow TCHD to assess current capacity, expand understanding of external opportunities, and build the capacity of our workforce to take on work in this area. TCHD engaged many partners in the process by hosting small stakeholder meetings as well as convening a large group of housing and health partners from across the three counties. From there, TCHD set three goal areas and embarked on meaningful work to achieve goals and objectives on Health and Housing as a developmental focus area.

The COVID-19 pandemic generated renewed focus and areas of growth for TCHD's work in Health and Housing. The pandemic reinforced the interconnectedness of the three goal areas and the importance of addressing health and housing at multiple levels from direct service to policy change. The following summary report attempts to highlight the transformation of TCHD's Health and Housing work in association with each goal area. However, the impact of the various efforts has contributed to advancing our work in multiple goal areas.

Population Health Measures	2017	2018	2019	2020	2024 Target
Overcrowding: Proportion of households with more than one person per room[1]					
Adams	4.8	4.2	4.1	N/A	**3.9**
Arapahoe	2.7	1.9	1.9	N/A	**2.5**
Douglas	1.3	0.8	1.1	N/A	**0.0**
Proportion of all owners that spend more than 30% of income on housing[1]					
Adams	25.7	25.1	25.6	N/A	**23.6**
Arapahoe	23.1	22.5	22.9	N/A	**16.8**
Douglas	19.9	19.3	19.6	N/A	**17.6**
Proportion of all renters that spend more than 30% of income on housing[1]					
Adams	57.4	56.3	53.4	N/A	**47.0**
Arapahoe	53.5	57.7	50.0	N/A	**48.6**
Douglas	39.9	49.8	51.7	N/A	**34.2**
Number of homeless people[2]					
Adams	157	466	483	476	**N/A**
Arapahoe	562	198	228	245	**N/A**
Douglas	45	34	14	53	**N/A**

[1]U.S. Census Bureau, American Community Survey, 5-Year Estimates (2020 data not yet available for these indicators)

[2]Metro Denver Homeless Initiative, Point in Time Estimates

Goal 1: Improve quality of housing for TCHD population, especially for those most vulnerable in our communities (people of color, immigrants and refugees, and people with low income).

The first goal of TCHD's work in Health and Housing leveraged many existing programs to further understand how to best address housing conditions in Adams, Arapahoe, and Douglas Counties. TCHD's existing Environmental Health, Community Health Promotion, and Nursing Divisions already address housing conditions in a variety of ways. As a developmental goal area, TCHD identified steps that would prepare TCHD for expanded work in this area. The main activities to advance housing quality in the TCHD service area included conducting internal assessments and external policy scans in addition to participating in statewide and regional coalitions and capacity building activities.

Goal 1: Improve quality of housing for TCHD population, especially for those most vulnerable in our communities (people of color, immigrants and refugees, and people with low income).

Objective 1: By 2020, conduct an internal scan of current activities related to healthy housing at TCHD

TCHD conducted three internal assessments including an inventory of technical assistance provided by TCHD programs related to housing, an assessment of Medicaid Reimbursement opportunities for healthy homes, and summary of opportunities for screening for social determinants of health in TCHD's clinical settings.

TCHD staff also completed a series of external policy and resource scans, including a comprehensive scan of healthy housing policies across 26 cities and towns in three counties. The scan utilized the 12 main standards outlined in the National Healthy Homes Standard (National Center for Healthy Housing and American Public Health Association) and scanned the building and land development codes in the study areas to assess whether regulations addressed the standards. The results of this scan will be used as TCHD takes the next steps of prioritizing local policy work to address healthy housing.

Key Accomplishments

- TCHD conducted three internal assessments. These include:
  - An inventory of technical assistance provided by TCHD programs related to housing.
  - An assessment of Medicaid Reimbursement opportunities for healthy homes.
  - A summary of opportunities for screening for SDoH in TCHD's clinical settings.
- TCHD's Land Use and Built Environment Team conducted a comprehensive scan of healthy housing policies across 26 cities and towns and three counties. The scan utilized the 12 main standards in the National Health Homes Standard (National Center for Healthy Housing and APHA) and scanned the building and land development codes in the study area to assess whether regulations addressed the standards. The results of this scan will be used as TCHD takes the next steps of prioritizing local policy work to address healthy housing.

Goal 1: Improve quality of housing for TCHD population, especially for those most vulnerable in our communities (people of color, immigrants and refugees, and people with low income).

Objective 2: By the end of 2020, increase capacity of public health workforce to effectively and innovatively participate in efforts to improve health outcomes through improved housing options

Building capacity of TCHD staff was a high priority in order to prepare the agency to address housing quality in a more meaningful way. TCHD participated in several statewide conferences that focused on housing, including Rocky Mountain Land Use Institute Conference and Colorado Health Foundation's Annual Meeting. Several staff training and capacity building opportunities were developed by TCHD and in partnership with TCHD partners to expand knowledge and understanding of racial equity and justice. Among them, TCHD co-hosted two tours for public health professionals of the "Undesign the Redline" Exhibit which illustrated the history of redlining in Denver. TCHD staff actively participate in the Colorado Healthy Housing Coalition and the Colorado Housing Policy Work Group. Through these coalitions, TCHD has provided letters of support for three legislative efforts to address housing conditions and stability for Mobile Home Community residents including HB19-1309, HB20-1196, and HB20-1201.

Key Accomplishments
- Co-hosted two tours for public health professionals of the "Undesign the Redline" Exhibit which illustrated the history of redlining in Denver. - Pursued agency-wide health equity training that included an online module on history of housing and race. - Sponsored training in conflict resolution for staff who address complaints - Hosted a Tenants Rights and Eviction Prevention training presented by Colorado Legal Services in July 2020 with approximately 70 TCHD staff participating. - Developed presentation with talking points about the nexus between health and housing and shared presentations with local housing coalitions, health alliances, and at a state conference of urban planners and economic development professionals

Goal 1: Improve quality of housing for TCHD population, especially for those most vulnerable in our communities (people of color, immigrants and refugees, and people with low income).

Objective 3: By the end of 2020 compile applicable evidence-based research, best practices, and community information/data to support recommended action to implement an enhanced healthy housing program

TCHD has conducted research, convened partners, and explored community data as it worked to compile resources to implement enhanced healthy housing strategies. From 2018-2019, TCHD convened housing partners across the three counties on a quarterly basis with the purpose of fostering shared learning on the nexus of health promotion and housing. Shortly before the COVID-19 pandemic, partners began to discuss what convening model would be most valuable moving forward. During the pandemic, partners addressed the need to shift focus to the needs generated due to the pandemic. TCHD shifted to address COVID-19 prevention with housing partners and began to participate in county-led pandemic response work groups related to housing.

TCHD staff have been instrumental in researching critical topics to advance our efforts to bring evidence-based best practices into decision-making on policies and programs to improve the quality of housing. TCHD has provided technical assistance to our local governments through land use planning and regulation development to address local policies that address housing quality. In addition, TCHD has participated on the Colorado Housing Policy Group where partners discuss and strategize on how best to move forward policy changes to support housing quality. Through this coalition, TCHD has provided letters of support for three legislative efforts to address housing conditions and stability for Mobile Home Community residents including HB19-1309, HB20-1196, and HB20-1201.

Key Accomplishments
- Convened housing partners monthly for capacity building and information exchanges - Provided technical assistance to municipal partners on eight different comprehensive plan updates and four land development regulation updates - Joined housing partners in communicating support for three state policy updates to address housing

Goal 2: Improve access to attainable housing for TCHD population, especially for those most vulnerable in our communities.

The fundamental challenge in our communities related to housing is that wages are not keeping pace with housing costs, and the COVID-19 pandemic has exacerbated this phenomenon. Since public health does not provide or construct housing, TCHD recognized that collaboration and cross-sector partnerships would be the essential channels for working toward this goal. TCHD is a part of many cross-sector coalitions including coalitions in Brighton, Commerce City, Sheridan, and Englewood where housing advocacy and healthy housing promotion is a critical component to the collaborative work. Staff have also been part of county-led work groups to develop plans and strategies to address homelessness in Adams and Arapahoe Counties. Through this participation, TCHD brings knowledge of best practices, data analysis, and public health considerations to inform the coalitions' strategies and initiatives.

Goal 2: Improve access to attainable housing for TCHD population, especially for those most vulnerable in our communities.

Objective 1: By the end of 2020, improve connections to homeless service providers and affordable housing partners to understand their goals around housing issues

TCHD is engaged in a number of collaborations where access to attainable housing is a critical objective. Through this participation, TCHD has expanded collective understanding of the key access barriers and worked to develop strategies to address access.

One area for addressing access to safe, affordable, and accessible housing is data that effectively describes the current situation. Without good data it is difficult to encourage well-researched and informed decisions. TCHD has provided coordinated support to 'Point in Time' (PIT) events in all three counties for the annual, federally mandated count of people experiencing homelessness which brings funding to local communities. Several TCHD staff played critical roles in planning for the PIT count and many TCHD staff participated over the few days of the PIT to collect data and information at sites throughout the three counties. While many recognize that the methodology of this annual data collection effort underrepresents the scale of homelessness, it remains one of the few reliable estimates of this population and is critical data as communities plan strategies to support this population.

In August 2020, TCHD created the Homeless Liaisons role, a unique position in the COVID-19 Public Health Incident Management Team, to support community partners in navigating COVID-19 prevention, COVID-19 testing, and COVID-19 respite care strategies to support the unhoused population, especially during the winter months. Through this work, TCHD staff have developed strong relationships with community-based organizations who serve the unhoused.

Key Accomplishments
- Mobilized staff support for Point in Time (PIT) data collection efforts - Established unique positions in the Public Health Incident Management Team to address the needs of people who are unhoused

Goal 2: Improve access to attainable housing for TCHD population, especially for those most vulnerable in our communities.

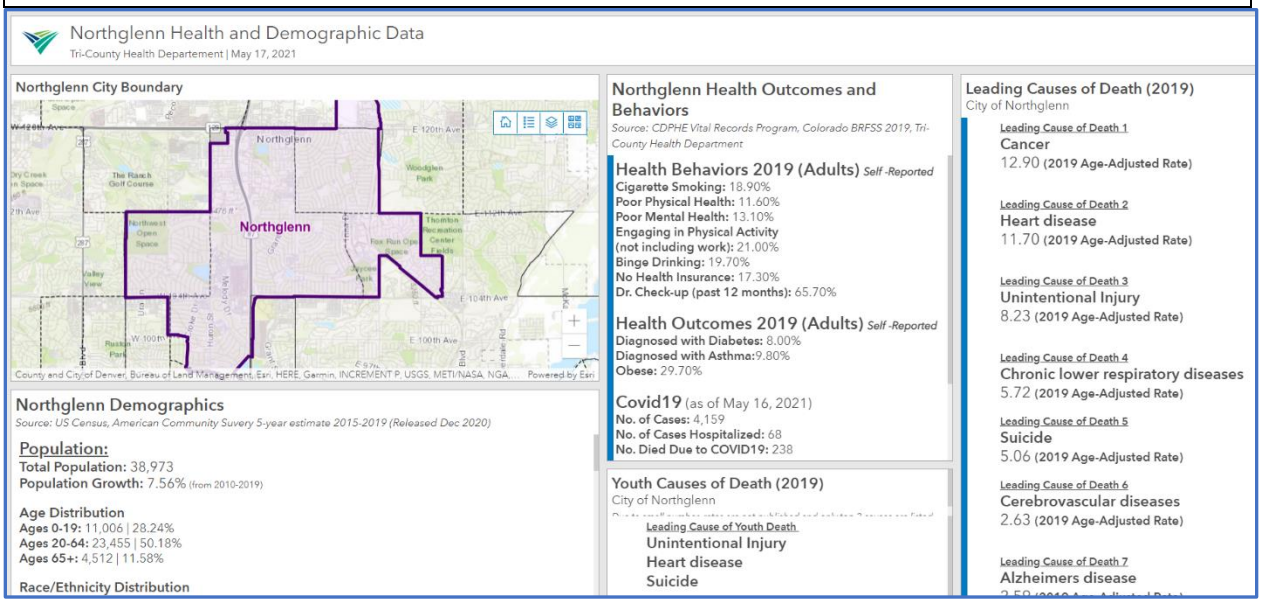
Objective 2: By the end of 2020, conduct an internal scan of current activities related to attainable housing at TCHD

TCHD spent time learning and understanding the opportunities for engaging in activities that support this goal area. In 2019, TCHD staff completed a summary of policy and technical assistance work currently provided to partners through TCHD programs. The summary was a powerful illustration of the areas of opportunity to expand TCHD's work related to housing access as it illuminated the current program activities across TCHD that were already addressing attainable housing efforts. TCHD has participated in capacity building trainings and convenings to learn about model policies and projects aimed at impacting access to attainable housing. One of the main lessons learned is that zoning regulations are often the biggest barrier to the development of more attainable housing options.

Much of our ability as communities to address the need for more attainable housing is rooted in more equitable policies, including our local government policies, to allow a spectrum of housing types across our communities. TCHD staff went beyond this PHIP objective of an internal scan and actively engaged in eight Comprehensive Plan updates and four local regulation updates by providing technical assistance and best practices for removing regulatory and policy barriers and promoting housing options that are attainable to people with lower incomes. For example, TCHD worked closely with the City of Sheridan on the development of their Accessory Dwelling Unit regulations and with the City of Littleton on their Comprehensive Plan and Land Development regulation processes to promote inclusive housing policies and other health promoting policies to allow for the expansion affordable housing options.

Key Accomplishments

- Developed multiple data dashboards for collaborative work across partners in Northglenn, Commerce City, Brighton, and Englewood to inform policy and system changes to address housing (See example of the data dashboard below.)
- Conducted internal activity scans to understand the current opportunities for addressing attainable housing
- Provided technical assistance to local communities for eight comprehensive plan updates
- Provided technical assistance to four land development regulation updates to incorporate health into housing-related considerations



Example of a data dashboard created for the City of Northglenn to incorporate into their Comprehensive Plan process.

Goal 3: Prevent displacement of TCHD population, especially for those most vulnerable in our communities.

TCHD staff know from our work in community that the fear of displacement was a concern that many community members shared prior to the onset of the COVID-19 pandemic. The social and economic impacts of the pandemic have not only increased the risk of displacement but have also increased the risk of losing access to stable housing all together. In an analysis of eviction filing data, Adams and Arapahoe Counties are among the top four counties with the highest rates in Colorado. With this tremendous wave of housing instability, this third PHIP goal area has become increasingly more critical.

Participation in the DRCOG Accountable Care Communities initiative not only assisted TCHD in understanding models for screening and referrals, participation in this regional initiative has provided lessons in how the entire process from screening, to referral, to establishment of care and resources should be examined together. Screening without resources is not adequate. These lessons were a great foundation as TCHD expanded screening and navigation work during the public health response by establishing the TCHD Community Services Branch (CSB) and the Homeless Liaison positions.

Policy and systems-level changes are also an essential area of work to address displacement and prevent eviction. TCHD explored several opportunities through the PHIP to engage in this work and are already expanding our partnerships to engage more deeply in this area.

Goal 3: Prevent displacement of TCHD population, especially for those most vulnerable in our communities.

Objective 1: By the end of 2020, conduct an internal scan of current activities related to population displacement

An initial and brief inventory was conducted in 2018-2019 to understand how TCHD might engage in housing screening and referral processes in our clinical settings. TCHD was offered an opportunity to participate in the Accountable Care Communities initiative to improve referrals for SDoH supports while in a clinical setting. TCHD's WIC program participated alongside DRCOG using a universal screening tool for SDoH and an active referral process to address clients' needs. After a short pause in participation during the early months of the COVID-19 pandemic as TCHD navigated program adjustments to meet COVID-19 prevention and social distancing requirements, TCHD renewed their commitment to the program in 2021. Since April 2021, TCHD has conducted 1,585 screenings and, among those screenings, "living situation" was the most common social determinant identified by clients.

Goal 3: Prevent displacement of TCHD population, especially for those most vulnerable in our communities.

Objective 2: By the end of 2020, determine TCHD's role to support current efforts to prevent displacement

TCHD's navigation and referral capacity increased tremendously during the public health response with the creation of the Community Services Branch (CSB) of the Public Health Incident Management Team (PHIMT), which provides navigation services to individuals who identify needing supports to safely isolate during their COVID-19 recovery. CSB has provided services to over 3,728 individuals since the start of the pandemic. While CSB was not able to track requests in detail prior to January 2021, "living environment" was identified by over 10% of people served since the start of 2021.

TCHD prioritized displacement prevention during the COVID-19 response with the support of the County's Emergency Service Function 6 – Human Needs response activities. TCHD staff provided technical support to each of the County's response activities related to housing.

Through their work in disease prevention, TCHD's Harm Reduction Team is a significant touchpoint for the unhoused population. This team is engaged in street outreach four to five days per week and continued this outreach during the COVID-19 pandemic. Through their work in building trust with participants, this team explores needs with participants and makes referrals for food assistance, Medicaid enrollment, substance use support, behavioral health and physical health services.

Key Accomplishments
- Participated in DRCOG Accountable Care Communities Initiative to improve referrals for social determinants of health in clinical settings including housing. - Supported the development of COVID Respite models for people who were unhoused across the three counties. - Set up a Community Services Branch to address housing and other needs while individuals safely isolated while recovering from COVID-19.

Goal 3: Prevent displacement of TCHD population, especially for those most vulnerable in our communities.

Objective 3: By the end of 2020, increase efforts to preserve existing stock of affordable housing through policy and system changes

Through research and engagement, TCHD staff have discovered that sound policies to ensure affordable housing options in community and economic development strategies that benefit existing residents are the key drivers of mitigating displacement. Displacement mitigation continues to be a focus in TCHD's policy research. During the COVID-19 pandemic, the focus shifted to a more specific outcome of preventing eviction. What is the status of this work moving forward?

To further our understanding of the existing resources to assist community members with staying in their homes and their communities, TCHD's Environmental Health staff conducted outreach to city and county programs that provide home improvement grants and loans. They then shared the information internally with clinical programs who are working with community members who may need additional resources to maintain their housing.

Addressing eviction prevention through policy development was another important area of work for TCHD. Through collaboration across many of the cross-sector collaborations mentioned earlier in this summary, TCHD provided technical assistance and support for four statewide policy efforts to create policy interventions to support residents in their efforts to maintain housing throughout the pandemic. TCHD has also joined the Power Building Partnerships for Health to increase relationship-building between local public health and community-based organizations to foster collaboration for policy and system-level change.

Key Accomplishments
- A summary of resources was compiled illustrating the current resources for energy audits. This information will serve as a launching point for our future work plan.