



2025-2028

COMMUNITY HEALTH IMPROVEMENT PLAN

Pueblo County Board of Health Approved on
November 27, 2024

AUTHORS

Pueblo Department of Public Health and Environment
in partnership with CommonSpirit St. Mary Corwin
Hospital and UHealth Purview Medical Center

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Acknowledgements

The 2024 joint community health assessment (CHA) followed by the development of the 2025-2028 joint Community Health Improvement plan are historical milestones for Pueblo County. The CHA process included the Pueblo Community Health Center, Health Solutions, UC-Health Parkview Medical Center, Common Spirit St. Mary Corwin Hospital, the Pueblo Department of Public Health and Environment, and Colorado State University- Pueblo. Together the partners leveraged their strengths and community partnerships to extend the reach and depth of the assessment. The process intentionally focused on reaching populations in our community, the voices of which are often absent from assessments including the unhoused, those with disabilities, youth, elderly, and Spanish-language communities.

Following the success of the CHA, three partners, UC-Health Parkview, Common Spirit St. Mary Corwin, and Pueblo Department of Public Health and Environment, agreed to work on a joint community health improvement plan (CHIP). These partners meshed their individual organizational needs for a CHIP with the broader needs of the community. Two priority areas were identified: Mental Health and Risky Behaviors.

The following plan lays out a framework for success over the next three years. I want to acknowledge all of the partners in this process and acknowledge their interest in improving the health of the Pueblo Community. The level of collaboration is a model for other communities across Colorado. Thank you!



Randy Evetts

Public Health Director

It has been an honorable and impactful experience, not only collaborating with health partners for the Community Health Improvement Plan (CHIP) implementation, but also for the plan's creation and prioritization. Optimistically, this novel experience will expand the existing foundation formed during the 2024 joint Community Health Assessment (CHA) and be leveraged for future alignment and community impact efforts. Having both Pueblo County hospitals at the table for the 2025-2028 CHIP is significant for Pueblo to demonstrate a unified effort towards improving the health and well-being of our residents, especially due to the diverse set of services, resources, expertise, and populations served at each partnering agency. This diversity will be the fuel that drives the much-needed improvements around mental health and risky behaviors not only the next three years but for generations to come.



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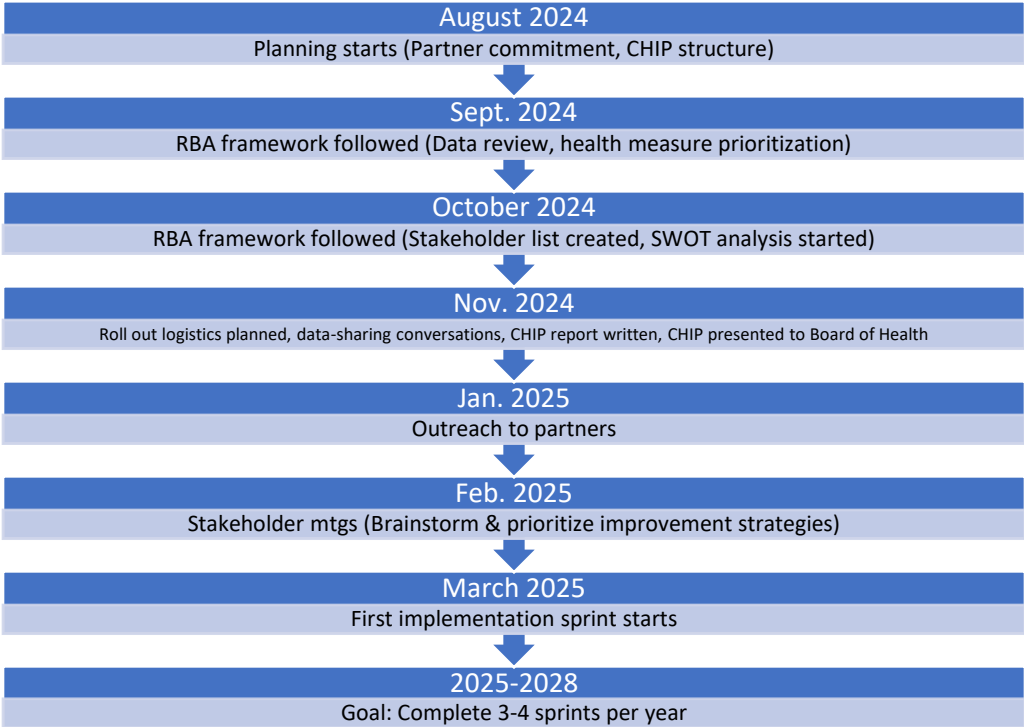
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Executive Summary

The Community Health Improvement Plan (CHIP) is the outline to make actionable improvements towards the health priorities identified through the most recent Community Health Assessment (CHA). As a local public health agency (LPHA), the Pueblo Department of Public Health and Environment (PDPHE) is state mandated to create and implement a CHIP that is community- and data-driven.

Pueblo County has taken this requirement as a higher standard by aligning with two major health systems in the community: CommonSpirit St. Mary Corwin Hospital and UCHealth Parkview Medical Center. The composition of the three key health systems in Pueblo allows improvement strategies to meet diverse needs and have systems-change impacts.

The 2025-2028 CHIP was developed throughout Fall 2024 to be implemented at the start of 2025. The advisory committee, which was comprised of several key staff from the three partner agencies, met weekly to plan and draft the joint CHIP.



Two strategic frameworks will continue to be instrumental for the CHIP, including the Results-Based Accountability (RBA) framework for planning and the Equity Action Lab framework for implementation. Both capitalize on limited capacity and resources, community involvement, and performance management practices. As part of the planning process, the CHIP highlights a total of 21 health measures and indicators that will be used to narrow and drive future improvement strategies by local stakeholders. Those measures include health topics within mental health and risky behaviors, which were the two health priorities resulting from the 2024 CHA. As improvement strategies occur over the next three years, updates and successes will be communicated to the public and stakeholders on a consistent basis.

2024 Community Health Assessment (CHA) Data & Results

Two health priorities rose to the top of all secondary data, primary data, and community feedback: **mental health** and **risky behaviors/substance use**. The highlights from the secondary data (publicly available federal, state, and local data) and primary data (data collected during the 2024 CHA via surveying) are included in the 2024 Community Health Assessment (CHA) report that can be found on the pueblohealth.gov website.

Community Health Improvement Plan (CHIP) Creation

Development Framework

Two distinct frameworks were and will be used for the 2025-2028 CHIP: one for development, the Results-Based Accountability (RBA) framework, and one for implementation, the Equity Action Lab framework. The implementation framework will be described in more detail later in this report.

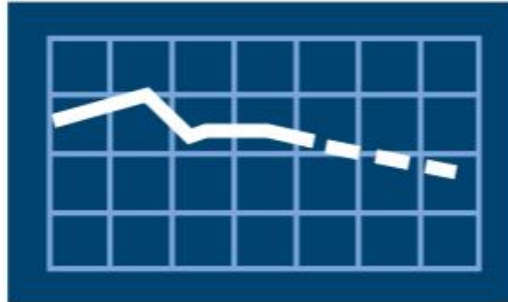
It was clear to PDPHE's Planner that this CHIP creation would need to be slightly different due to the collaborative nature among the three health agencies. It was also important to acknowledge that all three agencies serving on the advisory committee have limited capacity and resources for the CHIP. After initial conversations with the partners, the Planner determined that all health partners already track various quality measures and health indicators that are consistent across all systems. In order to leverage this commonality, the Planner sought to find a framework that would bring PDPHE into that performance measure world, as historically PDPHE's CHIPs have been created in different ways.

The RBA framework was first brought to PDPHE's attention when the Colorado Department of Public Health and Environment (CDPHE) stated that RBA would be used for their CHIP development. The guide used by this group and PDPHE's Planner was the "Results Based Accountability Guide" by Results Leadership Group. The 10-page guide walks through the six-step process to determine: 1) What is the end? 2) How are we doing? 3) What is the story behind the curve? 4) Who are partners who have a role to play in turning the curve? 5) What works to turn the curve? And 6) What do we propose to do to turn the curve? The details of decisions made during all six steps of the RBA framework are as follows:

II. THE RBA "TURN-THE-CURVE" TEMPLATE

This template is an overview of the step-by-step RBA "turn-the-curve" decision-making process.

- 1** **What is the "end"?**
Choose either a result and indicator or a performance measure.
- 2** **How are we doing?**
Graph the historic baseline and forecast for the indicator or performance measure.



- 3** **What is the story behind the curve of the baseline?**
Briefly explain the story behind the baseline: the factors (positive and negative, internal and external) that are most strongly influencing the curve of the baseline.
- 4** **Who are partners who have a role to play in turning the curve?**
Identify partners who might have a role to play in turning the curve of the baseline.
- 5** **What works to turn the curve?**
Determine what would work to turn the curve of the baseline. Include no-cost/low-cost strategies.
- 6** **What do we propose to do to turn the curve?**
Determine what you and your partners propose to do to turn the curve of the baseline.

Figure 1: The RBA framework was used for 2025-2028 planning, guiding the advisory committee through prioritizing data health measures and indicators through various criteria, also acting as a template for future communication of results.

Step 1: What is the end?

The objective of the first RBA step is to select the performance measures (PMs) that will be the goal of any project, ours being the two health priorities for the 2025-2028 CHIP. As described in the guide, this step is a fairly simple prioritization matrix to narrow down one PM out of a researched list of several options. Because this project is focused on improving health outcomes through systems-change improvements, the partners adapted RBA's step one to allow for a tiered approach. Instead of just one PM for the health priority, the partners determined a need for long-term health measures followed by

leading, proxy indicators to allow for more timely and consistent data for implementation course correction and flexibility among the diverse partners and stakeholders (services, programming, funding, regulations).

The advisory committee first reviewed the 2024 CHA’s secondary data to identify any longer-term health measures from federal or state sources that would be a good first-tier PM. To do so, the Public Health Planner facilitated the completion of a long-term measure prioritization, which used the criteria of severity in Pueblo County (based on data points compared to the state) and how much the measure aligned with each agency’s current efforts and priorities.

After that, a prioritization matrix was created and completed by each agency’s representative using the criteria for which they would need to report results (level of importance). They considered if the measure was a good proxy to other indicators, and if the data was available on a timely basis. The second prioritization matrix did not separate out the measure for each priority as much as hoped, but a theme was identified through those results to form the recommendation presented by the Planner and included below:

Health Priority	Long-Term Measure	Data Source & Frequency	Leading, Proxy Indicator	Data Source	Data Frequency
Mental Health	Age-adjusted rate of suicide deaths (per 100,000 population)	CO Health & Hospital Assoc.; last data in 2018-2020	Percent of high school students who seriously considered attempting suicide during the past 12 months	Healthy Kids Colorado Survey	2 years; next in 2025
			Of people ages 5+ reported poor mental health	Colorado Health Institute	Every 2 years; last in 2023
	Age-adjusted rate of suicide hospitalizations (per 100,000 population)	CO Vital Statistics; every year	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	Healthy Kids Colorado Survey	2 years; next in 2025
			Percent of women who experienced postpartum depression	Pregnancy Risk Assessment Monitoring System (PRAMS)	Every year; last available is 2022

			Depression screenings	Local Hospital Data	
			Follow up after depression screening results	Local Hospital Data	
			Access to mental health care	Regional Accountable Entity (RAE) claims data	
Risky Behaviors	The percent of older adults (65+ years) who were up to date on a core set of clinical preventive services	Behavioral Risk Factor Surveillance System (BRFSS) /VISION; every 2 years	The percent of females aged 40+ who have had a mammogram within the last 2 years	Behavioral Risk Factor Surveillance System (BRFSS)	every 5 years, last data in 2022
			Percent of sexually active high school students using an effective method of birth control to prevent pregnancy (Among students who had sexual intercourse during the past three months, the percent who used birth control pills to prevent pregnancy before sexual intercourse the last time)	Healthy Kids Colorado Survey	2 years; last data in 2023
			HIV screenings, prevention	Local Hospital Data	
	Overdose death crude rate (per 100,000)	CO Vital Statistics; every year	Percent of adults who reported binge drinking (males 5+/females 4+ drinks on one occasion) in the past 30 days	Behavioral Risk Factor Surveillance System (BRFSS)	Every 5 years, last data in 2022
			ER visit follow up	Local Hospital Data	
			Women who drank alcohol in the last	Pregnancy Risk Assessment	Every year; last

			trimester of pregnancy	Monitoring System (PRAMS)	available is 2022
			Overdose incidence from opioids	Colorado Vital Statistics	Every year; local substance use data dashboard via PDPHE
	Percentage of students who have ever used an electronic vapor product	Healthy Kids Colorado Survey; last data in 2023	Tobacco Use, prevention, & cessation	Local Hospital Data	
			Percent of high school students who used marijuana one or more times during the past 30 days	Healthy Kids Colorado Survey	2 years; next in 2025

The approval of the five long-term health measures and 16 leading, proxy indicators further sparked conversations around data-sharing agreements for the local hospital data that would need to be shared and tracked on a consistent basis.

Step 2: How are we doing?

After the advisory partners approved the 21 total measures, the second step of the RBA framework instructs teams to collect historical baseline data and visualize each measure. This step was critical because it allows partners to communicate results on a consistent basis and make data-driven “course corrections” if needed throughout the next three years. The framework mentions this template as an “accountability tool”, which is well-suited for the CHIP.

The “story behind the curve” section in the accountability tool will include the results from each health priority’s SWOT analysis (pgs. 18-19) for each measure. For the long-term health measures, the leading, proxy indicators will serve as the template’s “What we propose to do to improve progress” section. That section will include the actual improvement strategies prioritized by the stakeholder groups during implementation (pg. 25).

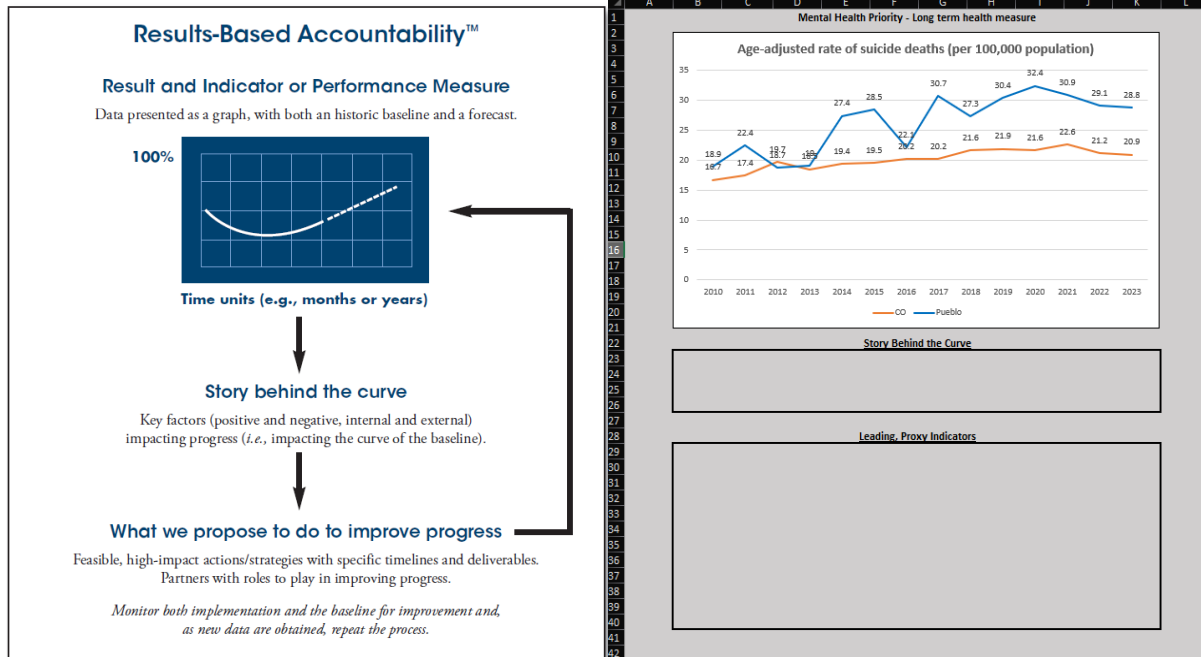


Figure 2: The RBA Framework includes a template for tracking and communicating results/impact after implementation. The two visuals above include the frameworks template and that created in Excel for the CHIP.

The ongoing tracking and report out of these measures and visuals are the responsibility of the Public Health Planner over the following three years, made possible through the dependable data sharing provided by the CHIP partners.

Data sharing agreement conversations continued to determine the specific local data measures to collect consistently across both hospital systems, frequency of collecting the data, and necessary legal agreements to support confidential usage.

Step 3: What is the story behind the curve?

The third step of the RBA framework starts building out the limitations and constricting factors that influence each health measure. To complete this step, the Public Health Planner walked the advisory committee partners through Strengths, Weaknesses, Opportunities, Threats (SWOT) analysis. A SWOT analysis highlights the internal and external assets that can be leveraged and weaknesses that could be barriers.

SWOT ANALYSIS



Figure 3: A SWOT analysis or matrix is a tool used during strategic planning to identify and plan for internal and external influences on the project or priority, whether good or bad.

A SWOT analysis was completed for each health priority in general: mental health and risky behaviors. This SWOT whiteboard was started by the advisory committee with the intention of having each health priority's stakeholder teams finish them off at the beginning of 2025.

The Mental Health SWOT matrix, visualize above, features:

- Strengths
 - Sources of Strength programming in school districts
 - Health Solutions
 - Behavioral health integrated into primary care and residency
 - PCHC mental health providers
 - Support after screenings – wraparound supports
 - Assessment process – continue to implement suicide and perinatal screenings
- Weaknesses
 - Capacity for civil care at CMHIP – discharge into Pueblo
 - Assessment process
 - Lack of providers – some that take private insurance
 - Inpatient beds – there is not an inpatient facility
 - Not enough healthy activities
 - LGBTQ+ focused clinicians
 - Not many housing options for those going through treatment

- Opportunities
 - Healthy Steps model @ SMC – advancing and expanding
 - SOCOYOGO youth prosocial program & rewards
 - Pueblo Suicide Prevention Coalition
 - School districts want more and are interested in more - need capacity & supports.
 - Could have better mapping on resources! Have screenings at other resource meetings. United211. Care coordination.
 - Community Health Workers
 - Partner collaboration - care transition
 - Expanding BH specialists - PCC workforce tract. Could we expand this to high school students?
- Threats
 - Pueblo's stigma as a community
 - Work life Balance
 - Stigma of seeking help
 - Lack of funding for healthy activities
 - Beacon is challenging to work with regarding sustainability of services.
 - No model to support individuals not meeting treatment.

The Risky Behaviors SWOT matrix, visualize above, features:

- Strengths
 - Collaboration among providers and healthcare
 - Preventive health screenings - women's health, public outreach
 - Additional HKCS data analysis
 - Early screening rates
 - Peer support groups
 - Trusted Adult classes and information
 - Immunizations at PDPHE
- Weaknesses
 - No real sex ed in school districts
 - Gun violence
 - Lack of transportation options
 - Not enough healthy activities
 - Not operating from a trauma-informed lens
 - Assessment for unstable housing individuals
- Opportunities
 - More early childhood programs that work with the whole family
 - Leverage CSUP to offer resources
 - Coordinate services within public school system
 - School districts want more and are interested in more - need capacity & supports.
 - Expanding BH specialists - PCC workforce tract
 - PDPHE in school for Sex ed - expand? Sustainable?

- Social-emotional education for youth.
- Colorado Roots - wants to move into Pueblo; looking for grant funding. Comm partner alignment.
- Substance Use Response Ecosystem
- Regional Opioid Funding
- CDPHE mobile vaccine van
- Telehealth for substance use, alternatives
- Early screening rates - expand and increase
- Gun lock distribution
- Partnerships collaboration for wraparound
- Threats
 - Closure of Parkview CDU
 - Harm reduction is heavily politicized
 - Knowledge of peer support groups limited

A great success from this activity was the documentation of possible improvement projects to be implemented in the next three years. For mental health:

- “Explore judicial support for CMHIP; not meeting treatment” and
- “Expanding BH specialists with PCC workforce tract (could we expand this to high school students?)”

For both mental health and risky behaviors:

- “Expand gun lock distribution”
- “Zero suicide programming”.

These improvements can be made as recommendations to the implementation teams in 2025.

Step 4: Who are the partners who have a role to play in turning the curve?

For the fourth step of the RBA framework, the advisory committee compiled a list of Pueblo County stakeholders that would potentially have a role in “turning the curve” for the five long-term health measures and 16 leading, proxy indicators. A total of 40 individual stakeholders were identified as a focus for outreach to begin CHIP implementation. A more detailed list of these partners is included later in this report (pg. 25). Next steps include reaching out to these stakeholders to develop the two guiding health priority stakeholder groups.

Step 5: What works to turn the curve?

The remaining two RBA framework steps will be completed in 2025 during the beginning stages of CHIP implementation. This will be when the joint CHIP planning framework (pgs. 11-12) and implementation framework (pgs. 24-25) and will slightly overlap.

After the two stakeholder groups for each health priority are recruited and brought together in early 2025, both groups will be tasked with researching, prioritizing, and recommending improvement strategies for the CHIP health measures.

The RBA framework states that teams should consider four criteria when researching possible strategies, 1) Does the option address one or more of the root causes you have identified, 2) Is the proposed option

evidence-based, 3) Have “no-cost/low-cost” options been developed, and 4) Is additional research necessary to determine what would work or to identify other options.

This step will also serve as the “Prep” phase of the CHIP’s Equity Action Lab implementation framework, which focuses on bringing together a leadership group to review data, make improvement suggestions, and allocate resources and capacity to get the work/initiative done.

The goal is to bring the stakeholder groups together in January/February 2025.

Step 6: What do we propose to do to turn the curve?

RBA’s step six is where the CHIP stakeholder groups, in addition to the advisory committee, prioritize the researched improvement strategies. To complete this step, all parties involved will prioritize the compiled options using the criteria set forth by the RBA framework, which includes:

- Leverage: How strongly will the proposed strategy impact progress as measured by the baseline data?
- Feasibility (or reach): Is the proposed strategy feasible?
- Specificity: Is the strategy specific enough to be implemented?
- Values: Is the strategy consistent with the values of the community and agency?

The goal is to have the stakeholder groups and advisory committee prioritize the improvement strategies in February/March 2025.

Structure

For the development and implementation of the 2025-2028 CHIP, a structure was established to ensure that capacity and expertise are used strategically to avoid overtaxing the participants and burnout. A graphic of that structure is included below:

2025 – 2028 Community Health Improvement Plan (CHIP) Structure



Figure 4 This structure diagram visualizes how decisions are made, and diverse stakeholder groups are brought in to inform the 2025-2028 CHIP.

At the very top is the advisory committee, which consists of the joint CHIP agencies PDPHE, UC Health Parkview Medical Center, and CommonSpirit St. Mary Corwin. In total, the committee is comprised of six individuals that bring the health-specific knowledge and decision-making capabilities from within their agency. The role of the advisory committee was to review the data collected during the 2024 CHA as it related to the two health priorities, determine a framework for CHIP planning and implementation, and prioritize the data to help guide improvement strategies. During CHIP development, the advisory committee met every week from August – November 2024, and during implementation the committee will start meeting monthly and potentially decrease to meeting once per quarter.

Below the advisory committee in the CHIP structure are the two larger stakeholder groups that will further guide improvement strategies during implementation. These individuals would represent local agencies that have a part to play in “turning the curve”, with a strong understanding of the community’s resources, gaps, needs, and strengths when it comes to the two health priorities. During CHIP development the advisory committee compiled a list of possible stakeholders to recruit and will do so in January 2025 to kick off implementation. The role of these two groups will be to look at the prioritized data measures (pgs. 13-15) and SWOT analyses (pgs. 17-21) set forth by the advisory committee and determine the best improvement strategies to implement.

Once larger stakeholder groups are formed for each health priority and each group has compiled a list of feasible improvement strategies, the Equity Action Lab framework for CHIP implementation will begin and smaller, more focused teams will be formed for the first 100-day improvement “sprint”. These implementation teams will vary and evolve over the next three years in membership and focus.

Approval

This CHIP report is a multi-purpose tool. The report will serve as documentation of the collaborative process for both hospital partners to later be approved by hospital system leadership in 2025 and 2028. The report will also be documentation for PDPHE’s state mandated requirement through Pueblo County Board of Health review, as well as a detailed description of the process for CHIP duplication in the future.

The CHIP process, prioritized health measures, and final report were presented to Board of Health in November 2024 for approval.

CHIP Implementation

Equity Action Lab Framework

The Equity Action Lab Framework was utilized by PDPHE and collaborative partners during the 2021-2024 CHIP implementation. A visual of the framework is included below.

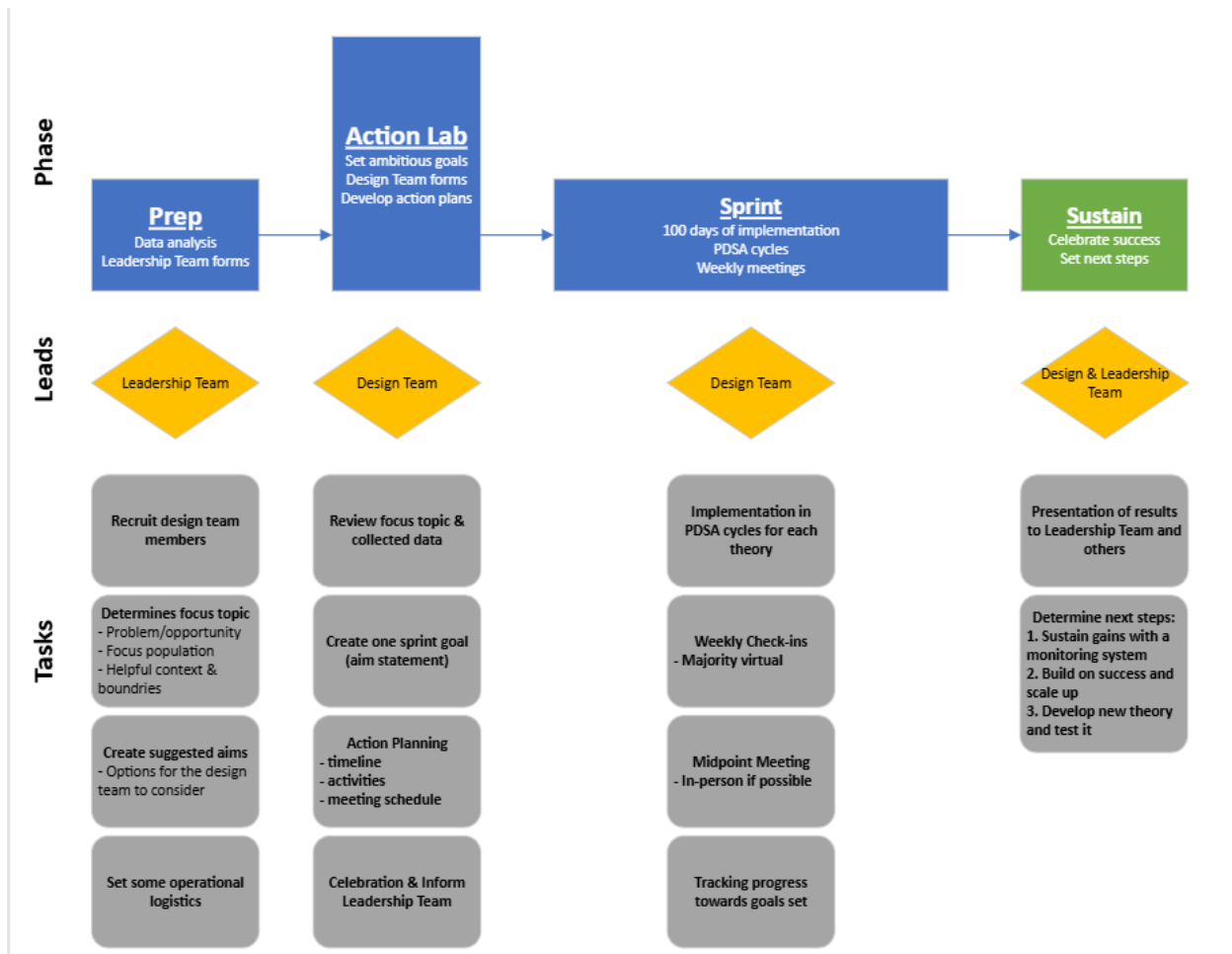


Figure 5: The Equity Action Lab framework will be used for 2025-2028 CHIP implementation, which is a re-designed PDSA model for continuous quality improvement.

The Equity Action Lab Framework is a re-designed Plan, Do, Study, Act (PDSA) Cycle, which is a common quality improvement tool and process. The framework is broken out into distinct phases and focuses on completing shorter implementation projects, called “sprints”, that are very narrowly focused. Each sprint is 100 days in length, where implementation teams meet regularly to test the project in a real-life scenario. After those 100 days, the teams evaluate the success and impact of the improvement project to determine if the change should be adopted, adapted, or abandoned. Each sprint can be built from the previous or can be completely unique, it is entirely up to the stakeholders involved, progress, resources available and the data priorities presented.

The goal of each year of the CHIP is to complete a minimum of two sprints per health priority, with a total of four sprints per year. The sprints for the two health priorities can happen simultaneously or sporadically depending on the complexity of the proposed improvement and partner capacity/resources. A timeline of each year’s sprints will be decided at the beginning of each CHIP implementation team by the advisory committee, stakeholder groups, and sprint teams.

The goal is to begin the first CHIP sprint by March 2025 for either of the two health priorities.

Identified Potential Partners

Through the creation of a Google spreadsheet that all advisory members could edit, a compiled list of local stakeholders to reach out to and recruit for CHIP implementation. Those agencies included:

- Pueblo Department of Public Health & Environment
- Pueblo City School District #60
- Pueblo Food Project
- Center Health Progress
- Health Solutions
- Pueblo Community Health Center
- Pueblo Community College
- Colorado State University-Pueblo
- Colorado Roots
- Boys & Girls Club
- County Commissioners
- City Council
- Friendly Harbor
- House Bill 1451
- Senior Resource Development Agency (SRDA)
- SMC Residency Clinic
- Servicios de la Raza
- PASADA
- Veteran's Center
- Project Angel Heart
- Hospital & Health Neighborhood Transformation
- Cooperative Care
- Nourish Colorado
- Pueblo Child Advocacy Center and Domestic Violence community task force
- Colorado Youth Detention Continuum
- Pueblo YMCA
- Packard Fund
- Juniper
- Mariposa
- The Friendly Harbor
- Catholic Charities of Southern CO
- Law Enforcement Assisted Diversion
- Southern Colorado Health Network - Access Point Pueblo
- Pueblo County School District #70
- Southern Colorado Harm Reduction Association
- Pueblo City-County Library District
- National Alliance for Mental Illnesses (NAMI)
- Pueblo Cooperative Care Center
- Pueblo City Fire Department
- Crossroads' Turning Points

These agencies will be contacted at the start of implementation in January 2025 and help guide improvement strategy prioritization.

Community Engagement and Communications Plan

Community Engagement

It was important for PDPHE to include intentions around additional community engagement throughout the CHIP, not just during the joint CHA completed in 2024. However, a constraint is the limited budget and resources among all involved partner agencies to incentivize community engagement in the next three years. A compromise identified by PDPHE and the advisory committee is to intentionally ask if community engagement should be integrated at the beginning of each implementation “sprint”. This acknowledges that for some improvements community engagement will not be necessary and if it is deemed so, then more conversation should happen around resources and purpose.

For all CHIP community outreach and engagement, PDPHE’s equity and engagement initiatives coordinator will be involved and best practices such as incentives and limiting or removing access barriers will be discussed.

Communications

The CHIP communication plan is as follows for 2025-2028:

- Annual Reports – An annual report will be created and promoted to all partner agencies, key stakeholders, and the general community that includes a summary of CHIP improvement projects, successes, involved partners, and next year’s goals.
- Quarterly Reports – Quarterly reports via an e-mailed newsletter will go to partner agencies who are involved in the CHIP effort.
- Community Presentations – Every year of the CHIP PDPHE and advisory agencies will host one round of presentations of outcomes and projects for the community. It will be important to “meet the community where they are” and ensure the location and times of these presentations are accessible. This means that there could be one, single presentation or a series of smaller presentations throughout the County. This could also include presentations at existing community meetings for coalitions, support groups, or other gatherings.
- Quarterly Webpage Updates – It will be the Public Health Planner’s responsibility to update the PDPHE CHIP webpage to ensure up-to-date information on projects, timeline, and partner involvement. The webpage will be a tool promoted by the CHIP advisory team for all stakeholders to use as a communication tool. The URL of this webpage is pueblohealth.gov/CHIP.
- Google Drive Measure Tracker Updates – As data becomes available, the Planner will update the RBA tracker containing the long-term health measures and leading, proxy indicators. This tracker will be available in the secure Google Drive folder accessible by all CHIP advisory committee members and respective agency contacts.

The communications plan for the 2025-2028 CHIP can be updated and adjusted as deemed necessary by those involved in the efforts and external leadership recommendations. The goal of the communications plan is to foster transparent, consistent communication and accountability between the health systems and the community.

Evaluation Plan

There will be a combination of short-term and long-term evaluation practices for the 2025-2028 CHIP.

A smaller scale evaluation will occur during and directly after each improvement “sprint” by the implementation stakeholder teams to set the next sprint team up for success. A longer-term evaluation will happen on a quarterly and annual basis to set the stage for future years of improvements.