



Summit County 2023-2028 Community Health Improvement Plan

August 2022



Photo Credit: Colin Lloyd

Summit County

Community Health Improvement Plan

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Suggested Citation: OMNI Institute (2022). Summit County Community Health Improvement Plan. Submitted to Summit County Public Health & St. Anthony Summit Medical Center, Summit County, Colorado.

Summit County

Community Health Improvement Plan

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Supplemental Documents:

- Completed Implementation Plans for each Strategy

Executive Summary

Summit County Public Health and St. Anthony Summit Medical Center are pleased to present the 2023 – 2028 Community Health Improvement Plan (CHIP), a strategic framework for identifying and linking community assets, leveraging expertise and resources, and enhancing initiatives already underway to create a community that is healthy, prosperous, and sustainable.

Following the guidance and requirements of the Colorado Health Assessment and Planning System (CHAPS) and requirements of non-profit hospitals, the Community Health Needs Assessment (CHNA) and 2023-2028 CHIP were conducted and developed over a span of 7 months. The plan was informed by data and priority health concerns identified by over 300 respondents to a survey and subsequent community conversations with local leaders and residents. Full results from the 2022 CHNA can be viewed on the [Summit County Public Health website](#).

The 2022 CHNA and CHIP processes occurred in the context of unprecedented times for modern public health: in the midst of the COVID-19 pandemic. Summit County came together to contain the disease, and to support our most impacted community members whose basic needs and health were drastically compromised. COVID-19 has shined a spotlight on the stark disparities that exist within our communities and confirmed the importance of the CHIP as a means to move toward more equitable health and well-being. The pandemic has underlined how crucial it is for us to work in collaboration if we hope to see improved outcomes for all. **The priorities identified in the 2023 – 2028 CHIP are the following:**



Inclusive Community: For all health improvement work in Summit County, there will be an overarching focus and intentional inclusion of populations with marginalized or oppressed identities (race, ethnicity, disability, LGBTQ+, religion, etc.) with the recognition that when an initiative, program, policy, or strategy is designed for people who are marginalized, everyone benefits.



Economic Livability

We aim to address the root causes and interrelated social determinants of health with a specific focus on housing, economic mobility, living wages, and childcare, as well as how these areas impact other key aspects of health, including food security and healthcare provider availability.



Behavioral Health

We aim to address both mental health and substance use across the spectrum from prevention, to harm reduction, treatment, and recovery.

We urge you to examine the goals, objectives, and strategies outlined in this plan to determine how you can enhance initiatives in your business, school, organization, faith community, and/or neighborhood to support this effort. Working together on aligned efforts and common goals will have the greatest impact. We look forward to a continued collaboration in the years ahead.

Together, we will build a healthier community!

Respectfully,

Amy Wineland, RN, MSN, ND
Director
Summit County Public Health

Lee Boyles
Chief Executive Officer
St. Anthony Summit Medical Center

Acknowledgements

Leaders from across Summit County contributed extensive time and expertise to the development of Summit County's 2023 – 2028 Community Health Improvement Plan. Summit County Public Health and St. Anthony Medical Center thank the following individuals for their role in developing this plan.

Robin Albert	Summit County Youth and Family Services
Jeanne Bistranin	The Summit Foundation
Lee Boyles	St. Anthony Summit Medical Center
Lucinda Burns	Early Childhood Options
Jason Dietz	Summit County Housing Authority
Elizabeth Edgar	Summit School District
Jaime FitzSimons	Summit County Sheriff
Lauren Gilbert	Summit County Public Health
Lt. Daric Gutzwiller	Summit County Sheriff's Office, S.M.A.R.T Program
Ruby Hornback	Summit County Sheriff's Office, S.T.A.R.R. Program
Taylor Jamieson	St. Anthony Summit Medical Center
Jennifer McAtamney	Building Hope
Inger McDonald	Summit County Sheriff's Office, S.M.A.R.T Program
Danielle McQueen	Family and Intercultural Resource Center
Tema Nnamezie	St. Anthony Summit Medical Center
Don Parsons	Community Member
Tamara Pogue	Summit County Commissioner
Helen Royal	Summit Community Care Clinic
Mackenzie Russo	St. Anthony Medical Center
Lindsay Simbeye	Colorado Consortium for Prescription Drug Abuse Prevention
Sylvia Simms	Summit County Sheriff's Office, S.T.A.R.R. Program
Noelle Sivon	Early Childhood Options
Brianne Snow	Family and Intercultural Resource Center
Joanne Sprouse	Summit County Human Services
Bryan Trujillo	Centura Health
Sarah Vaine	Summit County
Lorie Williams	Summit County Community and Senior Center
Amy Wineland	Summit County Public Health

Thank you!

The Summit County CHIP at a Glance



Improve Economic Livability

To improve the economic livability for all, leverage resources to provide systems-level solutions for local residents and the workforce, allowing them to access stable housing, living wages, childcare, and food needs.



Improve Behavioral Health*

To improve behavioral health for all, foster a community where residents build healthy, stable (long-term), and supportive social connections and support networks where all people belong, are valued, and are able to access culturally-relevant behavioral health services when needed.



There is a **distinct interconnection between behavioral health and economic livability**, and an opportunity to leverage this overlap to address the shared root causes of both goals and create well-connected systems that understand and support the unique needs of residents and the workforce in Summit County.

Housing

- Identify and reduce barriers for the creation and preservation of attainable housing
- Build public and political support and work to implement policy change to generate sustainable funding to support creation and preservation of affordable housing options

Wages

- Provide education and awareness on the importance of having a truly livable income for all, and how this is connected to health outcomes

Food

- Address food insecurity by reducing barriers and coordinating a comprehensive and community-driven food system

Childcare

- Support a county-wide scholarship/ supplemental program for childcare tuition
- Bolster friends/family/neighbors (FFN) to increase childcare options, and support FFN in obtaining licensure (as desired)



Inclusivity is included via a Targeted Universalism¹⁰ approach: creating universal goals for the whole population and using strategies that focus on supporting groups of people who experience the biggest health disparities.

Connection

- Improve felt sense of connection among residents through providing and hosting diverse opportunities

Substance Use

- Implement initiatives to raise awareness of the impact of alcohol to build support for change
- Implement opioid misuse/abuse education, prevention, and harm reduction efforts
- Implement MAT program

Treatment & Crisis Response

- Expand and connect treatment and recovery services, including adding more culturally relevant treatment providers
- Support reintegration of people returning from treatment/crisis as they transition back into the community
- Support current work to improve connection between behavioral health services, including providing a 'warm hand off' after a crisis to improve ongoing support
- Increase and improve crisis response, including expanding the SMART program, and providing support for front-line staff and first responders after traumatic situations

* "Behavioral Health" includes both mental health and substance use disorder, and recognizes the interconnected nature of these two areas and the overlap in services and supports across the spectrum from prevention to treatment and recovery.

Summit County

Community Health Improvement Plan

This report includes Summit County's public health improvement goals for 2023 – 2028 and respective strategies to accomplish those goals. OMNI Institute prepared this report in 2022 for Summit County Public Health and St. Anthony Summit Medical Center.

Introduction

Every five years, all public health agencies in Colorado are required to follow the Colorado Health Assessment and Planning System (CHAPS) process and create a Community Health Improvement Plan (CHIP) for submission to the Office of Public Health Practice, Planning, and Local Partnerships. Summit County, Colorado's last CHIP was for 2017 - 2022.^{1,2} In 2022, Summit County Public Health and St. Anthony Summit Medical Center, Centura Health, partnered with [OMNI Institute](#) to conduct Summit County's Community Health Assessment (CHA) and this corresponding Community Health Improvement Plan for 2023 - 2028.

The Community Health Assessment process took place between February and May of 2022 and included comprehensive input from more than 300 community leaders and community members. This report is the corresponding Community Health Improvement Plan and details the CHIP process, goals, and strategies to be prioritized across community work in the public health system, as well as the Strategy Leaders and Implementation Plans for each strategy.

Collaborative Focus

While it is the role of the Public Health Department to lead community health improvement processes, the social determinants of health perspective, with a focus on addressing upstream and root causes, requires work far beyond that of the Public Health Department alone. With this in mind, this plan was developed with a collaborative perspective, specifically calling out areas where Public Health will be leading work alongside a wide spectrum of partners and other community organizations whose work has the opportunity to positively impact health for the Summit County community.

The collaborative nature of this CHIP is intentional and leverages the strengths of Summit County by tapping into the specific expertise of community partners. This approach also increases the likelihood of success in accomplishing the goals and strategies, as it leverages capacity and expertise from more organizations and experts in the community, harnesses the power of collaborative work to solve complex challenges, and generates shared accountability for moving the work forward.

Upstream and Root Causes Lens

The goals and strategies in this CHIP reflect an understanding that to prevent the burden of disease and reduce negative health outcomes, the public health system must focus on both "upstream" and "downstream" factors that affect health outcomes (see CHA report for more details). Acknowledging the strong connection between upstream factors and population health, this planning process intentionally integrated a strong upstream lens to identify the root causes of challenges the community is experiencing, alongside the more traditional downstream perspective, and identified goals and strategies along the spectrum to address both the current health needs of the community while also working towards systemic change that will impact prevention of negative health outcomes.

Planning Process

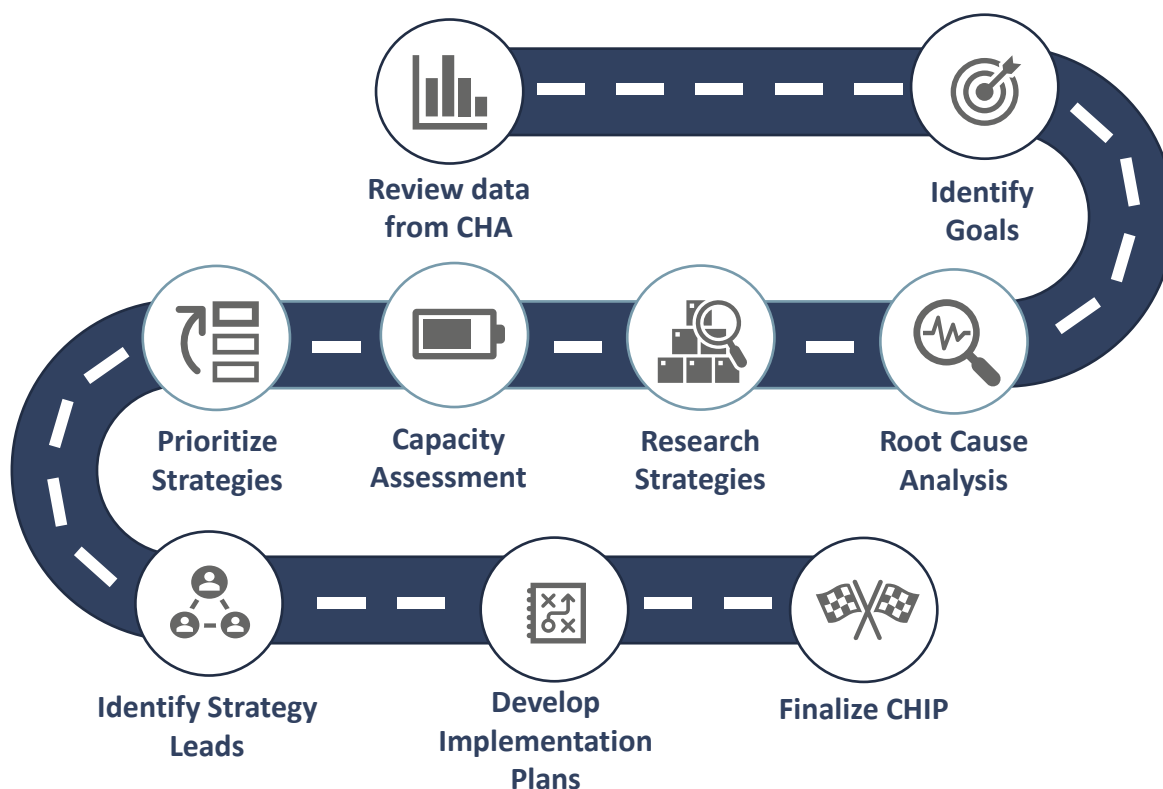
Decision-Makers: Steering Committee & Community Input

The Steering Committee was the primary decision-making body for this CHIP, and all contributors are listed in the Acknowledgements (page 5). The Steering Committee was comprised of members from the Summit County Health Care Collaborative, with the addition of leaders from organizations and groups across the county, community members, and representatives from the county government. A benefit of engaging a pre-existing group is that this Steering Committee will continue meeting beyond the development of this plan to support the ongoing implementation of the CHIP.

Significant community input was received through the assessment process, which heavily informed the decisions made by the Steering Committee. The top priorities the community identified in the assessment are represented as the top priorities in this plan. Focus groups provided additional nuanced information, and an open-house style Town Hall invited community members to provide feedback and input on strategies, especially the strategy around how to build connection within the community.

Process Overview

This section of the report details the planning process the Steering Committee underwent to develop this CHIP. Below is a high-level summary, followed by a more detailed explanation of each step.



Planning Process

Planning Process Synopsis

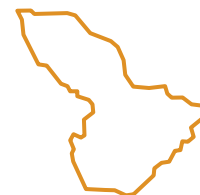
Using a collaborative approach, the Steering Committee worked through a series of steps to develop this Community Health Improvement Plan. Consensus decision-making was utilized for all major decisions, and various facilitation techniques, coupled with technological platforms (such as Padlet and Mentimeter), allowed for everyone to provide input, both during and in between meetings.

- **Review CHA Data.** Using a data gallery format, the Steering Committee reviewed and interpreted the CHA data, highlighting areas of concern, discussing what the data meant for the community, and identifying the interconnected nature of many of the data collection priority areas identified during the CHA.
- **Identify Goals.** Based on data and deep community knowledge, the Steering Committee engaged in collaborative goal-setting by prioritizing and merging interconnected issues, ultimately identifying two goals.
- **Root Cause Analysis.** Following identification of the goals, the Steering Committee conducted a root cause analysis for each goal, as well as the interrelated causes, to better focus strategies on remedying root causes while continuing to meet the immediate needs of the community.
- **Strategy Research.** The Steering Committee conducted research to identify potential strategies to address the goals, focusing on strategies shown to be effective at alleviating the root causes, strategies that would impact both goals areas, and strategies that address current community needs.
- **Capacity and Impact Assessment.** The potential strategies were analyzed on the current or potential capacity of the community to implement the strategy and the potential impact that strategy would have on alleviating priority health needs. Current efforts were also considered to avoid duplication and encourage collaboration.
- **Prioritize Strategies.** Based on the capacity and impact assessment, the Steering Committee used consensus decision-making to identify the top and final strategies to accomplish each goal.
- **Identify Strategy Leads.** For each prioritized strategy, specific positions within community organizations were identified to be the community leaders for these strategies. The Strategy Leads are responsible for ensuring work towards their strategy continues to move forward.
- **Develop Implementation Plans.** Strategy Leads developed Implementation Plans, which include data-focused measurable objectives, action steps, and community partners, for their respective strategies. A Targeted Universalism approach was integrated by identifying specific priority focus populations for each strategy.
- **Finalize CHIP.** Finally, all decisions and information generated throughout this process were compiled and refined into this report and supporting documents to inform and guide progress over the next 5 years.



Summit County Profile

Summit County is nestled in the Colorado Rockies and comprised of six municipalities—Blue River, Breckenridge, Dillon, Frisco, Montezuma, and Silverthorne. Breckenridge is the largest town, with a population of 5,078 in 2020, followed by Silverthorne (4,402), Frisco (2,913), and Dillon (1,064). Blue River and Montezuma each had a population of fewer than 1,000 residents in 2020. Overall, these six municipalities account for 47% of the county’s residents. The remaining 53% live in unincorporated areas.^{3,4}



Summit County is a popular tourist destination, with an estimated 2 overnight visitors per resident in the busy season (e.g., winter). Tourism has many impacts on the community, creating economic stimulation as well as contributing to wealth and housing disparities.⁵

Demographics

According to the 2020 Census Count, **31,055** people live in Summit County. Due to the unique nature of Summit County as a tourist destination, the seasonal nature of the workforce, as well as potential issues with the 2020 Census count, this population estimate, as well as the statistics cited from the 2020 Census below, should be viewed as estimates and may not fully reflect the characteristics of the population.⁶



20% of Summit County’s population lives in a **rural area**.⁷



14% of Summit County residents are **below 18 years old** (22% for Colorado).
13% of Summit County residents are **65 years or older** (15% for Colorado).⁷

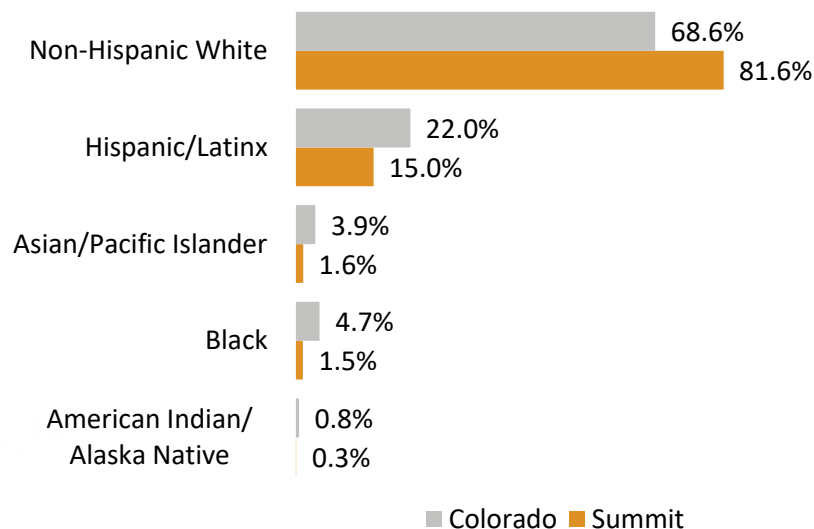


45% of Summit County’s population identifies as **female**⁷ (50% for Colorado; **47%** for Summit School District).⁸

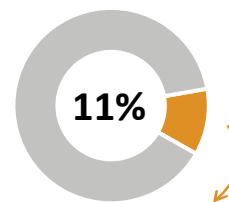


4% of Summit County residents are not proficient in English;⁷ **26%** of Summit School District Students are in the English Language Learner Program.⁸

The majority (81.6%) of **Summit County** identifies as non-Hispanic White, a larger share than **Colorado** overall (68.6%).^{7,a}



11% of Summit County’s population are foreign-born⁹



These individuals were born in:⁹

- 61% Latin America
- 23% Europe
- 8% Africa
- 5% Asia

Three-quarters of foreign-born residents are not United States citizens, and the majority (78%) entered the U.S. before 2010.⁹

^a: Population Estimates were used in lieu of 2020 census data.



2023 – 2028 Public Health Improvement Plan Overview

From the CHA process, the interconnected goals of Economic Livability and Behavioral Health emerged as the top areas to improve overall health and wellbeing in Summit County. For each of these goals, multiple priority areas from the CHA data were identified by Steering Committee as being so interconnected they could not be meaningfully separated (see graphics to the right). It was also recognized that working towards one area will create positive change in other areas.

These areas were prioritized by the Steering Committee as urgent, and also as interconnected root causes. For example, if the cost of housing is addressed and wages increase, Summit County will be able to attract and retain more behavioral health providers, which would then positively impact the overall behavioral health of the community. If childcare needs are met for everyone in the county, it would significantly reduce stress within families, and improve long-term behavioral health outcomes for youth.

As such, key data for each of these areas from the CHA were merged to reflect their interconnectedness and are presented here as background information for understanding the reasoning behind the selection of the goal areas.

In the following sections, an overview of key data, the public health improvement goal statement, and an exploration of the root causes are provided for each goal area.



Economic Livability

Interrelated Data Priority Areas

- Housing
- Wages
- Food Access
- Childcare
- Provider Availability



Behavioral Health*

Interrelated Data Priority Areas

- Substance Use
- Mental Health and Wellness
- Social Connection
- Provider Availability

* "Behavioral Health" includes both mental health and substance use disorder.



Inclusivity Lens - Targeted Universalism Approach

Inclusivity is central to this Community Health Improvement Plan. A Targeted Universalism approach¹⁰ is integrated throughout the CHIP goals and their associated strategies. The Targeted Universalism approach entails setting universal goals for an entire population while using 'targeted' strategies that are both open to all and focused on supporting groups of people who are the most negatively impacted by health disparities. For Summit County, this means addressing the goals of economic livability and behavioral health by centering the groups of people in the community who are most impacted by these areas when developing and implementing strategies: working from the grassroots up. Diverse identities, such as race, gender, ability/disability, citizenship status, work status, age, language, socioeconomic status, current sense of health and mental health, and more will be intentionally and equitably centered throughout the implementation of this plan.



Public Health Priority: Economic Livability Data

This section of the report summarizes data from secondary data sources and data collected via the CHA survey related to Economic Livability in Summit County.



Stable Housing

46%

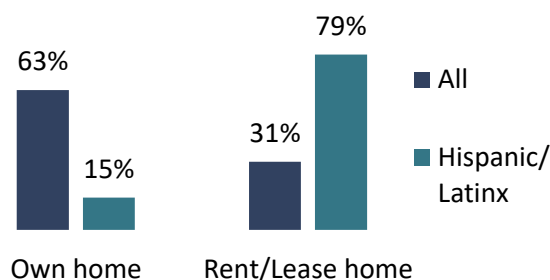
of CHA survey respondents think their monthly housing payment is **higher than what is affordable**.

15%



of Summit County adults are worried that in the next 2 months they may not have stable housing, compared to **7%** of all Coloradoans.¹¹

63% of all CHA survey respondents own their home, compared to **15%** of all **Hispanic/Latinx** respondents



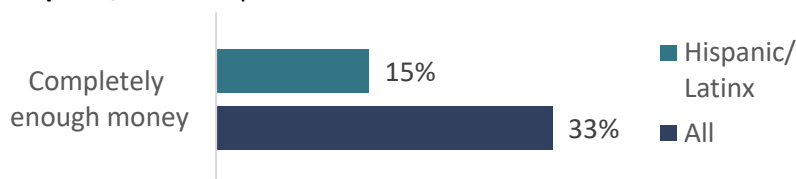
Living Wages

28%



of Summit County's Hispanic/Latinx children live in poverty, compared to **1%** of White children.¹²

33% of all CHA survey respondents indicated having **completely** enough money to meet their needs, compared to **15%** of **Hispanic/Latinx** respondents.

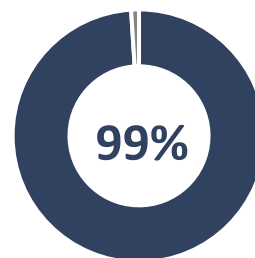
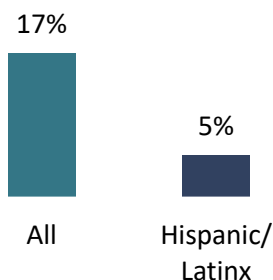


Food & Childcare

\$4.51

is the average cost of a meal in Summit County, compared to **\$3.35** in Colorado.¹³

17% of all CHA survey respondents indicated having **completely** enough money to meet their needs, compared to **5%** of **Hispanic/Latinx** respondents.



Of CHA survey respondents who are parents indicated that it is somewhat or very important for Summit County to focus on more childcare availability in the next three years.



Public Health Priority: Economic Livability Goal

Improve Economic Livability in Summit County

To improve the economic livability for all, leverage resources to provide systems-level solutions for local residents and the workforce, allowing them to access stable housing, living wages, childcare, and food needs.



Root Causes



Balancing Tourism & Workforce Needs

The glaring livability concerns in Summit County point to an uneven distribution of resources. There is a direct loop connecting the thriving tourism economy to the workforce that supports it; and, at a certain point, the unsustainable livability concerns of the workforce undermine the tourism economy when the workforce can no longer afford to live and work to support it. This connection underlines how vital it is for the economy and its residents to prioritize resource sharing before the tourism economy and the workforce become unsustainable.



Household Expenses Compound Stress

The interconnected pieces of economic livability - affordable housing, livable wages, childcare, and food access - all move together, meaning that a resident affected by one of these pieces is likely impacted by most or all of them. Furthermore, this interconnectedness means that residents may experience compounded stress and a sense of being overwhelmed trying to address so many challenges at once. It also means that by addressing one piece of the puzzle, inevitably progress will be made on the other pieces.



Housing Costs

Increasing housing costs demonstrate that wealth and abundance continue to flow into the community; however, its shift excludes many of the local residents and workforce from affording long-term housing. This is compounded by wage increases not keeping up with housing costs or the true cost of living in the county and is related to the nationwide trends of slow or stagnant wage growth despite increased profitability of corporations. Overall, economic livability concerns are the result of inequitable distribution of wealth and resources in the community, along with systemic wealth extraction from the community as a whole (i.e., resources leaving the community rather than circulating within the community). Addressing these root causes must center analysis of the current state of resource allocation and extraction in order to move towards equitable sharing of resources on a systemic level while also meeting the immediate needs of community members.



Public Health Priority: Economic Livability Strategies

This section of the report summarizes the strategies that will be implemented to accomplish the Economic Livability Goal, along with the leads who are responsible for moving the work forward and the data selected to measure impact by the end of 2028. *Please refer to the Implementation Plans in the supplemental documents of this report for more details, and to Appendix B for Indicator data sources.*

Strategy	Lead(s)	Indicators
Housing		
1. Identify and reduce barriers for the creation and preservation of attainable housing 2. Build public and political support and work to implement policy change to generate sustainable funding to support creation and preservation of affordable housing options	Summit County Housing Jason Dietz, Housing Director Supports: Vail Resorts, Breck Grand Vacations, Public Health, Housing Authority, Intergovernmental collaborations	• % of houses occupied by full-time residents • % of Summit residents worried that they might not have stable housing in the next 2 months • % of households that spend more than 50% of their income on housing • True cost of living • Average annual wages • Median household income
Wages		
Provide education and awareness on the importance of having a truly livable income for all, and how this is connected to health outcomes	Summit County Public Health Amy Wineland, Director Supports: Summit Foundation	• # of presentations given • # of people in attendance • # of community leaders educated • # of media-related data, such as impressions, # of ads/articles run, etc,



Public Health Priority: Economic Livability Strategies

Strategy

Lead(s)

Indicators

Food

Address food insecurity by reducing barriers and coordinating a comprehensive and community-driven food system (with multiple access points to no-cost community food and resources each day of the week)

Summit FIRC

Danielle McQueen, Outcome & Evaluation Director

Supports: Centura, Food Advocacy Organizations, Summit County Government, Summit Foundation, The Colorado Health Foundation, Vail Resorts

- Increase \$ of food distribution
- Decrease # of people experiencing food insecurity
- Decrease % of shoppers and school district families who report hunger
- Strengthening of local food system
- Increase in % of eligible residents enrolled in SNAP

Childcare

Support implementation of county-wide scholarship/supplemental program for childcare tuition

Early Childhood Options

Supports: To be identified

- % of families accessing tuition assistance
- # of children on waitlists combined with overall capacity/number of slots

Bolster friends/family/neighbors (FFN) to increase childcare options, and support FFN in obtaining licensure (as desired)

Early Childhood Options

Supports: Communities that Care Coalition

- # of licensed in-home daycare
- # of children on waitlists combined with overall capacity/number of slots



Public Health Priority: Behavioral Health* Data

This section of the report summarizes data from secondary data sources and data collected via the CHA survey related to the behavioral health status and care of Summit County residents.



Mental Health

Summit County's **mental health status** is poorer in comparison to national measures and Summit County's **mental health care** leaves certain community members without care.

50%

of CHA survey respondents said their **mental health was excellent or very good** in the past month.



46%

of Summit County adults report a high number of **poor mental health days** compared to **28%** of U.S. residents.¹⁴

28%

of CHA survey respondents reported they or a loved one **did not receive the mental health care they needed** in the past 12 months.



Substance Use

Summit County has a higher prevalence of binge drinking compared to Colorado overall, but a lower rate of drug overdose emergency department visits than Colorado overall. Community members report difficulty in accessing **substance use treatment services**.

27%

of CHA survey respondents reported **binge drinking alcohol** in the past month (5+ drinks for men and 4+ drinks for women), compared to **19%** of Coloradans.¹⁵



83%

of Summit County residents agree that **alcohol is important to social life for most people** in the community.¹⁴

8%

of CHA survey respondents indicated they or a loved one **did not receive the substance use disorder treatment they needed** in the past 12 months.



38%

of Summit County adults say there are times when they **lack companionship, feel left out, or feel isolated from others**.¹⁴

**"Behavioral Health" is a phrase that is used to include both mental health and substance use disorder, and recognizes the interconnected nature of these two areas and the overlap in services and supports across the spectrum from prevention to harm reduction, treatment, and recovery.*



Public Health Priority: Behavioral Health Goal

Improve Behavioral Health in Summit County

To improve behavioral health for all, foster a community where residents build healthy, stable, long-term, and supportive social connections and support networks where all people belong, are valued, and are able to access culturally-relevant behavioral health services when needed.



Connection to Services

Connection to behavioral health services continues to be a challenge, especially for community members experiencing the early warning signs of distress or crises. This is further complicated by low availability of providers, especially culturally-relevant providers, as well as systems navigation challenges.



Stigma

Stigma around recognizing and experiencing behavioral health challenges, both in relation to substance use and mental health as well as accessing services and supports, contribute to ongoing behavioral health challenges in the community. In addition to the general stigma that exists around behavioral health, the party culture and the social isolation further compound stigma in this resort community. The party culture tends to decrease the recognition of substance use challenges due to the normalization of high levels of use in social settings. The challenge of finding and maintaining meaningful social connections, often due to the transient nature of people in the resort community, also contributes to the ability to recognize and support residents in addressing behavioral health challenges.



Lack of Meaningful Social Connection

A lack of meaningful social connection results in many residents experiencing a level of social isolation that negatively impacts behavioral health. Challenges in the community include difficulty in building long-term relationships due to the transient nature of people moving in and through the resort community; many social settings being focused around (often White-centric) recreation and sports that require a high level of physical activity, ability, and financial commitment; and a built environment that lacks traditional neighborhoods in many areas and is geographically spread out.



Party Culture

A prominent party culture is prevalent in Summit County as is often the case in resort communities. Substances, especially alcohol, are central to most public events and activities, as well as integrated into many work-related and private/personal social settings. This leads to increased risk factors for substance use disorder, such as access to substances, a normalization of heavy use, and peer pressure to use substances to fit in.



Public Health Priority: Behavioral Health Strategies

This section of the report summarizes the strategies that will be implemented to accomplish the Behavioral Health Goal, along with the leads who are responsible for moving the work forward and the data selected to measure impact by the end of 2028. *Please refer to the Implementation Plans in the supplemental documents of this report for more details, and to Appendix B for Indicator data sources.*

Strategy	Lead(s)	Indicator
Connection		
Improve felt sense of connection among residents through providing and hosting diverse opportunities.	Building Hope Jennifer McAtamney, Executive Director Emily Steingart, Events Manager Supports: SMART team, community partnerships	• % of adults who are lonely • HKCS social connection data • % of adults who agree they can trust people in their community
Substance Use		
Implement initiatives to raise awareness of the impact of alcohol to build support for change	Building Hope Jennifer McAtamney, Executive Director Emily Steingart, Events Manager Supports: To be Identified	• % of adults reporting binge or heavy drinking • # of media campaign impressions, # of articles/ads • # of local detox admissions (local community members only)
Implement opioid misuse/abuse education, prevention, and harm reduction efforts	Summit County Public Health Amy Wineland, Director Supports: Sheriff's Office, Drug Take Back Task Force, Centura, Colorado Consortium for Prescription Drug Abuse Prevention	• # of drug overdose hospital admissions • # of drug overdose ER visits • # of local detox admissions • Pounds from Drug Take Back • Opioid prescribing decrease • # of media impressions
Implement Medication Assisted Treatment (MAT) program	St. Anthony Hospital / Centura Dr. Godwin (Tema) Nnamezie, Director Mission Integration and Community Health Supports: Sheriff's Office, Centura, Colorado Consortium for Prescription Drug Abuse Prevention	• # of overdose deaths • # of Nalaxone trainings and # of number of administered doses • # of MAT providers/types of MAT



Public Health Priority: Behavioral Health Strategies

Strategy

Lead(s)

Indicators

Treatment and Crisis Response

Expand and connect treatment and recovery services, including adding more culturally relevant treatment providers	Building Hope Jennifer McAtamney, Executive Director Supports: FIRC, Colorado Consortium for Prescription Drug Abuse Prevention, Care Clinic, Summit Wellness Hub	• % of adults with frequent mental distress • % of residents with high number of poor mental health days • Total mental health ED hospitalizations per 100,000 population • HKCS suicide statistics
Support reintegration of people returning from treatment/ crisis as they transition back into the community	S.M.A.R.T. Program, Summit County Sheriff's Office Lt. Daric Gutzwiller Supports: Building Hope, Centura, Care Clinic, FIRC (navigation), Summit Wellness Hub, High Country Healthcare	• % of adults with frequent mental distress • % of residents with high number of poor mental health days • Total mental health ED hospitalizations per 100,000 population • HKCS suicide statistics
Support current work to improve connection between behavioral health services, including providing a 'warm hand off' after a crisis to improve ongoing support	Building Hope Jennifer McAtamney, Executive Director Supports: SMART, Centura, Care Clinic	• % of adults with frequent mental distress • % of residents with high number of poor mental health days • Total mental health ED hospitalizations per 100,000 population • HKCS suicide statistics
Increase and improve crisis response, including expanding the S.M.A.R.T. program, and providing support for front-line staff and first responders after traumatic situations	S.M.A.R.T. Program, Summit County Sheriff's Office Lt. Daric Gutzwiller Supports: Building Hope, Centura, Care Clinic	• % of adults with frequent mental distress • % of residents with high number of poor mental health days • Total mental health ED hospitalizations per 100,000 population • HKCS suicide statistics



Interconnection: Economic Livability & Behavioral Health

Economic Livability and Behavioral Health are Interconnected

There is a distinct interconnection between behavioral health and economic livability, and an opportunity to leverage this overlap to address the shared root causes of both goals and creating well-connected systems that understand and support the unique needs of residents and the workforce in Summit County.



Wealth Disparity & Shame

When resources are not equitably shared, residents and the workforce witness wealth and material success daily, but may not experience it. This wealth disparity may create a perceived sense of failure or feelings of shame when the expectation of 'success' is pinned to obtaining a level of wealth (i.e., owning a home), despite this not being the reality for most. As a result, people are less likely to seek the behavioral health support they need to live well and are less likely to connect with others in the community about their challenges, which would support the normalization of the challenges so many face when living here. When there appears to be no solution to these struggles, people may choose to move away (contributing to the continued transient community issues) or turn to risky behavior, such as substance use, as an escape.



Paradise Paradox

The "Paradise Paradox" is a unique overlap between mental health and economic livability. Many people choose to relocate to Summit County as a 'paradise', hoping the change will improve their mental health. However, they soon discover that while some things may be better, the stress of economic livability challenges here, along with the potential of the change in location not addressing their original mental health concerns, their life has not improved as much as expected. The cycle of shame and a sense of failure at not achieving their goal of improving their life, coupled with the additional financial stress and the inherent loss of social support related to relocation, generate the "paradise paradox".



Implementation Plan Overview

Overview & Approach

This CHIP is supplemented by Implementation Plans for each identified strategy. Through a collaborative approach, community leaders volunteered to take the lead on strategies that best fit their current scope of work and align within their sector of community health. While Public Health, St. Anthony Summit Medical Center, and other community leaders will all play supportive roles in driving the work forward; the Strategy Leads will use their expertise to guide the community to achieve the outcomes on each strategy. This guiding process starts with Strategy Leads building the Implementation Plans for each strategy and identifying the indicator data used to track progress and outcome targets. Throughout the next five years, Strategy Leads will continue to revisit Implementation Plans and oversee the activities for each strategy.

The following sections outline the parts of the Implementation Plan each Strategy Lead completed.

Please see Appendix A for the Implementation Plan Instructions and Template.

Please see Supplemental Documents for completed Implementation Plans for each strategy.

Indicator Data

Several indicator data points were chosen for each strategy to measure change over time. These chosen indicators were chosen due to their availability to establish baseline data and/or because a Strategy Lead pointed out the value it would bring to measure root cause changes to the strategy. *See Appendix B for the Indicator Data.*

Objectives

Based on the Indicator Data, each Strategy Lead defined SMART (Specific, Measurable, Achievable, Realistic, Time-bound) objectives that operationalize how they will carry out the strategy. These objectives will guide the rest of the work in the Implementation plan.

Reach/Focus Population & Targeted Universalism

In this section of the Implementation Plan, Strategy Leads name the group(s) they plan to directly impact in the strategy. This may include community engagement efforts or community partnership efforts. Example reach/target populations may be new residents to Summit County, marginalized or at-risk groups, etc.

Targeted Universalism describes the overarching goal of centering inclusivity throughout the plan. In the Implementation Plan this section asks each Strategy Lead to explicitly consider how they will use the Targeted Universalism approach by focusing their work on serving groups of people most negatively impacted by the challenges and disparities related to their strategy. Target Universalism may look unique for each strategy. It may include finding ways to give voice and power to people who haven't historically had a voice in making changes on a strategy. It might include building services or offerings specifically with the most marginalized groups in mind. It might look like building a bottom-up approach to serving the community in a strategic area.



Implementation Plan Overview

Roles

In the Implementation Plan, one of the first activities to complete is defining roles and supporters to accomplish the objectives. Below are types of supports that the Strategy Lead will identify while building out the plan:

- **Strategy Lead(s):** Strategy Leads are the people and organizations who are responsible for moving the strategy forward in a collaborative and inclusive way. This includes meaningfully incorporating the voices of contributors (see below for this role) in the process, building buy-in and support for the strategy, and generally paving the way for the strategy to move forward. Strategy Leads may not be responsible for doing all the work, but they are responsible for coordinating the efforts of everyone working on the strategy and ensuring tasks are completed in a timely manner. The Strategy Lead is also responsible for leading the team through challenges and barriers that arise in the process.
- **Contributor(s):** Contributors are people and organizations who will be sharing information and ideas, contributing to the work required to move the strategy forward as guided by the Strategy Lead, making recommendations, and guiding the strategy. Contributors for every strategy will include people and organizations who will ultimately be impacted by the decision, and a Targeted Universalism approach should inform who are recruited as contributors to the process.
- **Decision Maker(s):** Decision-makers are the people, organizations, and positions who hold the power to make the decisions for the strategy, such as approving a final proposal or adopting a policy.
- **Performer(s):** After decisions are made, the performers are the people who are putting the strategy into practice. This may include developing new protocols, policies, or practices, gathering and integrating feedback on the impact, or more.

Action Plan

The Action Plan details specific, concrete steps that need to be done to accomplish the strategy and objectives. Together, they lay out a plan for how the strategy will be accomplished and outline how all the moving parts fit together to reach the end goal. These steps are developed by the Strategy Lead in partnership with the Contributors, as appropriate. The Action Steps for each strategy will be custom and specific to that strategy. The chart below demonstrates the format for the action plan.

Activity	Timeline	Lead	Resources Needed	Updates



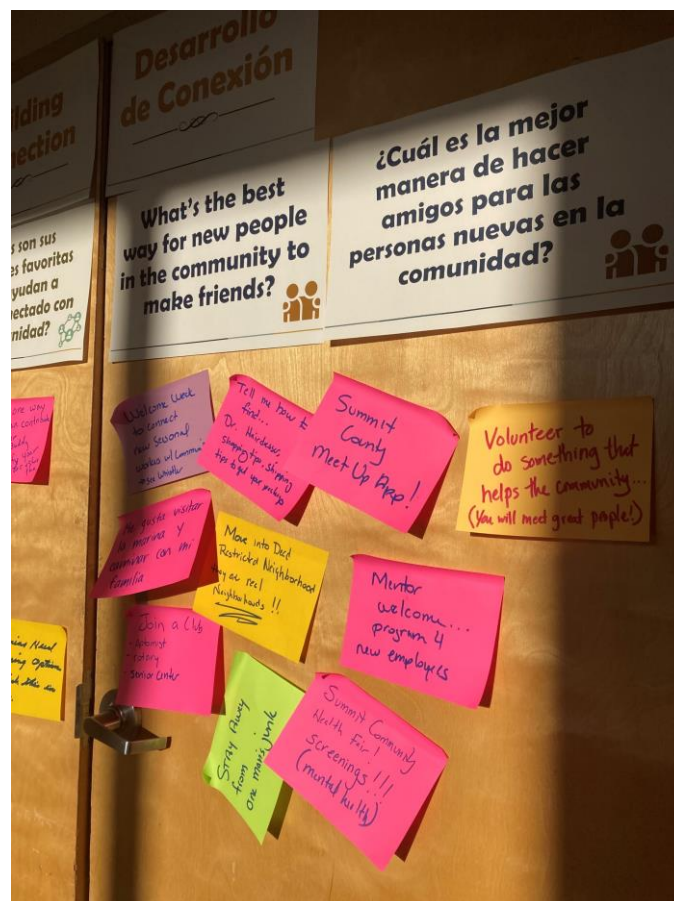
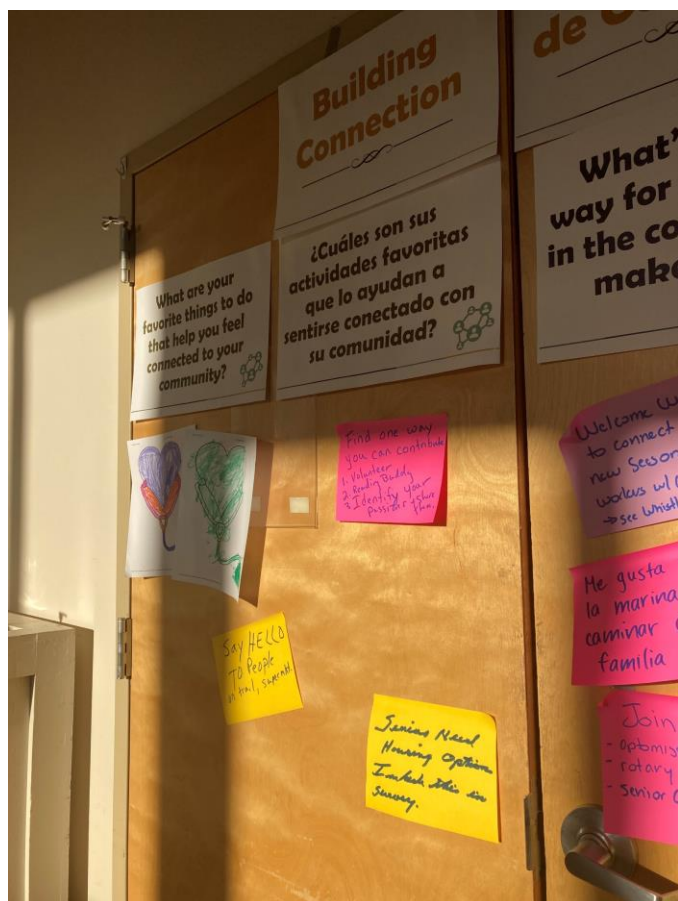
Conclusion and Next Steps

This Community Health Improvement Plan report marks a beginning on Summit County's journey toward improving economic livability and behavioral health in the community over the next five years. Both goals connect and expand upon work that has been ongoing in the community over many years, and objectives and strategies are designed to further collaboration, magnify existing efforts, and fill gaps and areas of need that are currently present.

Summit County Public Health and St. Anthony's Summit Medical Center have long been champions of collaborative partnerships to enhance and improve the health of our community and we are grateful to the partners across the county who continue to share their time, effort, and expertise in the public health system.

Next Steps

The implementation on this Community Health Improvement Plan will continue to be guided through the ongoing work of the Summit County Health Care Collaborative where we will continue in partnership to make a difference for the health and well-being of our community.



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Appendix A: Implementation Plan Instructions

Implementation Plan Overview

Developing an Implementation Plan improves the efficiency and effectiveness of your efforts to accomplish a strategy. The benefits of developing an Implementation Plan include:

- Increasing accountability
- Ensuring your work is directly aligned with the strategy
- Providing clarity to everyone involved as to the process and expectations
- Supporting the work being completed as efficiently as possible
- Identifying challenges and barriers that need to be addressed to move the strategy forward
- And more!

Overall, the Strategy Lead is responsible for completing the Implementation Plan and tracking the progress towards completion. As this is a plan and is likely to change as you move into the work, this 'living' document will also change and adapt. The Strategy Lead is in charge of updating the Implementation Plan as needed.

Measurement

For each strategy to be measured for success, the Strategy Lead will define and narrow the indicators, objectives, and reach/target populations.

- **Indicator:** Draft indicator data has already been chosen and populated into each individual implementation plan. These indicators will be used to measure the changes in the objectives. Strategy leads will decide which indicator data will best match the strategy and objectives. For more details, see Indicator Data Appendix.
- **Objective:** Craft SMART objective(s) (Specific, Measurable, Achievable, Realistic, Time-bound) that will operationalize how you will carry out the strategy. Use indicator data to set Objectives.
- **Reach/Target population:** Name the group(s) you are directly impacting in each strategy. This may include community engagement efforts or community partnership efforts. Example reach/target populations may be: working class citizens, new residents to Summit County, marginalized or at-risk groups, etc.

Roles

The plan for each strategy also identifies 4 main roles:

- **Strategy Lead(s):** Strategy Leads are the people and organizations who are responsible for moving the strategy forward in a collaborative and inclusive way. This includes meaningfully incorporating the voices of contributors (see below for this role) in the process, building buy-in and support for the strategy, and generally paving the way for the strategy to move forward. Strategy Leads may not be responsible for doing all the work, but they are responsible for coordinating the efforts of everyone working on the strategy and ensuring tasks are completed in a timely manner. The Strategy Lead is also responsible for leading the team through challenges and barriers that arise in the process.

Appendix A: Implementation Plan Instructions

Roles (cont'd)

- **Contributor(s):** Contributors are people and organizations who will be sharing information and ideas, contributing to the work required to move the strategy forward as guided by the Strategy Lead, making recommendations, and guiding the strategy. Contributors for every strategy will include people and organizations who will ultimately be impacted by the decision, and a Targeted Universalism approach should inform who are recruited as contributors to the process.
- **Decision Maker(s):** Decision-makers are the people, organizations, and positions who hold the power to make the decisions for the strategy, such as approving a final proposal, adopting a policy, ect.
- **Performer(s):** After decisions are made, the performers are the people who are putting the strategy into practice. This may include developing new protocols, policies, or practices, gathering and integrating feedback on the impact, or more.

Action Plan

The Actions Plan details specific, concrete steps that need to be completed to accomplish the strategy. Together, they lay out a plan for how the strategy will be accomplished and show how all the moving parts fit together to get to the end goal. These steps are developed by the Strategy Lead in partnership with the Contributors, as appropriate. The Action Steps for each strategy will be custom and specific to that strategy.

Overall, each action step should be concrete, clearly describing the specific action or decision that needs to be taken or made. Each Action Step should also be distinct and singular, meaning it will be clear when the action is complete and there is only one action listed. This helps support clear status updates. For example, “Develop and implement a social media campaign” is not distinct or singular. Once you have developed the campaign, you won’t be able to mark this as complete until you implement the campaign. And does ‘implement’ mean you start the campaign or finish it? A better way to list this might be “Develop all materials/digital assets needed for social media campaign”, “Launch social media campaign”, “Sustain social media campaign through completion”.

You may opt to group Action Steps together under a header to help provide clarity, such as:

Develop and implement a social media campaign:

- *Develop all materials/digital assets needed for social media campaign*
- *Launch social media campaign*
- *Sustain social media campaign through completion*

Timeline

Each Action Step needs to have a timeline associated with it. This indicates when that Action Step is expected to be finished. The timeline helps to coordinate the activities you are doing, especially if you are doing multiple things at once and a number of different people are contributing to the work. When setting timelines, please consider the true capacity needed to complete the action step alongside competing demands for resources to help you set realistic timelines. Oftentimes, unforeseen barriers and challenges arise that force the timelines to be adjusted.

Appendix A: Implementation Plan Instructions

Resources Needed

This section indicates the resources needed for each Action Step. These can, and should, include funding, human capacity, time and skills, as well as physical resources such as building space or food for meetings. Delineating the resources needed can help identify where resources might be missing and need to be gathered in order for the strategy to be a success, and can also help inform the timeline. Additionally, understanding what resources were used to accomplish the strategy on the back end can be helpful information to have for future efforts.

Status

The status for each Action Step in the plan is used to track progress throughout the process. This creates a level of accountability, helps in communication across the team, and supports the work in continuing to move forward.

The status for each Action Step for each strategy will be updated every 3-6 months by the Strategy Lead and reported to the Health Care Collaborative and Public Health. Status options include:

- Not started
- In progress
- Stalled – needs attention!
- Started, but paused
- Completed

The Strategy Lead should regularly check in on the status of Action Items, especially those with deadlines that are nearing. This will allow the early identification of barriers and challenges that need to be addressed.

Appendix A: Implementation Plan Template

Goal 1: *[Goal listed here]*

[goal description listed here]

Strategy:	
Indicators:	Objectives:
Reach/Target Population:	
Targeted Universalism: How will you use the targeted universalism in your approach for this strategy? (See goals and strategies document for full definition)	
Roles: • Strategy Lead(s): • Contributor(s): • Decision Maker(s): • Performer(s):	
Action Plan: <i>See Table Below</i>	

Action Plan

Activity	Timeline	Lead	Resources Needed	Updates

Appendix B: Indicator Data Sources

Economic Livability

Strategy	Indicator	Source	Baseline Data
Housing	1. % of houses occupied by full-time residents 2. % of Summit residents worried that they might not have stable housing in the next 2 months 3. % of households that spend more than 50% of their income on housing 4. True Cost of Living 5. Average Annual wage 6. Median household Income	1. TBD 2. Colorado Health Institute's The Colorado Health Access Survey 3. TBD 4. TBD 5. Northwest Colorado Council of Governments - Economic Data by County 6. U.S. Census, American Community Survey	1. TBD 2. 14.5% in 2019 3. TBD 4. TBD 5. \$51,792 in 2022 6. \$80,709 from 2016-2022
Wages	1. # of presentations given 2. # of people in attendance 3. # of community leaders educated 4. # of media-related data, such as impressions, # of ads/articles run, etc.	1-4. Process Data to be tracked by Strategy Leads	N/A
Food	1. Increase \$ of food distribution 2. Decrease # and % of people experiencing food insecurity 3. Decrease % of shoppers and school district families who report hunger 4. Strengthening of local food system 5. Increase in % of eligible residents enrolled in SNAP	1. Summit County Food Coalition Community Survey (2022) 2. Feeding America 3. Community Food Coalition Survey (2020) 4. See Implementation Plan 5. Feeding America	1. TBD 2. 9.8% in 2020, 2,970 people 3. 24% in 2020 4. See Implementation plan 5. TBD

Appendix B: Indicator Data Sources

Economic Livability

Strategy	Indicator	Source	Baseline Data
Childcare	1. % of families accessing tuition assistance 2. # of children on waitlists combined with overall capacity/number of slots	1. TBD 2. TBD	1. TBD 2. TBD
	1. # of licensed in-home daycare 2. # of children on waitlists combined with overall capacity/number of slots	1. Colorado Office of Early Childhood - Licensed Child Care Facility Lists 2. TBD	1. 41 in 2022 2. TBD

Appendix B: Indicator Data Sources

Behavioral Health

Strategy	Indicator	Source	Baseline Data
Connection	1. % of adults who are lonely 2. HKCS social connection data 3. % of adults who agree they can trust people in their community	1. 2020 PRC Community Engagement and Behavioral Health Survey Report 2. Healthy Kids Colorado Survey: High School & Middle School 3. NORC - Katz Amsterdam Foundation	1. 38.1% in 2020 2. TBD 3. 77% in 2022

Appendix B: Indicator Data Sources

Behavioral Health

Strategy	Indicator	Source	Baseline Data
Substance Use	<i>Implement initiatives to raise awareness of the impact of alcohol in the community to build support for change:</i>	NORC - Katz Amsterdam Foundation - Process Data to be tracked by Strategy Leads - TBD	20% in 2022 - N/A - TBD
	% of adults reporting binge or heavy drinking # of media campaign impressions, # of articles/ads # of local detox admissions (local community members only)		
	<i>Implement opioid misuse/abuse education, prevention, and harm reduction efforts</i> - Age-adjusted rate of drug overdose hospital admissions - Age-adjusted rate of drug overdose ER visits # of local detox admissions - Pounds from Drug Take Back events - Age-adjusted rate of opioid stimulant prescriptions - Age-adjusted rate of opioid analgesic prescriptions # of media impressions	CDPHE CoHealthViz CDPHE CoHealthViz - TBD - Drug Take Back Event Process Data CDPHE CoHealthViz - Process Data to be tracked by Strategy Leads	41.9* in 2020 119* in 2020 - TBD - TBD 128.2/1,000 240.5/1,000 - N/A *Rate per 100,000
	<i>Implement MAT (Medication assisted treatment) program:</i> # of overdose deaths # of Nalaxone trainings and # of number of administered doses # of MAT providers/types of MAT	- CDPHE CoHealthViz (link above) - Process Data to be tracked by Strategy Leads - TBD	11.2 in 2020 (rate of drug overdose deaths due to any drug per 100,000) - N/A - TBD

Appendix B: Indicator Data Sources

Behavioral Health

Strategy	Indicator	Source	Baseline Data
Treatment and Crisis Response	Indicators for all 4 strategies: 1. % of adults with frequent mental distress 2. % of residents with high number of poor mental health days 3. Total Mental Health ED Hospitalizations per 100,000 population 4. HKCS suicide statistics • Percent of high school students who seriously considered attempting suicide during the past 12 months • Percent of middle school students who ever seriously thought about killing themselves • Percent of high school students who attempted suicide one or more times during the past 12 months • Percent of middle school students who ever tried to kill themselves 5. Ratio of individuals to mental health providers	1. County Health Rankings: Behavioral Risk Factor Surveillance System 2. 2020 PCR Community Engagement & Behavioral Health Survey Report 3. St. Anthony Summit Medical Center 4. Healthy Kids Colorado Survey (High School & Middle School) 5. County Health Rankings: CMS, National Provider Identification	1. 11.0% in 2018 2. 46.3% in 2020 3. 1,428 in 2021* 4. HKCS: • 15.8% in 2021 • 17.9% in 2021 • 5.7% in 2021 • 6% in 2021 5. 316:1 in 2018 *Baseline data provided by Centura Health (2022)