

PUEBLO COUNTY 2024 JOINT COMMUNITY HEALTH ASSESSMENT

July 2024, Adopted by Pueblo County Board of Health on July 24, 2024



Figure 1: "Final Balloon" - Image made available through Share Pueblo, a collaboration to make content of Pueblo available for free for marketing.

Pueblo Department of Public Health and Environment

In partnership with:

UCHealth Parkview Medical Center

CommonSpirit St. Mary Corwin Hospital

Pueblo Community Health Center

Health Solutions

Table of Contents

Description of Pueblo County	3
Methodology.....	5
Phase One: Planning the Process.....	6
Timeline Alignment.....	6
Data Alignment	6
Accreditation.....	6
CHAPS Planning Phases for Community Assessments.....	6
Phase Two: Ensuring Equity and Community Engagement	7
Community Engagement	7
Equity	8
BARHII Framework.....	8
Phase Three: Conducting the Assessment.....	9
Secondary Data Collection	9
Community Member Survey	10
Community Member Focus Groups.....	10
Community Events	10
Phase Four: Assessing Capacity	11
Phase Five: Prioritizing Issues	12
Step One: Initial Joint CHA health priority guidelines.....	14
Step Two: Internal PDPHE Prioritization of Secondary Data	14
Step Three: Advisory Team Prioritization of Secondary Data.....	15
Step Four: Community Leader Survey	15
Step Five: Final Advisory Team Prioritization.....	16
Results.....	19
Mental Health	20
Secondary Data	20
Community Leader Assets & Gaps.....	22
Community Member Results	22
Risky Behaviors/Substance Use	26
Secondary Data	26
Community Leader Assets & Gaps.....	27
Community Member Results	27

Constraints & Evaluation 30
 Internal Process Evaluation..... 30
 External Partner Evaluation 30
Acknowledgments..... 31
Works Cited..... 32

Description of Pueblo County

Located in southeastern Colorado, Pueblo County is home to an estimated population (2020) of 168,162 residents (Pueblo County GIS, 2019). With a land area of 2,386.20 square miles Pueblo County is the 13 largest county in Colorado (United States Census Bureau, 2024). Pueblo County consists of 10 communities spanning from the southern Front Range and Wet Mountains in the West to the Arkansas River Valley and Great Plains in the East. Communities in Pueblo County are included in the information list below, Pueblo City neighborhoods displayed in figure 2 and Pueblo County communities displayed in figure 3.

- Avondale
- Beulah Valley
- Blende
- Boone
- Colorado City
- Pueblo City
- Pueblo West
- Rye
- Salt Creek
- Vineland

Historically Pueblo County has been home to generations of industrial and agricultural entrepreneurs who value culture, connection, and belonging deeply. The community holds deep Hispanic/Latinx roots due to the Arkansas River acting as the first U.S./Mexico border and hub for trade. This culture is complemented by a rich diversity of people who came to Pueblo to work in the Steel Mill operated by CF&I. Many of the neighborhoods displayed in the County map above were created generations ago and were influenced by cultural, financial, and language factors, as well as transportation hubs and business districts.

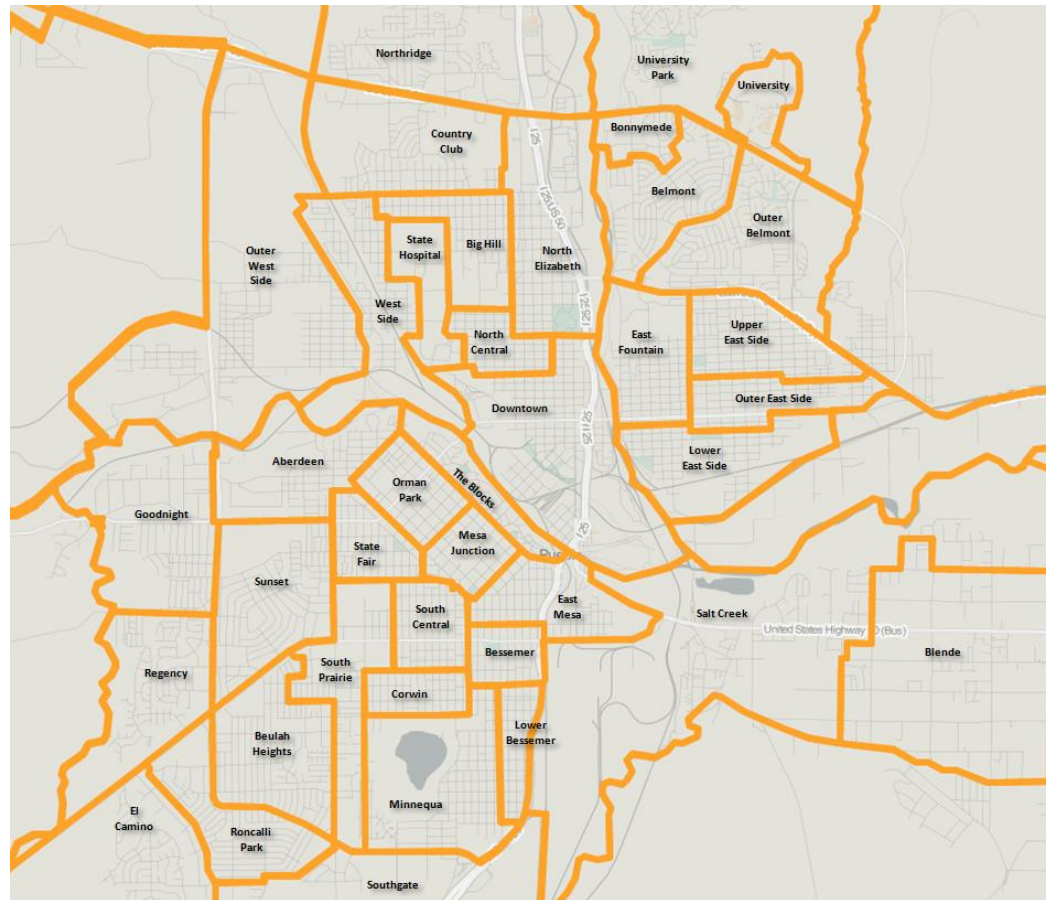


Figure 2: Image collected from “Geographical Perspectives”, local blog by CSU-P professor Justin Holman

Today, Pueblo County is known as the Steel City and Home of the Heroes. The community is comprised of 9.1% veterans, 16.2% of the County population speak a language other than English at home, the median household income is roughly \$58,723, 14.8% of the community live in poverty, over half of insured individuals use Medicaid or Medicare, and the employment rate is 51.7% (United States Census Bureau, 2024).

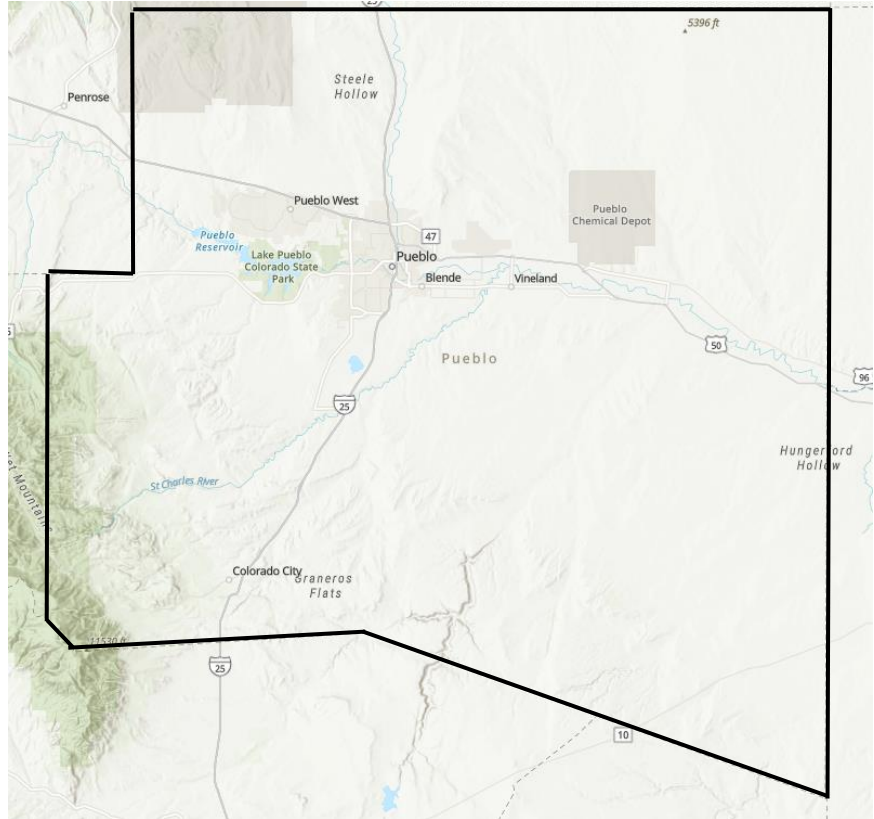


Figure 3: Image collected from Pueblo County GIS. Pueblo County boundary lines.

Methodology

Pueblo County’s joint CHA process spanned 11 months, from September 2023 through July 2024. Utilizing The Colorado Health Assessment and Planning System (CHAPS) (Colorado Department of Public Health and Environment, 2024), the framework provides guidance for Colorado public health agencies to develop community health assessments and community health improvement plans. The framework is supported by the Office of Public Health Practice, Planning, and Local Partnerships (OPHP) at the Colorado Department of Public Health and Environment (CDPHE), and this CHA occurred within five CHAPS phases:

1. Planning the Process
2. Ensuring Equity and Community Engagement
3. Conducting the Assessment
 - a. Secondary Data Collection
 - b. Community Leader Survey
 - c. Community Member Survey
 - d. Community Member Focus Groups
4. Assessing Capacity
5. Prioritizing Issues

For the 2024 joint CHA, CHAPS phases did not have firm start or end dates as some phases overlapped throughout the process and many happened simultaneously. The timeline in Figure 4 outlines key deadlines and objectives.

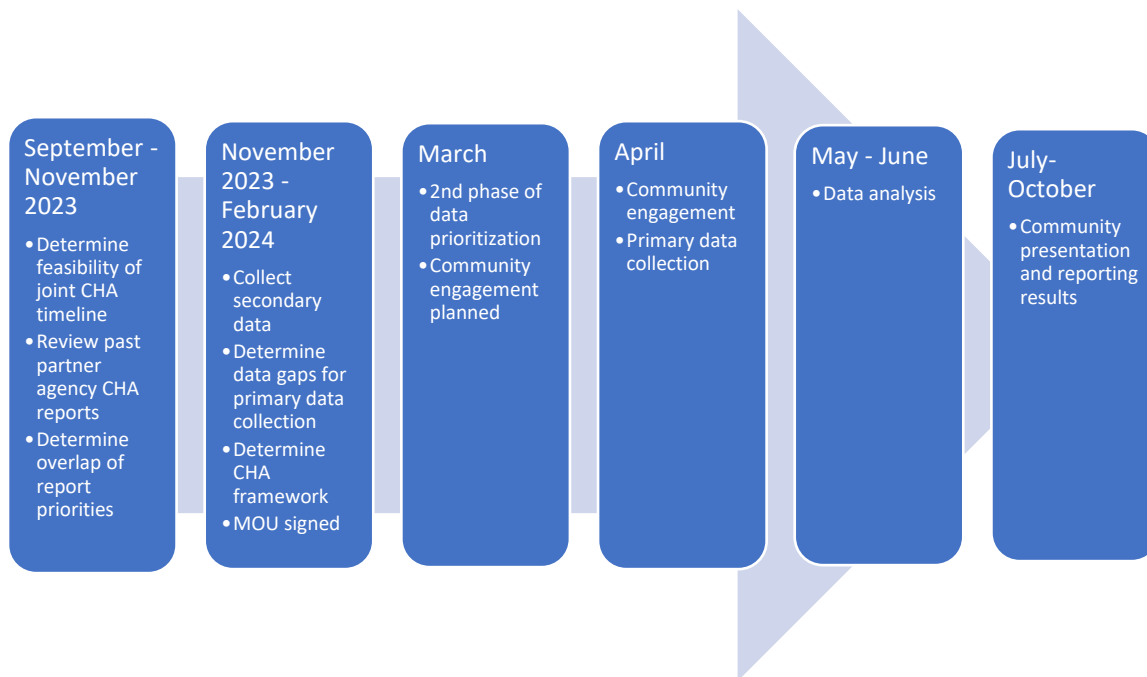


Figure 4: 2024 Joint CHA timeline with large tasks.

Phase One: Planning the Process

Starting in September of 2023, conversations began with the various health systems within Pueblo County about how a single joint CHA could be implemented. At first this collaborative started between PDPHE, UHealth Parkview (before the UHealth transition), and St. Mary Corwin (before the CommonSpirit transition). After the first three partners were interested in the collaboration, PDPHE staff reached out to Health Solutions and Pueblo Community Health Center (PCHC) to gauge interest. The partners expressed interest in collaborating, and meetings were arranged to start planning and determining feasibility.

Timeline Alignment

The first, and most important, step of the joint CHA was determining a single timeline. Historically, PDPHE and all public health entities need to conduct a CHA every five years. Since the last CHA was completed in 2021, this would mean that PDPHE was due for the next CHA in 2025. However, hospital systems are required to conduct a Community Health Needs Assessment on a three-year cycle determined by the Internal Revenue Service (IRS). Health Solutions was also working to align with new requirements which also require data collection and a health assessment. The idea of a joint CHA was exciting to Health Solutions as it would prepare them and meet their deliverable ahead of time. PCHC is also mandated to conduct community health needs and data collection on a timeframe similar to the hospital systems. As of September 2023, both hospital partners, Health Solutions, and PCHC needed to complete their next CHA/CHNA by the end of 2024 or the beginning of 2025. With the strong commitment of the four partners to conduct the first joint CHA, PDPHE agreed to come off cycle and conduct the CHA a year earlier than needed.

Data Alignment

All previous CHA reports from the partner agencies were collected and reviewed for overarching themes and data needs using an overlap matrix. The results demonstrated the majority of the CHA reports were similar in data leading to a conclusion that a collaborative CHA would meet the needs of all partners.

Accreditation

As an accredited public health department, PDPHE must participate in or lead a collaborative process resulting in a comprehensive community health assessment to learn more about community, specifically the health of the population, contributing factors to higher health risks, or poorer health outcomes of identified populations, and the community resources available to improve the health status. PDPHE staff reviewed the Public Health Accreditation Board Standards and Measures for community health assessment to ensure all necessary elements were addressed in the CHA process and are included in this report.

CHAPS Planning Phases for Community Assessments

As shown in figure 5, the eight phases of CHAPS supported the organization of the joint CHA. This integration is described in more detail in the “methodology” section of this report (pg. 5).

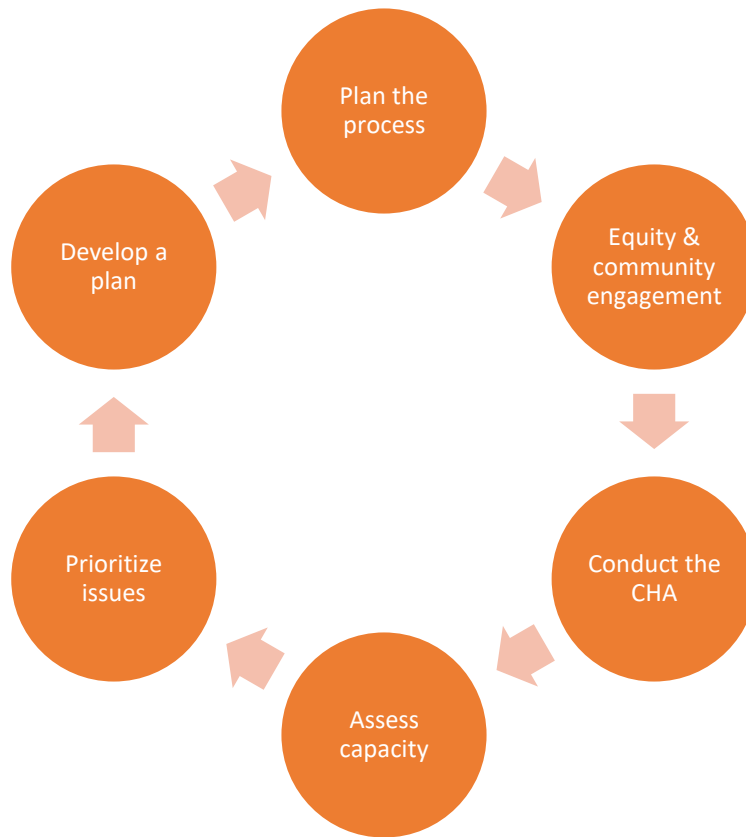


Figure 5: Eight CHAPS Phases for Community Health Planning, CDPHE

Phase Two: Ensuring Equity and Community Engagement

Community Engagement

The IRS required several of the partners to complete the CHA by June 2024. This left the advisory team and PDPHE’s internal team about six months to complete data collection, analysis, and reporting. To meet this deadline and still achieve a comprehensive data review, the PDPHE team suggested a two-pronged approach to community engagement – targeted outreach and community-wide survey collection.

The first strategy included outreach to targeted populations in the community that have historically been underserved or underrepresented in the data collection or needs assessments processes. These groups included: the Spanish speaking population, individuals living with disabilities, individuals experiencing unstable housing, young people (ages 0-25), and the aging population (approx. ages 60+).

The second strategy focused on sending out the community member survey to as many Pueblo County residents as possible through various avenues, explained in more detail in the “Phase Three: Conducting the Assessment” report section below.

Equity

Health equity was integrated into the 2024 joint CHA from the beginning and with the end in mind. All partners agreed that equity was an important aspect of the joint CHA and this motivated utilizing the BARHII framework for which equity is the foundation.

Additionally, the PDPHE Equity and Engagement Initiatives Coordinator participated on the internal planning and implementation team. With the coordinator's guidance, a community engagement plan (informed by best practices) and a motivational touchstone were created. Both documents ensured that the joint CHA incorporated diverse resident voice and was conducted with equitable goals in mind.

Joint CHA health equity in action included:

- Providing monetary incentives for time-intensive community engagement efforts.
- Providing material incentives for individuals that would benefit from supplies and life essentials.
- Meeting focus group participants where they already regularly met or congregated.
- Using a combination of community engagement methods to better accommodate individual populations' needs and daily life routines, such as focus groups, in-person surveying via conversation, paper surveys delivered to their homes, or sending the online survey link out via social media and emails.
- Providing in-person and virtual options for any community engagement and report-out presentations.
- Translating the community member survey and all promotional materials to Spanish.
- Having a Spanish speaker at Spanish-speaking focused community events.

BARHII Framework

The Bay Area Regional Health Inequities Initiative (BARHII) Framework was first introduced in California in 2002 to act as a "national engine for health equity thought leadership" (Bay Area Regional Health Inequities Initiative, 2002). The framework is to be used to transform communities' approach to public health practice and the continuum of prevention and care.

The BARHII Framework has been adapted and modified by the Pueblo County joint CHA team, shown in Figure 6 to guide equitable data collection and inform decision-making.

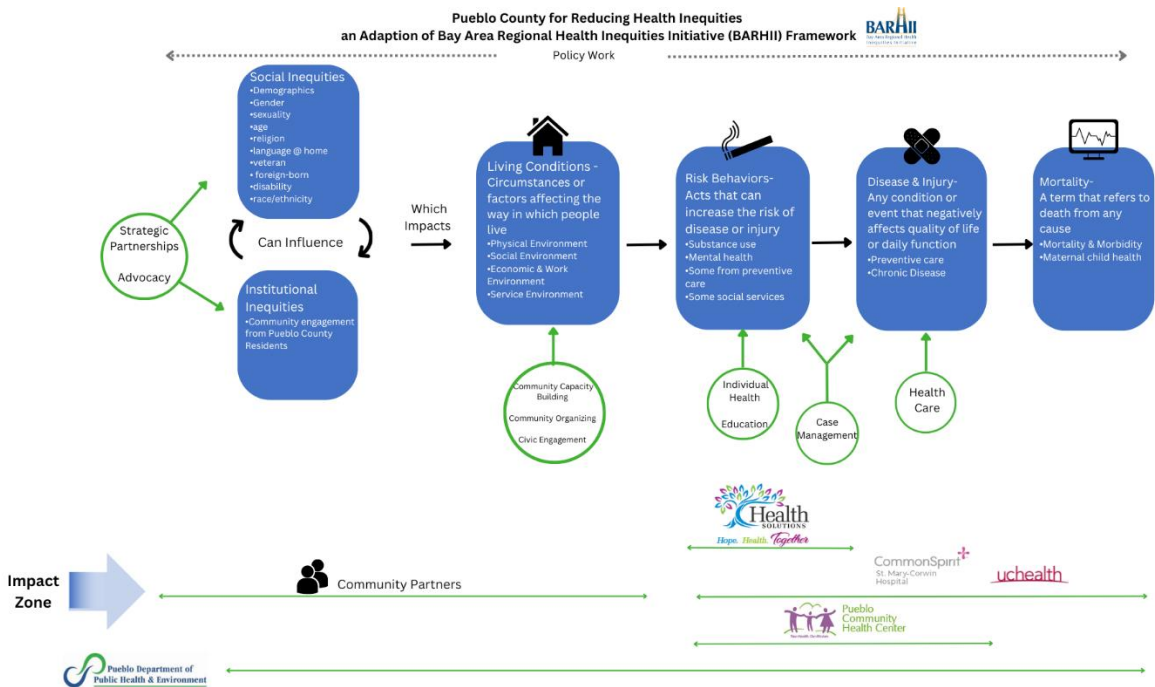


Figure 6: Pueblo County Adaptation of BARHII Framework.

Pueblo County’s BARHII visual displays the scope of each agency’s current services, programs, and community reach, labelled the “impact zone”. Strategies for prevention, intervention, and care are denoted through green circles. The six domains of the BARHII framework, described in the blue boxes, have not been altered and outline the aspects of individuals’ lives that impact their health potential and outcomes. These aspects range from influences within the community, risky behaviors in which they engage, to large-scale social inequities experienced throughout the world (examples).

The BARHII framework was integrated into the Pueblo County joint CHA via data prioritization criteria and community engagement strategies.

Phase Three: Conducting the Assessment

Secondary Data Collection

Using the data priorities identified through the overlap matrix process, various secondary data indicators were collected from available federal, state, and local sources. The collection of secondary data started in January 2024 and fully concluded in March 2024. In order to start the secondary data collection, the priorities set by the advisory team were overlapped with the health indicators list featured in Appendix C. This phase kicked off data collection and initiated the formation of PDPHE’s internal CHA team, which included the public health planner, data analyst, equity and engagement initiatives coordinator, area director, area program manager, and performance improvement coordinator. The PDPHE team met to dig through sources to collect the best data indicators, and determine what gaps in data would be beneficial to fill with primary data collection.

To begin, 110 separate data indicators were pulled and collected for multiple levels of prioritization. These indicators represented data on various topics including demographics, maternal and child health,

chronic disease, mortality and morbidity, preventative measures, behavioral health, and the social determinants of health according to Healthy People 2030 (U.S. Department of Health and Human Services, 2024). Additionally, economic and work environment, education, physical environment, and social context data were included in the analysis. A Colorado State University-Pueblo intern collected the actual data metrics from various accessible sites. The secondary data was also placed and categorized into the BARHII framework to support decisions about what data gaps required additional research.

Community Member Survey

The second community engagement strategy included a community member survey pushed out broadly throughout Pueblo County via social media, email lists, existing coalitions, clinic waiting rooms, in-person surveying at various locations, paper surveys mailed out, and attending community outreach events. Online survey participation was incentivized through an Amazon gift card drawing for each target population (aging individuals, Spanish-speaking population, and individuals living with disabilities).

A large aspect of the community member surveying included in-person surveying at various locations that support individuals experiencing unstable housing and the community's aging population. Because these individuals could possibly not have stable internet access, a home address, or ability to leave their homes, the PDPHE internal team decided that the best method would be to go to the agencies and locations that already support these population. The internal data collection team spent a full day at the Pueblo County Rescue Mission and another full day at the SRDA apartment complex. Incentives for participation at these locations ranged from a gift card drawing to goodie bags including daily essentials such as toothbrushes, socks, sexual health materials, and snacks.

Community Member Focus Groups

Outreach to the joint CHA target populations included facilitating three focus groups, meeting with a support group for individuals living with low vision, a support group for individuals living with a brain injury, and one larger focus group after a Senior Resource Development Agency (SRDA) congregate meal. The focus groups asked twenty-four community residents about their experiences living in the community and health priorities from their perspectives. Compensation was provided to each focus group participant at the conclusion of each session in the form of a Walmart gift card. Each of the three focus groups followed the same process and questions, ensured confidentiality, and was entirely voluntary.

Community Events

This community engagement targeted approach to the joint CHA primary data collection also included being very specific of which community events the PDPHE internal team attended. The events attended for joint CHA data collections included:

- Southern Colorado Youth Go (SoCoYoGo) Day
- Warrant Forgiveness Day
- Día de los Niños
- The PLACE Bessemer Block Party
- School District #60 Resource Day

Participation in the survey was incentivized at community events through a drawing for a partner promotional item basket. A basket for each community event was created by compiling promotional items from UCHHealth Parkview, PCHC, and various programs within PDPHE.

Phase Four: Assessing Capacity

The joint CHA team recognized and welcomed the use of capacity assessment activities throughout various phases of the assessment's data prioritization and community engagement. At the community leader open house event, formal and informal leaders were asked to provide community assets and gaps as it pertained to the eight health prioritized topics identified through the leader survey and the "blue wall" activities. The information from the community leader open house engagement activities resulted in the further prioritization of the health priorities from eight topics to five.

Additionally, capacity of the CHA partnering agencies was considered. For the first prioritization the advisory team conducted, "actionability" was included as a criterion on the matrix. This criterion asked the advisory partners to rate the degree each agency would be able to implement work and changes to impact that specific data indicator or topic. It was important to all joint CHA members that each agency involved needed to have final health priorities that the entity would have the ability to work on, otherwise, the ability for partners to address and positively impact the prioritized issues would be limited. The same criterion was utilized for the first prioritization matrix completed by the advisory team and the final prioritization by the advisory team to determine the final two health priorities. This allowed the criterion to be considered and weigh on the final result, but not completely sway the votes more than any primary or secondary data would.

Phase Five: Prioritizing Issues

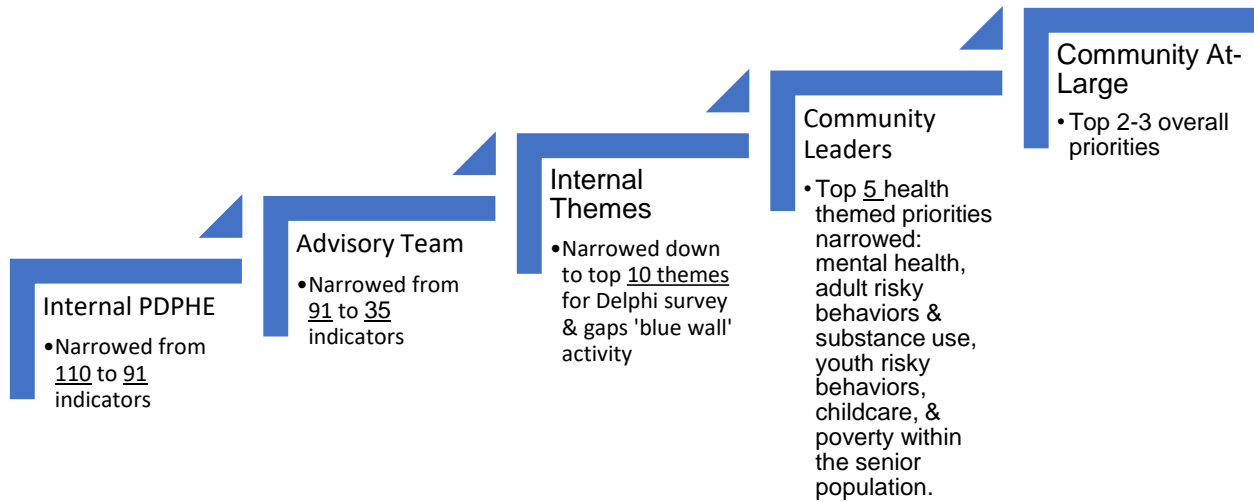


Figure 7: Simplified overview of the joint CHA prioritization process.

Figure 7 displays a simple overview of the entire prioritization process of the joint CHA, including how and in what order the data indicators were narrowed down and eventually condensed into overarching health topics or themes. Figures 8 and 9 visualize the details of which data indicators and health topics were narrowed down, by which criteria, by whom involved, and at what point in the joint CHA timeline.

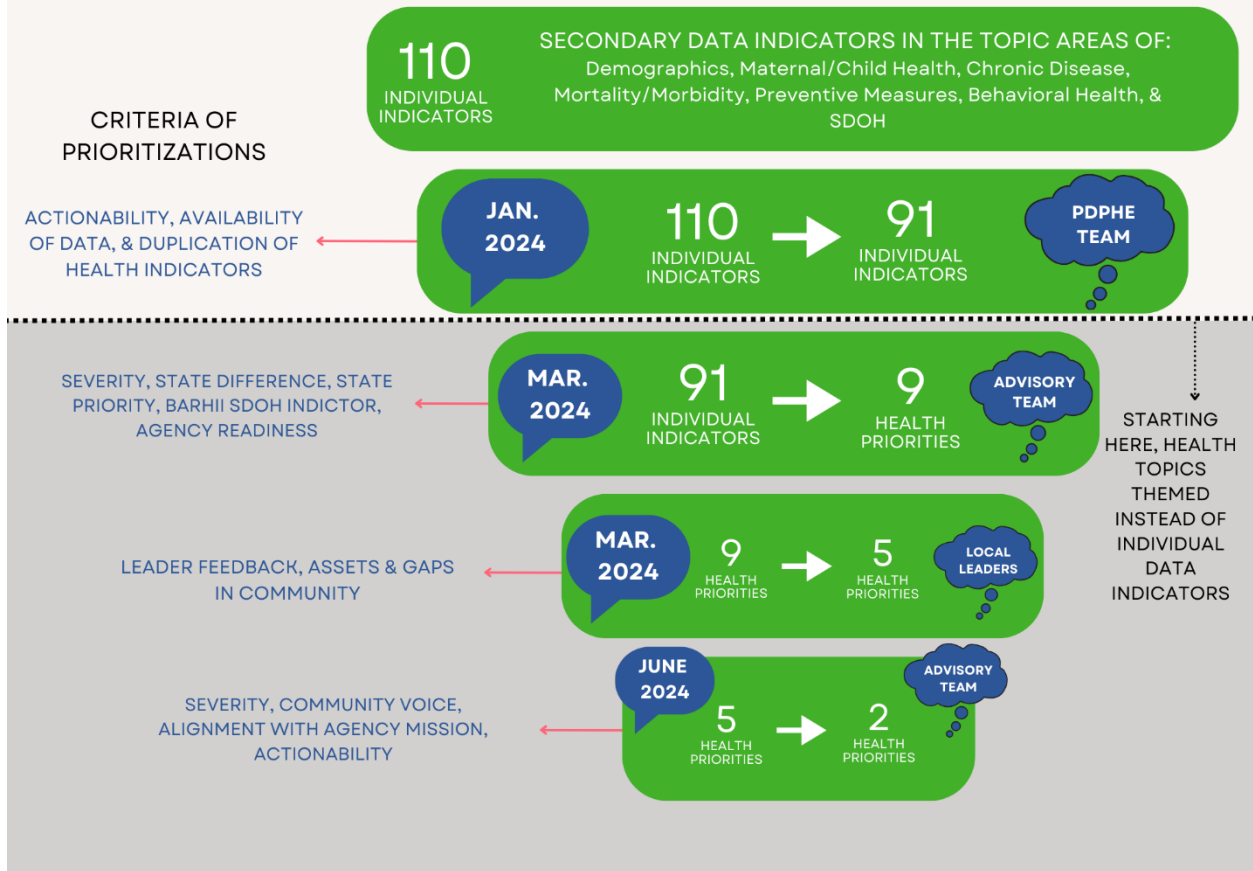


Figure 8: Visual of the joint CHA prioritization process, detailed with the number of indicators or health priorities, who made the decisions, when they were made, and what criteria was used.

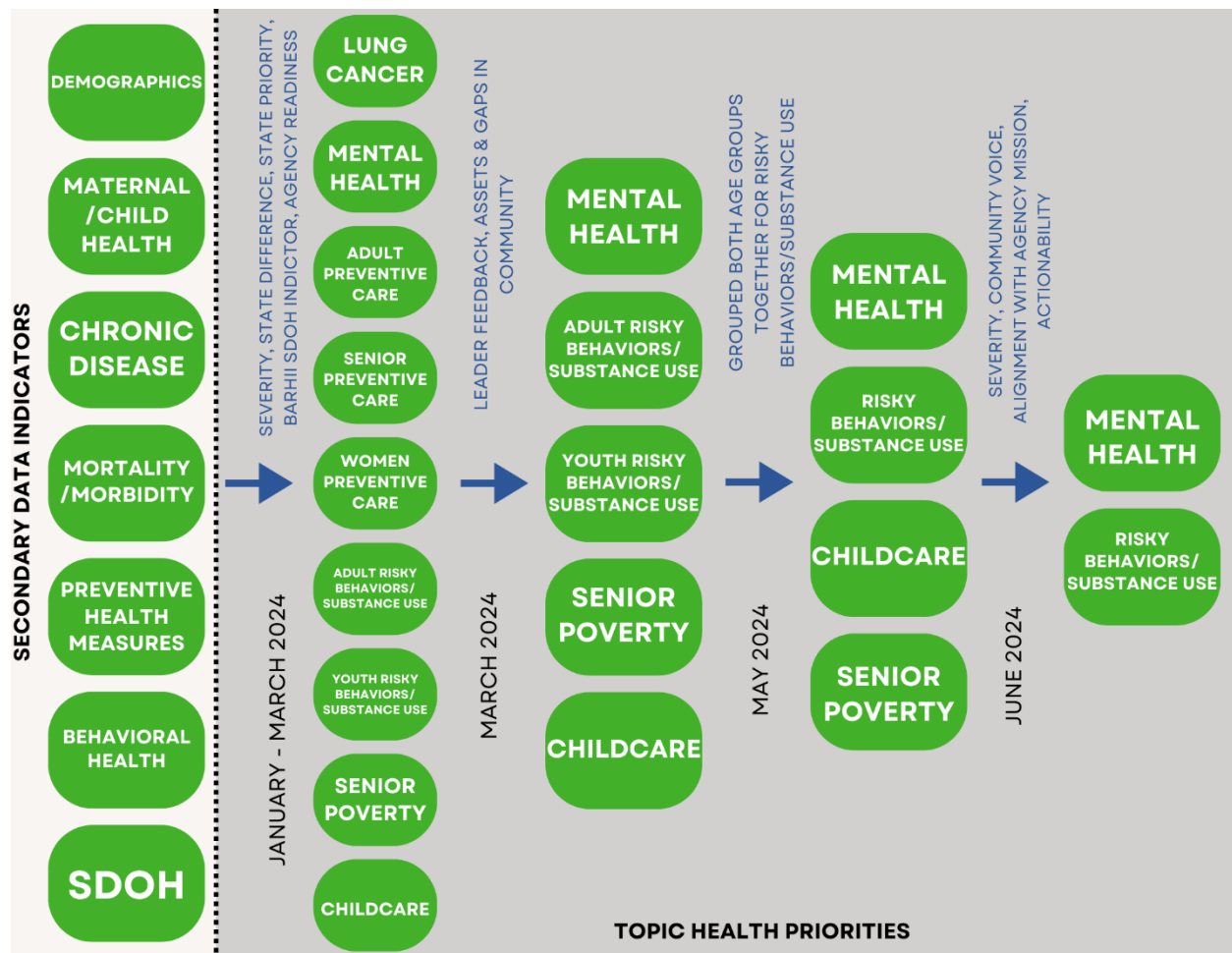


Figure 9: Visual of the joint CHA prioritization process, detailed with the data indicators and health priorities, when the prioritization occurred, and what criteria was used.

Step One: Initial Joint CHA health priority guidelines

As noted previously, the CHA advisory team needed to determine if a joint CHA would be beneficial and meet the requirements of each agency. The public health planner created a matrix that noted what health data each partnering agency needed to assess and report on. This information came from past assessments as well as any new requirements agencies knew about for future assessments. The matrix listed each data topic and determined how many of partnering agencies also needed to assess that same information. More overlap in the matrix would allow the team to know that a single joint CHA effort would be a good fit. More than 80% of the health topics were common to each of the partners' requirements. This information informed and sparked secondary data collection and future data prioritization phases.

Step Two: Internal PDPHE Prioritization of Secondary Data

After determining which secondary data indicators, the joint CHA team wanted to collect, the first level of prioritization was conducted. In February 2024, with support from a Colorado State University-Pueblo intern and a second review by the PDPHE data analyst and public health planner, the list of 110 data indicators was narrowed down to 91 indicators based on duplication of information, availability of data, and actionability by partnering agencies. The results from this initial narrowing can be found in Appendix

N. This aspect of the prioritization process was essential to provide a manageable list to the advisory team in the next step and matrix, explained in the following section.

After this step, it was necessary for the PDPHE CHA team to collect the full data metrics for the 91 indicators remaining for Pueblo County, as well as the state average.

Step Three: Advisory Team Prioritization of Secondary Data

In late February and early March 2024, the third step in the overall community health prioritization process asked joint CHA advisory members to continue to narrow down the 91 data indicators collected. The public health planner and PDPHE data analyst created a prioritization matrix that featured all 91 indicators and five criteria: the severity of the health issue, how different Pueblo County was from the state average, if the health topic/issue is a state priority (Colorado Health Improvement Plan, Winnable Battle), if the health topic/issue is included in the BARHII framework, and the advisory agencies' readiness to tackle the health topic/issue. PDPHE staff filled in the first four criteria and asked each partnering agency leadership to provide their readiness answer. A survey was created to ask this of each agency representative and weighed significantly in the matrix. The score for each criterion was added together for each of the 91 indicators and ranked in order of highest response to the lowest response. This process narrowed the 91 indicators down to the top 35 indicators, which had a total response of ten or higher.

These 35 data indicators were taken and then themed by the PDPHE data analyst. This was important because moving forward in the community engagement and data prioritization process, larger health topics needed to be assessed and not necessarily only individual indicators. The larger themes would support more flexibility in primary data collection and future health improvement planning. The nine health topics that were themed from those 35 indicators included lung cancer, mental health, adult preventive care, senior preventive care, women preventive care, risky behaviors and substance use in adults, risky behaviors in youth, poverty within the senior population, and childcare. These health topics were essential for the creation of the engagement activities completed at the community leader open house and other data collection and analysis.

Step Four: Community Leader Survey

To collect this feedback, a community leader open house was conducted in March 2024. A comprehensive list of formal and informal leaders in Pueblo County was created to include individuals with large spheres of influence. A total of 42 local leaders participated in this phase of the joint CHA data collection and prioritization process.

Leaders could attend and participate in person or through a virtual option to ensure better turnout and equitable engagement. During the open house, local leaders were guided through six stations that were facilitated by joint CHA advisory team members. Through the stations, local leaders started by learning what the CHA was, what data was being collected, and then were prompted to complete a survey and participate in a feedback collection activity. Virtual attendees completed the same leader survey and a Google Jamboard.

The survey asked each individual leader to first rank the top ten health topics or themes in order of highest priority to least priority for future improvement work. The results from that survey question are as follows in table 1. These ten topics/themes were pulled from the secondary data indicators prioritized by the joint CHA advisory team prior to the open house event (see Phase 5, Step 3 section for more

details on this theming process). The survey then asked each local leader to provide a list of community assets and gaps for improvement for each health topic/theme.

<i>Rank</i>	<i>Health Topic</i>	<i>Individual Rankings in Leader Survey</i>
1	Mental health	295
2	Adult risky behaviors/substance use	263
3	Youth risky behaviors/substance use	256
4	Childcare services	208
5	Poverty among the aging population	182
6	Adult and aging population preventative healthcare	155
7	Women preventative healthcare	153
8	Lung cancer	66

Table 1: Table of the results from the joint CHA community leader open house prioritization survey, detailed with the final ranking and number of individual votes in the surveys as a whole.

After each leader completed the survey, they moved to the feedback activity station called the “Blue Wall”. This activity was a continuation of the information in the leader survey, asking leaders to write down the biggest gaps for each health topic/theme and place it on the big blue wall for others to comment on and add to. The activity sparked great conversations within the small groups that were participating at the same time.

The feedback and guidance collected from the community leader open house was used to further prioritize the top health topics/themes from the ten presented to the top five. These top five health priorities, in order, were: mental health, adult risky behaviors, youth risky behaviors, childcare, and poverty within the aging population. These five health topics helped shape the community member survey questions, focus group questions, and the community demographic populations that the data collection team wanted to ensure were included in the assessment (see previous community engagement section for targeted populations).

Step Five: Final Advisory Team Prioritization

The final step in the joint CHA data prioritization process was to bring all the data results back to the advisory team for a final review and vote on the top five health topics that resulted from the community leader survey results in March. An important note is that before the advisory team completed the final prioritization, PDPHE’s public health planner decided that because risky behavior-related questions were not separated out by age that it would be helpful to group together youth and adult risky behaviors/substance use as a single health topic for the advisory members to vote on. This does not mean that for the Community Health Improvement Plan (CHIP) creation the health topic cannot be broken back down by any specific demographic or leading indicator.

For this step and process, in June 2024, partnering agencies reviewed support materials to apply four criteria to determine each agency’s readiness, community member perspective, severity, and how much each topic aligned with the agency’s mission, vision, funding, and/or strategic plan.

The results of the final advisory team prioritization step determined the overall top two health priorities that the joint CHA partners felt like were serious, impactful to the community, and feasible to work on in the future were **mental health** and **risky behaviors/substance use**. The results of the final survey are as follows, displayed in tables 2, 3, 4, 5 and figure 10.

<i>Mental Health</i>	
Question #	Response (average)
1	3.75
2	4.675
3	4.35
4	4.35
Total average	4.375

Table 2: Mental health final prioritization results.

<i>Risky Behaviors</i>	
Question #	Response (average)
1	4
2	4.25
3	4.25
4	4.5
Total average	4.25

Table 3: Risky behaviors final prioritization results.

<i>Senior Poverty</i>	
Question #	Response (average)
1	2.25
2	3.25
3	4
4	3.75
Total average	3.3125

Table 4: Senior poverty final prioritization results.

<i>Childcare</i>	
Question #	Response (average)
1	2.75
2	3
3	4.25
4	3.75
Total average	3.4375

Table 5: Childcare final prioritization results.

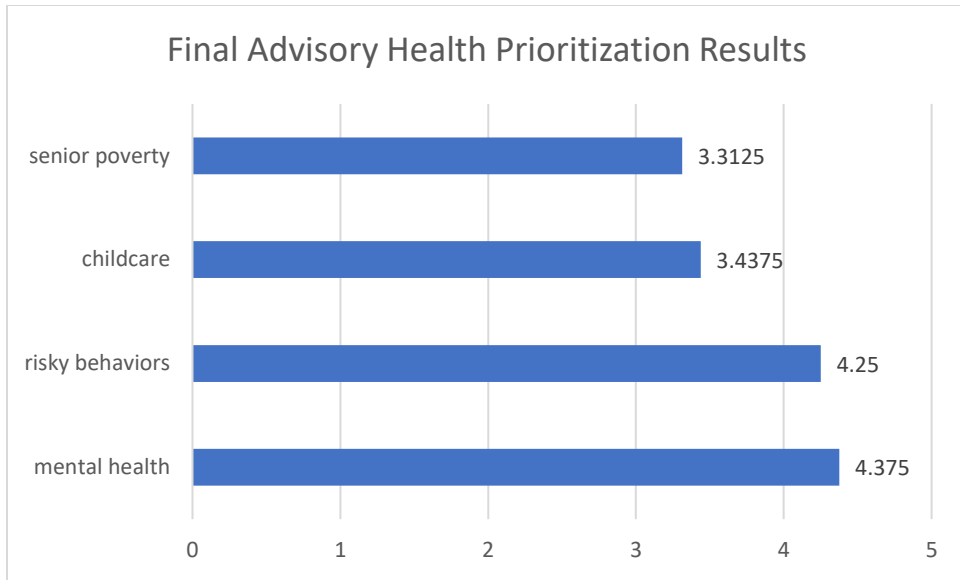


Figure 10: Bar graph of the results of the final joint CHA advisory team's prioritization survey.

Results

Two health priorities rose to the top of all secondary data, primary data, and community feedback: **mental health** and **risky behaviors/substance use**.

A total of 510 individuals responded to the community member survey, with demographics representing various populations that can be compared to the overall population of Pueblo County – visualized below in tables 6-9. In addition to the community member survey, 42 diverse Pueblo County leaders participated and provided feedback during the open house and the associated online option. An additional 26 community residents participated in three focus groups.

Zip code	Name	% of population	# of responses needed	Responses Gathered
81001	Pueblo City	18%	69	44
81003	Pueblo City	8.90%	34	79
81004	Pueblo City	15.40%	59	58
81005	Pueblo City	18.40%	71	64
81006	Blende, City	7.20%	28	21
81007	PW	20.50%	79	62
81008	Pueblo City	7.30%	28	26
81019	CO City	1.30%	5	8
81022	Avondale	0.88%	3	2
81023	Beulah	0.78%	3	6
81025	Boone	0.57%	2	2
81069	Rye	1.00%	4	9
Total		1.0023	385	381

Table 6: Joint CHA survey response distributed among all Pueblo County zip codes. Self-reported.

Gender	% of population	# of responses needed	Responses Gathered
Male	49%	189	88
Female	51%	196	230
Non-binary			6
Unknown			15
Total	100%	385	339

Table 7: Joint CHA survey responses distributed among gender demographics. Self-reported.

Age Group	% of population	# of responses needed	Responses Gathered
15-24*	12%	46	14
25-34	13.10%	50	48
35-44	12%	46	82
45-54	11.20%	43	62
55-64	13%	50	47
65+	20.30%	78	59
Total	81.60%	313	314

Table 8: Joint CHA survey distributed among age group demographics. Self-reported.

Race/Ethnicity	% of population	# of responses needed	Responses Gathered
White alone	63.90%	245	217
Black alone	2.20%	8	7
Native alone	2.30%	9	28
Asian alone	1.10%	4	5
Pacific Islander alone	0.10%	0	2
Hispanic origin	42.40%	163	107
Total		429	366

Table 9: Joint CHA survey responses distributed among race and ethnicity demographics. Self-reported.

Mental Health

Secondary Data

Ten individual health data indicators were collected which correlated with the mental health topic, included in table 10 below. It was important to benchmark Pueblo County data metrics to that of the Colorado state average, as well as the degree of severity in that specific health issue. The secondary data for mental health was the most severe for young people (high schoolers) and the need for mental health services was a high need – like much of the rest of the state. This data was collected from various sources such as Healthy Kids Colorado Survey, Colorado Health Access Survey, and more. Because this data does lag slightly, it was very important for all involved parties to view the secondary data alongside the primary data collected from the community residents.

Indicators	Severity in Pueblo	Comparison to CO Average
Percent of high school students who felt sad or hopeless almost every day for 2 or more weeks in a row so that they stopped doing some usual activities during the past 12 months	30.1% +	Worse
Age-adjusted rate of suicide deaths (per 100,000 population)	20.1 % - 30.0 %	No Difference
Percent of high school students who seriously considered attempting suicide during the past 12 months	20.1 % - 30.0 %	No Difference
Percentage of students who have an adult to go to for help with a serious problem	30.1% +	No Difference
Percent of women who experienced postpartum depression	20.1 % - 30.0 %	No Difference
Age-adjusted rate of suicide hospitalizations (per 100,000 population)	0 – 10.0 %	Worse
Needed mental health care or counseling services but did not get it at that time during the past 12 months (ages 5 and older)	10.1 % - 20.0 %	No Difference
Of people ages 5+ reported poor mental health	20.1 % - 30.0 %	No Difference
Expect to need mental health care in the next 12 months	10.1 % - 20.0 %	No Difference
Talked with a mental health provider about their mental health	10.1 % - 20.0 %	No Difference

Table 10: Secondary data collected pertaining to mental health for the 2024 joint CHA. Difference from the state average and severity listed for each metric.

Community Leader Assets & Gaps

Community leaders were asked to list all the community assets (programs, resources, services, people, places, events, etc.) and gaps within the community as it pertained to specific health topics. In mental health, 44 total unique assets were mentioned, ranging the entire continuum from pickleball courts to specific agencies operating in the County. There was also a total of 50 community gaps mentioned by local leaders, which included a lack of any sort of support system, needing Spanish-speaking therapists, and reducing stigma to accessing care. These assets and gaps will be most helpful during the creation of the 2025-2028 Community Health Improvement Plan (CHIP), when stakeholders come together to narrow down specific strategies to making improvements to the community’s mental health.

Community Member Results

The community member survey was completed by 510 Pueblo County residents – all asked various questions about their overall wellbeing, belonging, and life experience. There were eight questions that specifically touched on mental health within Pueblo County. The visuals and charts displaying the results from those survey questions are included below. It is important to note that each question was analyzed independently because survey questions were not required, and some community members skipped certain questions. For the following figures, note the question’s individual response rate in the caption below it.

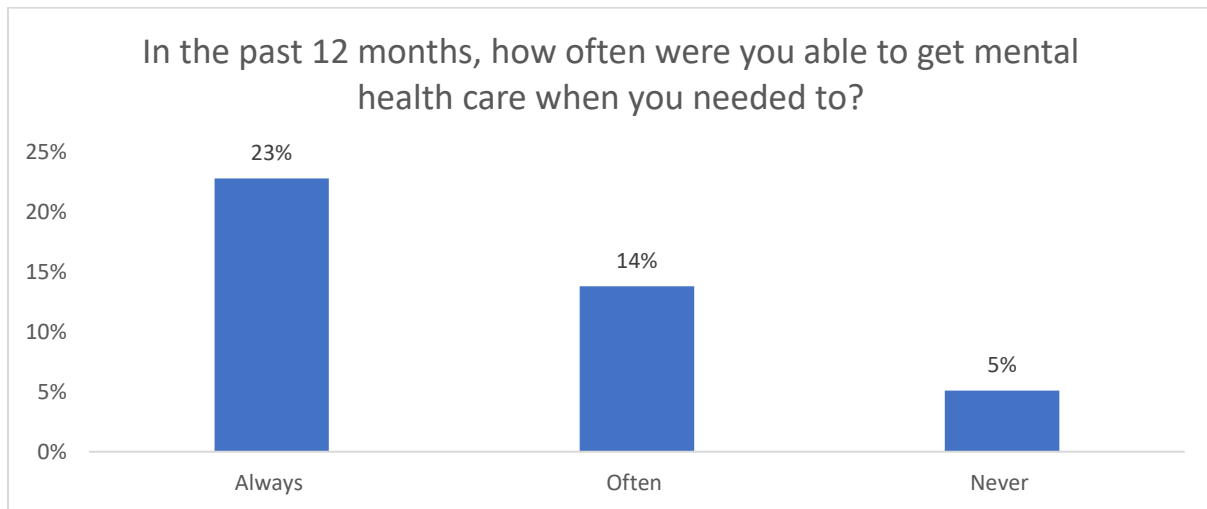


Figure 11: Joint CHA community member survey question #7, total 355 respondents. 23% of individuals that responded to this question stated that they are always able to receive the mental health care they need, 14% of respondents stating they are often able to access mental health care, whereas 5% of respondents stated they can never receive the mental health care they need.

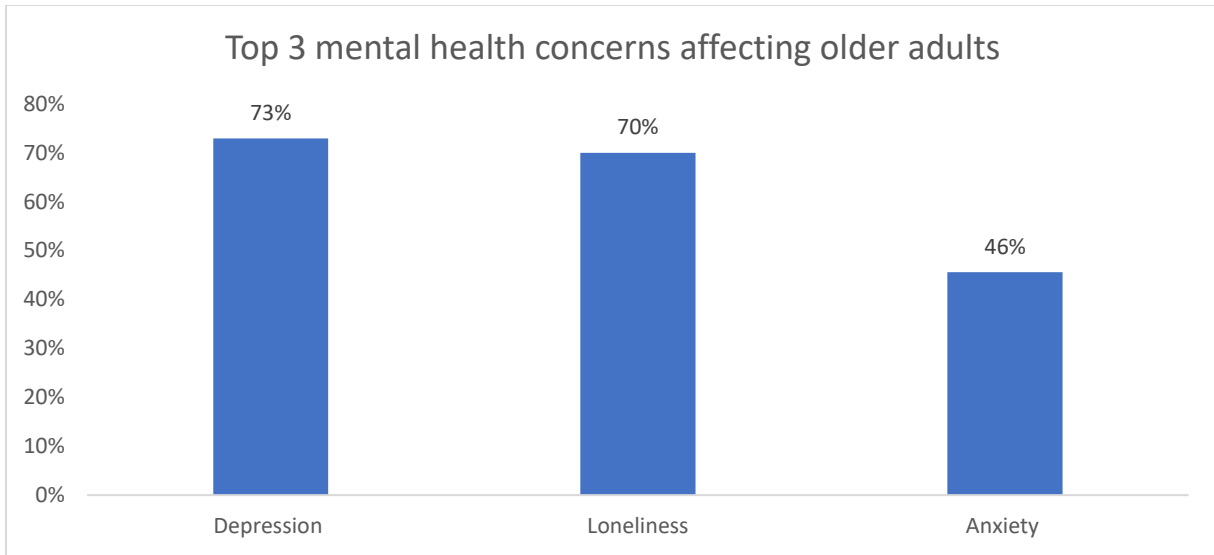


Figure 12: Joint CHA community member survey question #11, total 370 respondents. 73% of individuals that responded to this question stated that they thought depression was one of the top three mental health concerns affecting older adults, 70% of respondents stating it is loneliness, followed by 46% of respondents stating it is anxiety. These concerns were the top three responses from the question results.

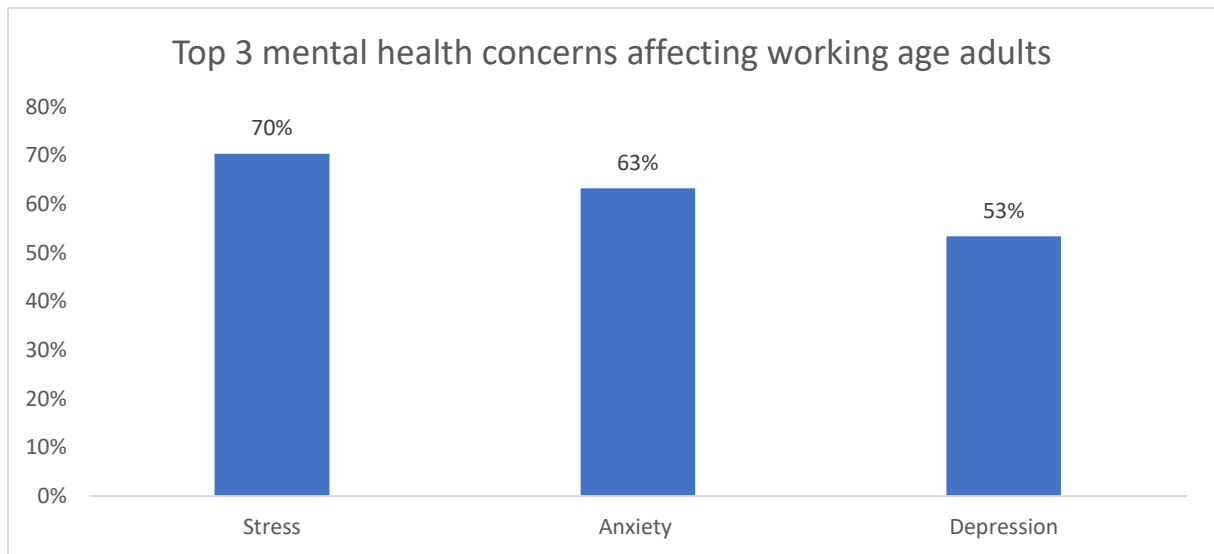


Figure 13: Joint CHA community member survey question #12, total 352 respondents. 70% of individuals that responded to this question stated that they thought stress was one of the top three mental health concerns affecting working-age adults, 63% of respondents stating it is anxiety, followed by 53% of respondents stating it is depression. These health concerns were the top three responses from the question results.

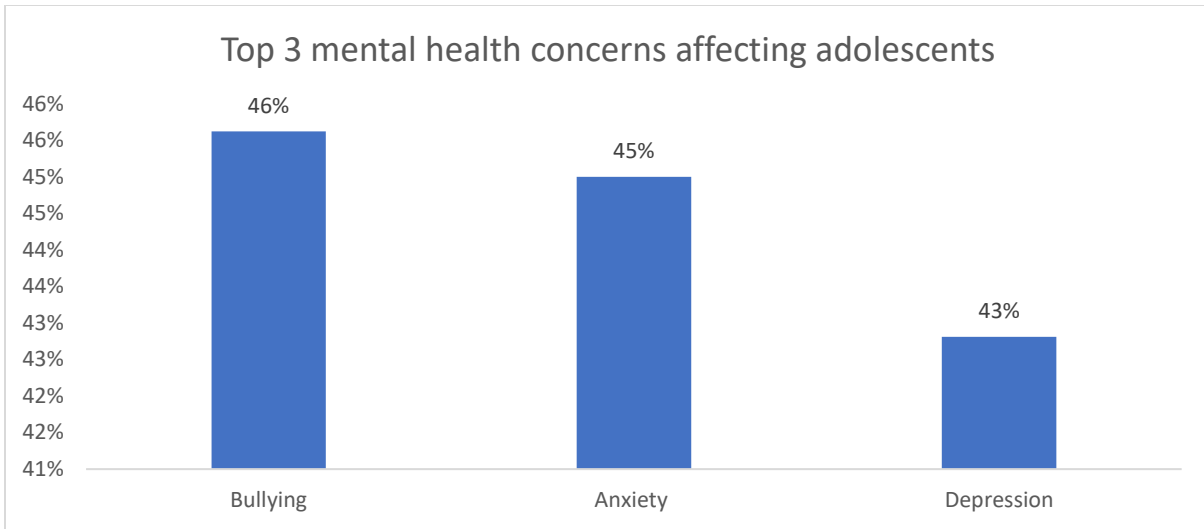


Figure 14: Joint CHA community member survey question #13, total 343 respondents. 46% of individuals that responded to this question stated that they thought bullying was one of the top three mental health concerns affecting adolescents, 45% of respondents stating it is anxiety, followed by 43% of respondents stating it is depression. These health concerns were the top three responses from the question results.

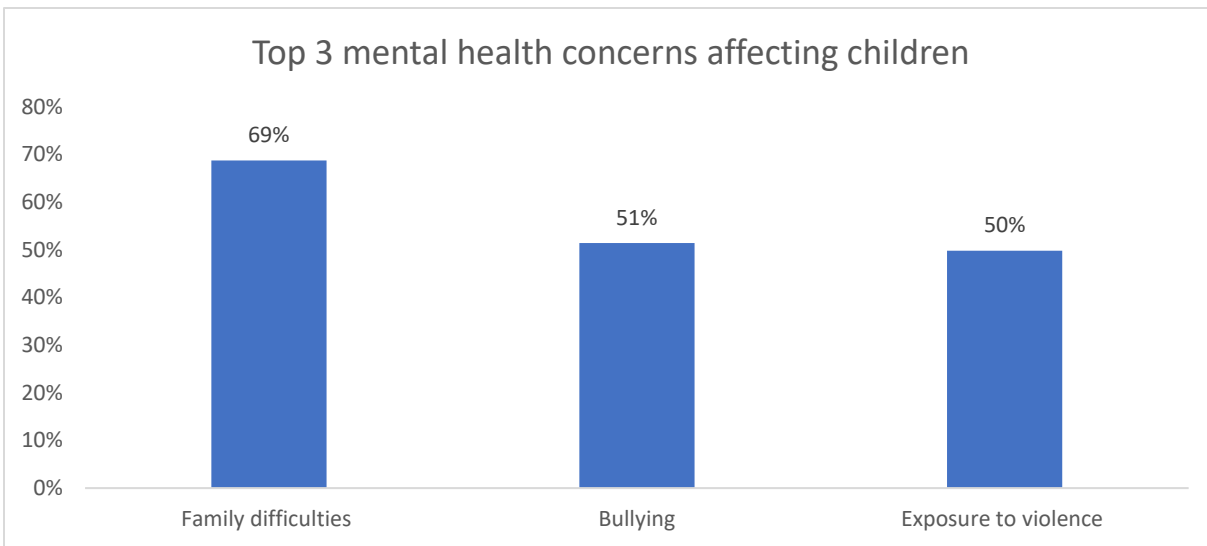


Figure 15: Joint CHA community member survey question #14, total 343 respondents. 69% of individuals that responded to this question stated that they thought family difficulties was one of the top three mental health concerns affecting children, 51% of respondents stating it is bullying, followed by 50% of respondents stating it is exposure to violence. These health concerns were the top three responses from the question results.

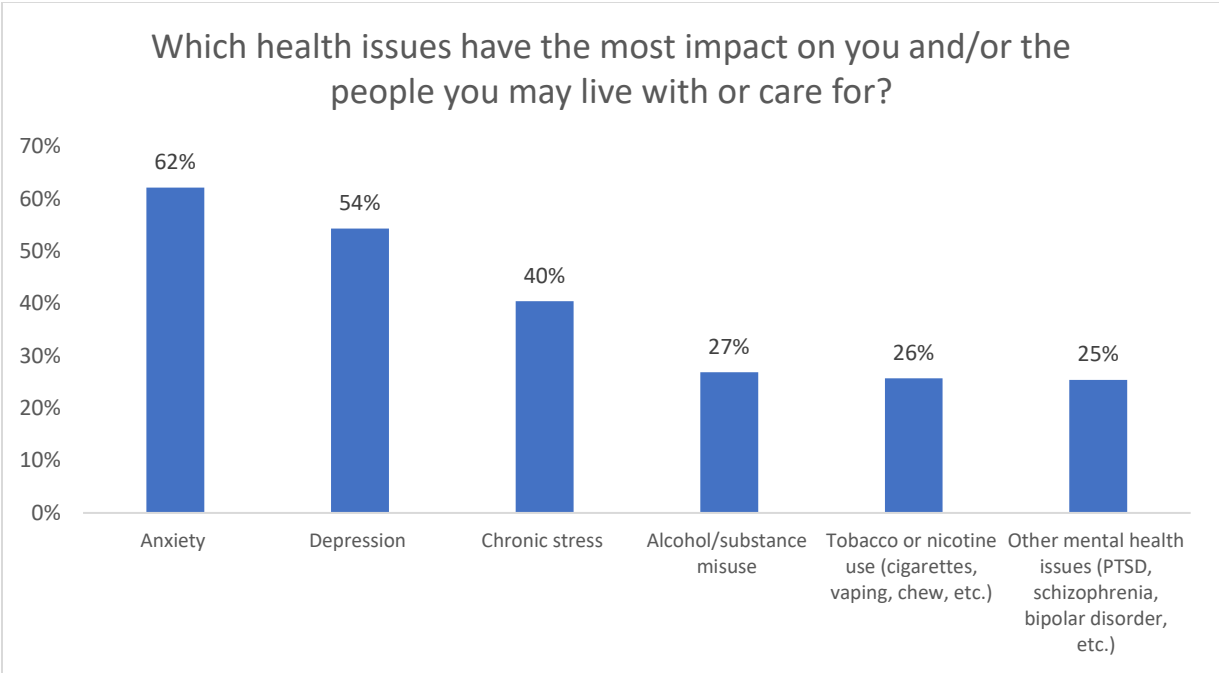


Figure 16 Joint CHA community member survey question #19, total 357 respondents. Out of all available and write-in responses to the survey question, those that pertained to mental health were selected for this visual. The mental health-related health concern that impacted 62% of participants was anxiety, followed closely by depression. With all responses listed, anxiety and depression were the top two most common responses by participants.

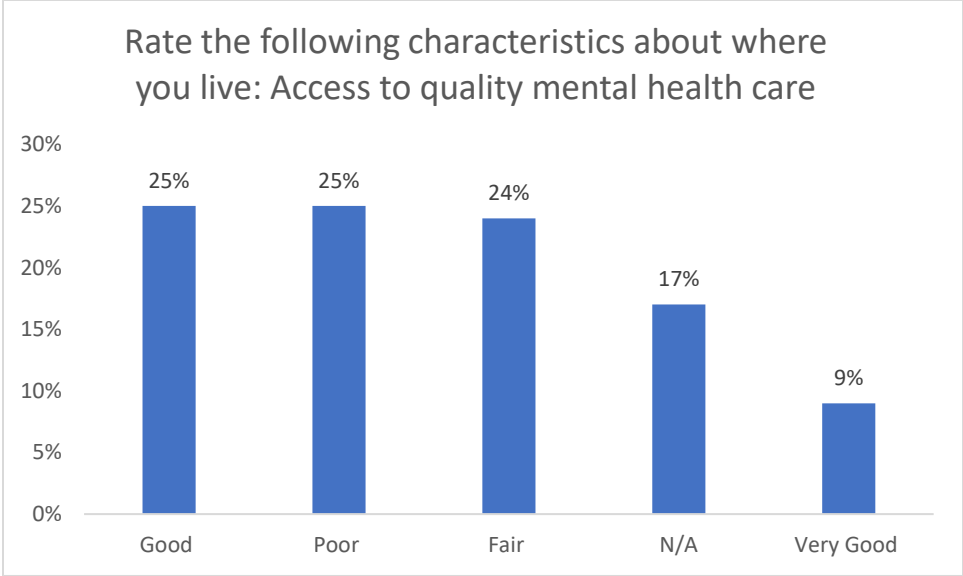


Figure 17: Joint CHA community member survey question #21, max total of 332 respondents. 58% of total respondents to this survey questions rated access to mental health care as fair, good, or very good. 25% of responses rated access to mental health care as poor and 17% of participants stated the questions did not apply to their experiences (N/A).

To summarize the results in mental health, most community members could access mental health care and services when they needed them. Many survey question responses identified anxiety, stress, bullying, depression, family issues, exposure to violence, and loneliness as top mental health concerns

impacting them and those they care about. These mental health concerns were consistent across various age group demographics in Pueblo County.

Risky Behaviors/Substance Use

Secondary Data

Eight individual health data indicators were collected which correlated with the risky behaviors and substance use topic, included in table 11 below. Like the mental health data, it was important to benchmark the Pueblo County data metrics to that of the Colorado state average, as well as the degree of severity in that specific health issue. The secondary data for risky behaviors and substance use communicated the differences between what is happening within Pueblo County and the rest of the state. In many of the metrics, Pueblo was worse off than the state average – specifically in adults who smoke cigarettes, youth who vape, youth who smoke marijuana products, and youth that feel unsafe at school. This data was collected from various sources such as Healthy Kids Colorado Survey and Behavioral Risk Factor Surveillance System (BRFSS). Because this data does lag slightly, it was very important for all involved parties to view the secondary data alongside the primary data collected from the community residents.

Indicators	Severity in Pueblo	Comparison to CO Average
Percent of adults aged 18+ years who currently smoke cigarettes	20.1 % - 30.0 %	Worse
Adults who currently use e-cig	10.1 % - 20.0 %	No Difference
Percent of women who smoked during the third trimester of pregnancy	10.1 % - 20.0 %	No Difference
Women who drank alcohol in the last trimester of pregnancy	0 – 10.0 %	Better
Percentage of youth who report current use of e-vapor products	30.1 % +	Worse
Percentage of students who did not go to school on one or more of the past 30 days because they felt they would be unsafe at school or on their way to or from school	10.1 % - 20.0 %	Worse
Percent of high school students who used marijuana one or more times during the past 30 days	10.1 % - 20.0 %	Worse
Percent of high school students who currently use cigarettes	0 – 10.0 %	No Difference

Table 11: Secondary data collected pertaining to risky behaviors and substance use for the 2024 joint CHA. Difference from the state average and severity listed for each metric.

Community Leader Assets & Gaps

At the Community Leader Open House, leaders were asked to list all the community assets (programs, resources, services, people, places, events, etc.) and gaps pertaining to specific health topics. At the time of the leader open house, risky behaviors and substance was still broken down into adults and youth. Both were merged into one health topic prior to the final advisory team prioritization phase. For reporting purposes, all mentioned assets and gaps for both adults and youth have been placed in one unified document. For risky behaviors and substance use, local leaders mentioned 66 total unique assets ranging the entire continuum from support groups, school activities and clubs, to specific agencies operating in the County. There was also a total of 95 community gaps mentioned by local leaders, which included a lack of any sort of support system, more education and coordination within the local school systems, reducing stigma and generational norms, and adding an inpatient care facility locally that can accept youth and adults. These assets and gaps will be most helpful during the creation of the 2025-2028 Community Health Improvement Plan (CHIP), when stakeholders come together to narrow down specific strategies to making improvements to the community’s mental health.

Community Member Results

The community member survey was completed by 510 Pueblo County residents – all asked various questions about overall wellbeing, belonging, and life experience. There were five questions that specifically touched on risky behaviors and substance use within Pueblo County. The visuals and charts displaying results from those survey questions are included below. As mentioned previously, note that each question was analyzed independently due to each question having unique response rates. For the following figures, note the question’s individual response rate in the caption below it.

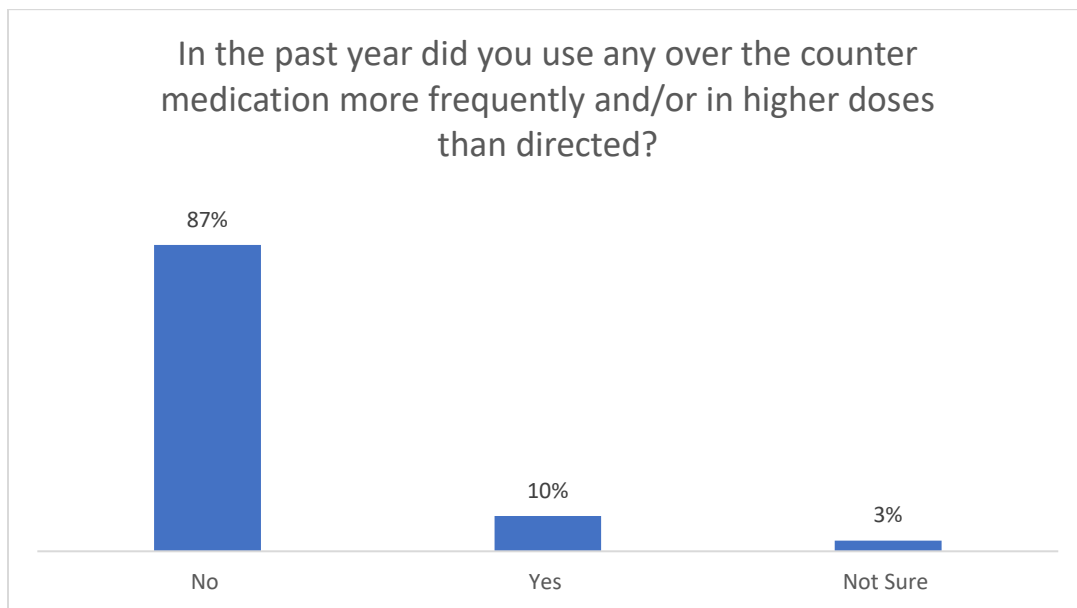


Figure 18: Joint CHA community member survey question #15, total 360 respondents. 87% responded that they did not take medication that was not prescribed to them or take more than prescribed within the past year.

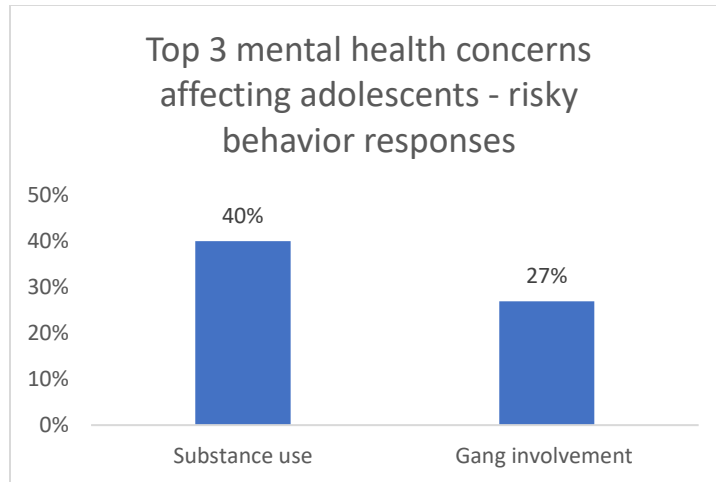


Figure 19 Joint CHA community member survey question #13, total 343 respondents. 40% of individuals that responded to this question stated that they thought substance use was one of the top three mental health concerns affecting adolescents, followed by 27% of respondents stating it is gang involvement.

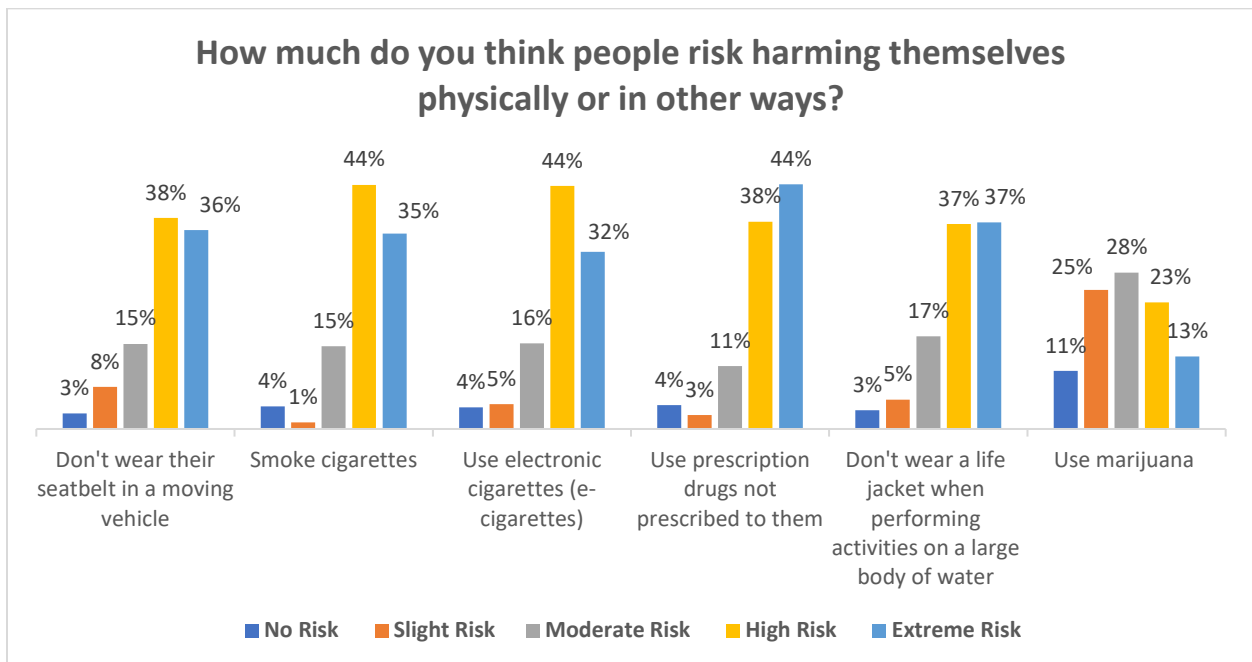


Figure 20: Joint CHA community member survey question #16, max total of 356 respondents. This survey questions listed six separate risky behaviors and asked survey participants to determine the level of risk by conducting the behavior. The majority of respondents thought there was high or extreme risk for doing most of the behaviors. The one behavior that had unique results was asking about marijuana usage, which had more respondents state it had slight risk.

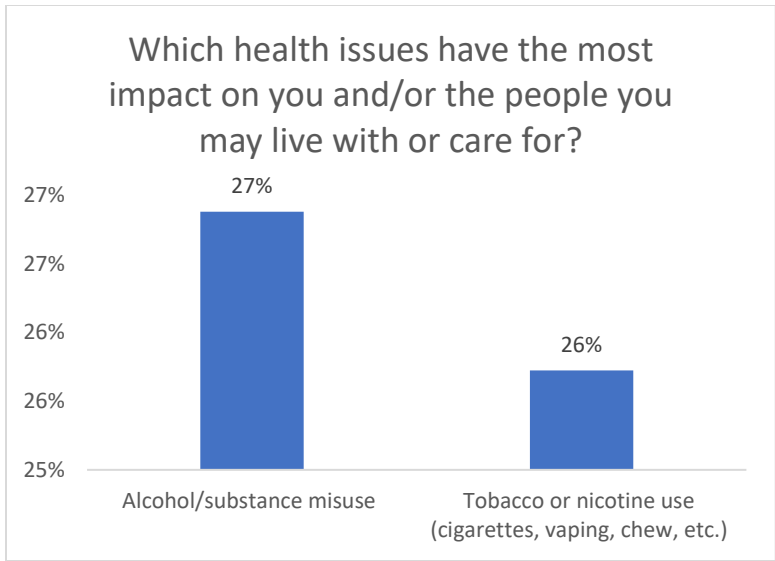


Figure 21: Joint CHA community member survey question #19. 27% of individuals that responded to this question stated that they thought alcohol and substance use was one of the top three mental health concerns themselves or those they love, followed by 26% of respondents stating it is tobacco or nicotine use. These two community health issues rose above many other responses.

Many community residents who completed the survey stated they knew what behavior is risky to an individual’s wellbeing, such as using prescribed drugs without a prescription, using more medication than prescribed, wearing a seatbelt or life jacket, and using tobacco products (cigarettes and e-vapor products). The one behavior that differed in the trend of responses would be the use of marijuana products, which was perceived as not as risky to individuals’ health. When asked how substance use and risky behaviors impacted the youth population within Pueblo County, 40% of question respondents stated substance use was one of the top three issues impacting children, followed by 27% of community members stating it was gang involvement.

Constraints & Evaluation

As successful and informational as the joint CHA results are, it is important to acknowledge the various constraints and limitations related to the collaborative project. As mentioned in the motivational touchstone section earlier in this report, there were constraints on this assessment that were known by all parties involved from the very beginning, including a short deadline for completion. To meet all joint CHA partner agencies' timelines for their Community Health Needs Assessments (CHNA), everything needed to be complete by June 30, 2024. Since the assessment process formally started in January 2024, this left the team six months to complete an entirely new process with new partners when normally a local health department dedicates an entire year. Additionally, as are many other community and governmental agencies within the state, resources and budgets are tight and spread thin. For these reasons, there were budget and staff capacity limitations, as well as differing perspectives on mission and goals of a health assessment – despite aligning the best all partners could from the start. Limitations were occasionally due to funding restrictions on how money could be spent.

Because these constraints are known, it makes evaluation even more important. PDPHE plans to utilize at least two different evaluation methods – an internal process evaluation and an external partner evaluation – throughout July and August 2024 with the conclusion of the joint assessment. These results will inform future process improvements.

Internal Process Evaluation

An internal process evaluation of the joint CHA work will be conducted by PDPHE's performance improvement coordinator. In the month of July 2024, the coordinator will walk all internally involved staff members through conversations about what worked, what didn't work and why, what the team would like to make note of for the next iteration of the CHA (joint or not), and if there are any potential quality improvement projects that could be started with this information. The results of these conversations will be used for internal staff to learn from past experiences and grow as an agency. This information will likely not be shared with external partners, aside from possible process changes implemented during the next joint CHA. Because this joint CHA report is being reviewed and published prior to the internal process evaluation, the results will be added to the Appendix once completed.

External Partner Evaluation

An external partner evaluation is important for this first joint CHA conducted in Pueblo County with currently involved partners. To learn from the collaborative experience and ensure a better relationship moving forward, PDPHE partnered with a Colorado State University-Pueblo business professor to conduct the surveying on behalf of the team. It is essential the partner evaluation is administered and analyzed by an external party to mitigate bias and ensure confidentiality. This will support agencies involved to be honest with responses. Conversations to plan, administer, and analyze the partner evaluation started at the end of June 2024 and will continue through late summer – all dependent on the professor's capacity with the Fall semester. Because this joint CHA report is being reviewed and published prior to the partner evaluation, results will be added to the Appendix once completed.

Acknowledgments

Pueblo Department of Public Health and Environment Staff Members

- Adler Mercado Martinez CEPR Administrative Assistant
- Akemi Trujillo Public Health Planner
- Alicia Solis CEPR Program Manager
- Joe Philip Performance Improvement Coordinator
- Moremi Hamblin Public Health Data Analyst
- Olivia Leyva Equity and Engagement Initiatives Coordinator
- Shylo Dennison CEPR Director
- Trysten Garcia Public Health Information Officer

Joint CHA Advisory Team

- Amelia Vigil UHealth Parkview Medical Center
- Donald Moore Pueblo Community Health Center
- Jessica Russell Health Solutions
- LeAnna Pacheco Health Solutions
- Marco Vegas CommonSpirit St. Mary-Corwin Hospital
- Shylo Dennison Pueblo Department of Public Health and Environment
- Akemi Trujillo Pueblo Department of Public Health and Environment

Community Engagement Partners

- Pueblo Cooperative Care
- The Pueblo Soup Kitchen
- Pueblo Rescue Mission
- Senior Resource Development Agency (SRDA)
- Center Toward Self Reliance

Colorado State University-Pueblo | Academic Health Partnership

- Various CSU-P internship students (names protected for confidentiality)
- Dr. Leonardo Bedoya-Valencia Data Analysis
- Dr. Yunhan Zhao Data Analysis
- Dr. David Volk Intern Coordination
- Dr. Margie Day Survey Review
- Dr. Alegria Ribadeneria Spanish Translation
- Dr. Alexandra Ribadeneria-Perez Spanish Translation
- Dr. Aaron Johnson Survey Review & Best Practices
- Dr. James Gilbreath Partner Evaluation

Works Cited

- Bay Area Regional Health Inequities Initiative. (2002). BARHII Framework. *Framework*.
- C-EA, W. (1920). The untilled fields of public health. *Science*, 51:23.
- Colorado Department of Public Health and Environment. (2024). CHAPS Phases. *Assessment and Planning*.
- Krause, H. (2021). Motivation Touchstones: Using Restrictions to Your Advantage. *We All Count*.
- Prevention First. (2024). About this center. *Center for Community Engagement*.
- Pueblo County GIS. (2019). *Demographic and income profile*. Retrieved from https://county.pueblo.org/sites/default/files/2019-12/Demographic_and_Income_Profile_CountyPueblo_1.pdf
- U.S. Department of Health and Human Services. (2024). Social Determinants of Health.
- United States Census Bureau. (2024). *Pueblo County, Colorado*. Retrieved from https://data.census.gov/profile/Pueblo_County,_Colorado?g=050XX00US08101