DOUGLAS COUNTY
HEALTH DEPARTMENT COLORADO

**Request to Approve DCHD Community Health Needs Assessment and Public Health Improvement Plan**

Staff recommend that your board review the attached Community Health Needs Assessment (CHNA) and Public Health Improvement Plan (PHIP) and requests your approval of these plans so they can be published.

DCHD worked with the two Advent Health hospitals in Douglas County in the first half of this year to complete a joint CHNA which is an activity required of non-profit hospitals as well as local health departments. By pooling our efforts, both organizations saved time and money. Further, local people were asked to provide input on one CHNA rather than two. Omni was contracted to facilitate the CHNA and DCHD then contracted with them again to complete the PHIP.

These documents will guide our work over the coming three years and will form the basis for a refresh of our Strategic Plan early in 2026.

Omni

June 2025

Omni Institute Report

# Douglas County:
# Community Health Needs Assessment

## 2025

Omni Institute Report

# Douglas County

## Community Health Needs Assessment

**Submitted to:**

AdventHealth Castle Rock
AdventHealth Parker
Douglas County Health Department


### For More Information

projects@omni.org



### Acknowledgements

Omni Institute would like to thank the members of Douglas County, Colorado, who contributed their time and expertise to this report by sharing their insights on key health concerns and assets through key informant interviews, focus groups, and facilitated meetings.


### Suggested Citation

Omni Institute (2025). Douglas County Community Health Needs Assessment. Submitted to AdventHealth and Douglas County Health Department, Douglas County, Colorado.

# Table of Contents

# Introduction

AdventHealth Castle Rock, AdventHealth Parker, and Douglas County Health Department are pleased to share our 2025 Douglas County Community Health Needs Assessment (CHNA). This report fulfills the Patient Protection and Affordable Care Act requirement for not-for-profit hospitals to complete a CHNA at least once every three years and the Colorado Public Health Assessment and Planning System (CHAPS) requirements of the Colorado Public Health Act. Douglas County's last CHNA was completed in 2022. In 2025, AdventHealth Castle Rock, AdventHealth Parker, and Douglas County Health Department partnered with Omni Institute (Omni) to conduct Douglas County's CHNA. This report details the health assessment process as well as data collected from prioritization meetings with county leadership and the community, key informant interviews, and focus groups with community members. Data gathered as part of the CHNA process will be used by AdventHealth Castle Rock and AdventHealth Parker and Douglas County Health Department to inform community health improvement planning and the key health priorities each entity will work to strategically address over the next three to five years.

# Community Overview

## Community Description

Located in Douglas County, Colorado, AdventHealth Castle Rock and AdventHealth Parker combined their service areas to define their community as the Primary Service Area (PSA), the area in which 75-80% of its patient population lives. This includes the 17 zip codes across Douglas County. AdventHealth Castle Rock and AdventHealth Parker's combined community will be referred to as the **"Hospitals' community"** or **"Hospitals' PSA"**. This community profile is based on the Hospitals' PSA and is representative of Douglas County.

Demographic and community profile data in this report are from publicly available data sources such as the U.S. Census Bureau and the Centers for Disease Control and Prevention (CDC), unless indicated otherwise. Data are reported for the Hospitals' PSA, unless listed differently. Data are also provided to show how the community compares locally, in the state, and at a national level for some indicators.[1]

## Community Profile

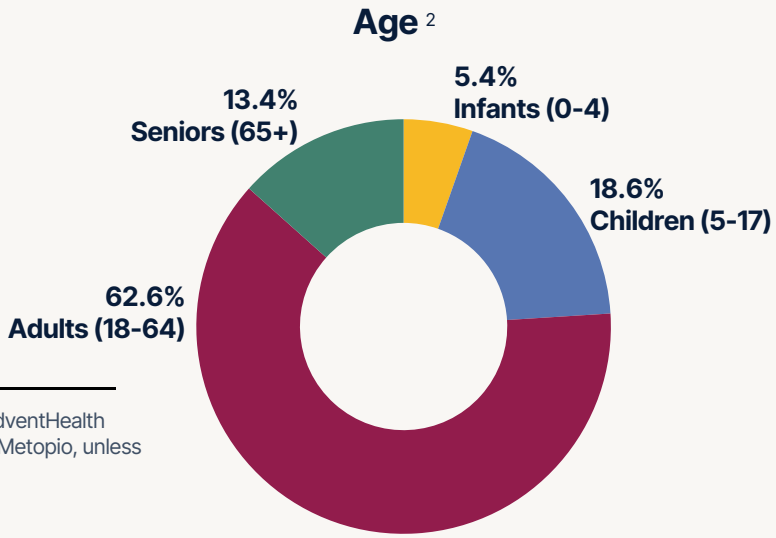
### Age and Sex

The median age in the Hospitals' community is 39.5, slightly higher than that of the state, which is 37.5 and the U.S., 38.7.

Males are the majority, representing 50.4% of the population. **Middle-aged men, 40-64 are the largest demographic in the community at 36.4%.**

Children make up 24% of the total population in the community. Infants, those zero to four, are 5.4% of that number. The community birth rate is 54 births per 1,000 women aged 15-50. This is higher than the U.S. average of 51.58 and that of the state, 48.86. In the Hospitals' community, 5.4% of children aged 0-4 and 22.9% of children aged 5-17 are in poverty.

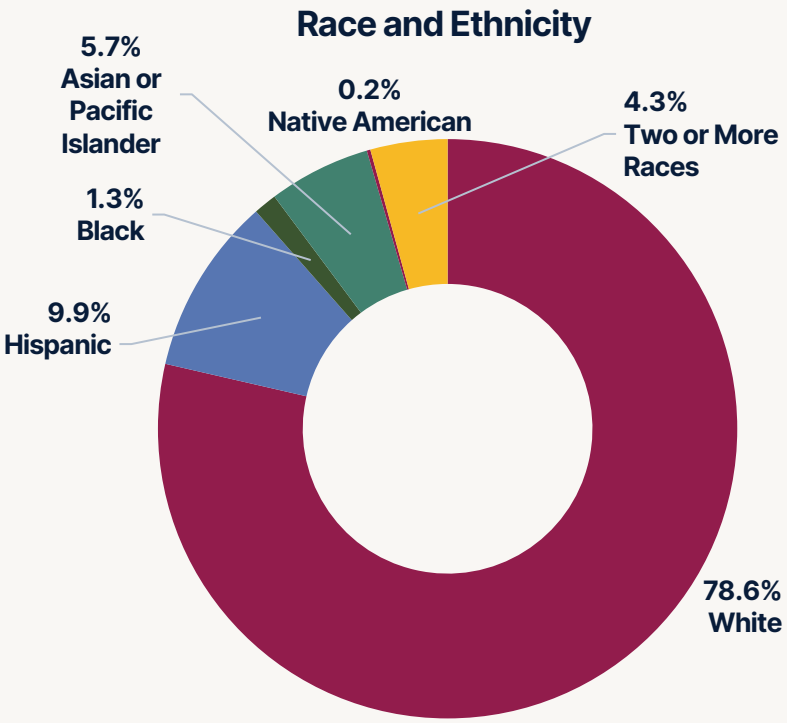
**Seniors, those 65 and older, represent 13.4%** of the total population in the community.




[1] All data were provided by AdventHealth
[2] Statistics for all charts from Metopio, unless otherwise stated.

## Race and Ethnicity

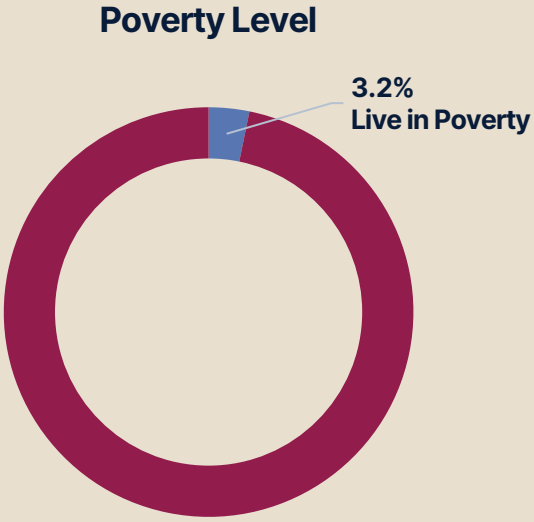
In the Hospitals' community, **78.6% of the residents are non-Hispanic White**, 1.3% are non-Hispanic Black and 9.9% are Hispanic or Latino. Residents who are of African or Pacific Islander descent represent 5.7% of the total population, while 0.2% are Native American and 4.3% are two or more races.




# Economic Stability

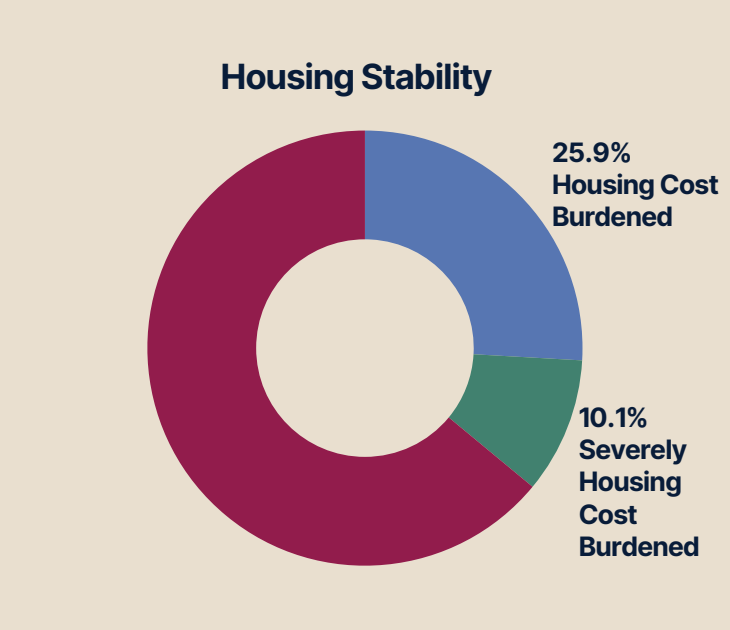
## Income

The median household income in the Hospitals' community is $145,737. This is above the median for the state, which is $81,883. Although above the median, **3.2% of residents live in poverty, the majority of whom are under the age of 18.**



## Housing Stability

Increasingly, evidence shows a connection between stable and affordable housing and health.[3] When households are cost burdened or severely cost burdened, they have less money to spend on food, health care, and other necessities. Having less access can result in more negative health outcomes. **Households are considered cost burdened if they spend more than 30% of their income on housing and are severely cost burdened if they spend more than 50%.**




## Education Access and Quality

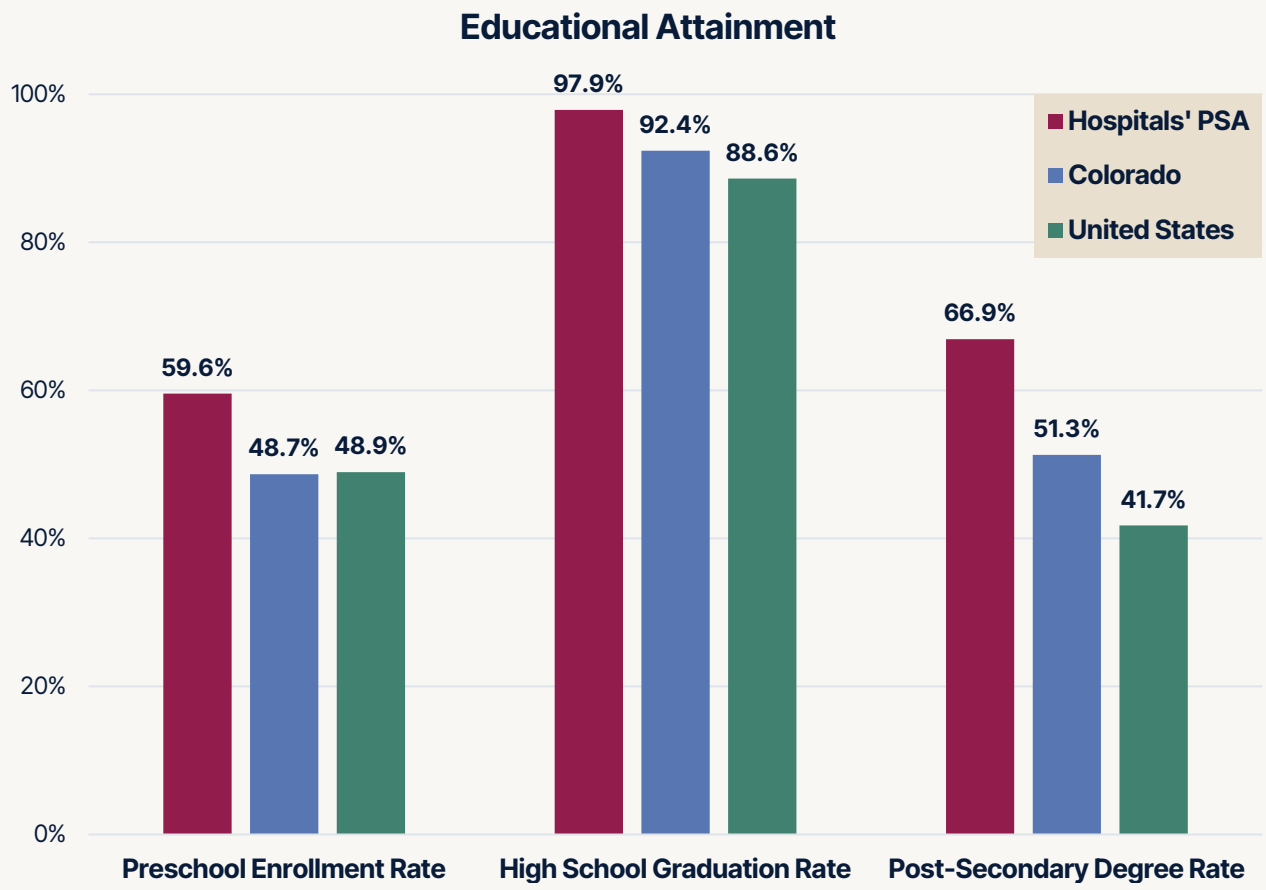
Research shows that education can be a predictor of health outcomes, as well as a path to address inequality in communities.[4] Better education can lead to people having an increased understanding of their personal health and health needs. Higher education can also lead to better jobs, which can result in increased wages and access to health insurance.

**In the Hospitals' community, there is a 97.9% high school graduation rate, which is higher than both the state, (92.4%) and the national average (88.6%).** The rate of people with a post-secondary degree is also higher in the Hospitals' PSA than in both the state and nation.

Early childhood education is uniquely important and can improve children's cognitive and social development. Early childhood education also helps provide the foundation for long-term academic success, as well as improved health outcomes. Research on early childhood education programs shows that long-term benefits include improved health outcomes, savings in health care costs, and increased lifetime earnings.[5]

**In the Hospitals' community, 59.6% of three-and four-year olds were enrolled in preschool.** Although higher than both the state (48.7%) and the national average (48.9%), there is still a large percentage of children in the community who may not be receiving these early foundational learnings.

[3] Severe Housing Cost Burden | County Health Rankings and Roadmaps
[4] The Influence of Education on Health: An Empirical Assessment of OECD Countries for the Period 1995-2015 | Archives of Public Health | Full Text (https://link.springer.com/article/10.1186/S13690-020-00402-5)
[5] Early Childhood Education | U.S. Department of Health and Human Services



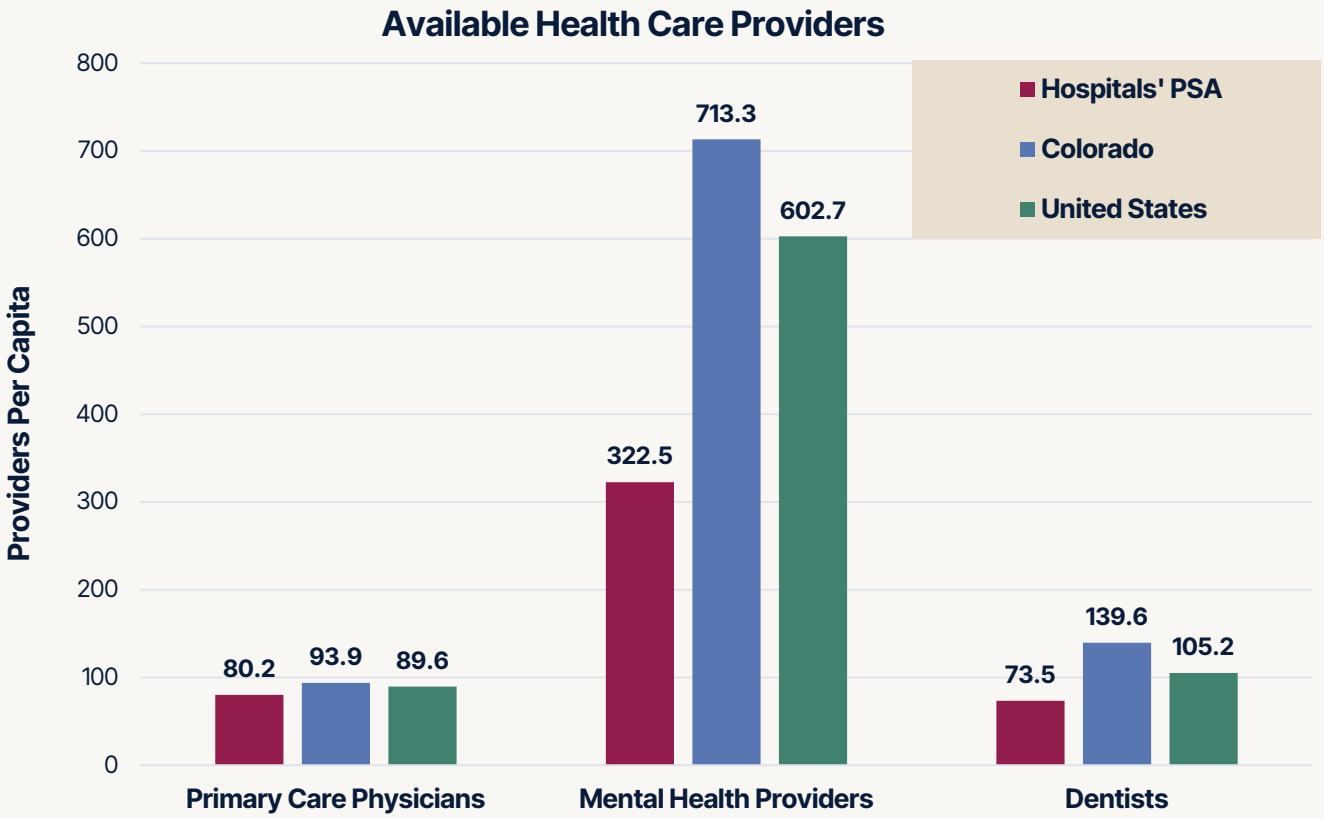

## Health Care Access and Quality

In 2023, the Colorado Health Institute reported 2.4% of uninsured community members aged 18-64 lacked health insurance. Without access to health insurance, these individuals may experience delayed care, resulting in more serious health conditions and increased treatment costs. Although health insurance coverage levels can be a strong indicator of a person's ability to access care, there are other potential barriers that can delay care for many people.[6]

Accessing health care requires more than just insurance. There must also be health care professionals available to provide care. When more providers are available in a community, access can be easier, particularly for those experiencing transportation challenges. **The Hospitals' PSA has slightly lower primary care providers available, 80.2 per capita, compared to the state which is 93.9 per capita.**

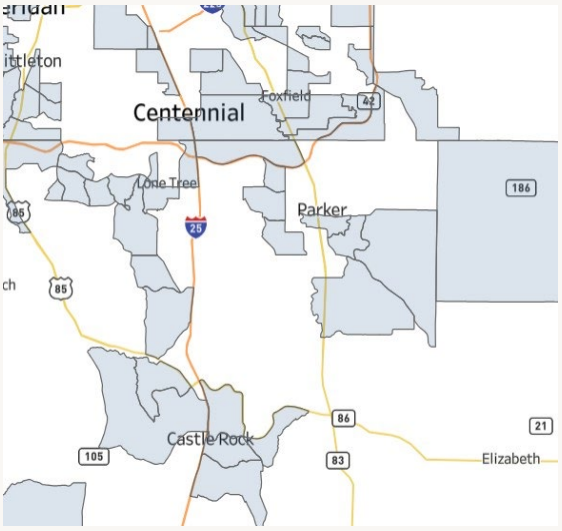
Routine checkups can provide an opportunity to identify potential health issues and when needed, develop care plans. **In the Hospitals' community, 84.5% of people report visiting their doctor for routine care.**

[6] Health Insurance and Access to Care | CDC




## Neighborhood and Built Environment[7]

Increasingly, a community's neighborhoods and built environment are shown to impact health outcomes. If a neighborhood is considered to have low food access, which is defined as being more than ½ mile from the nearest supermarket in an urban area or ten miles in a rural area, it may make it harder for people to have a healthy diet. A very low food access area is defined as being more than one mile from the nearest supermarket in an urban area or 20 miles in a rural area.




A person's diet can have a significant impact on health, so access to healthy foods is important. For example, the largest contributors to cardiovascular disease are obesity and type 2 diabetes, both of which can be impacted by diet.[8] **In the Hospitals' community, 5.6% of the community lives in a low food access area, impacting around 19,600 people.** The grey areas on the map show low food access areas.

[7] Blueprint to End Hunger
[8] Heart Disease Risk Factors | CDC

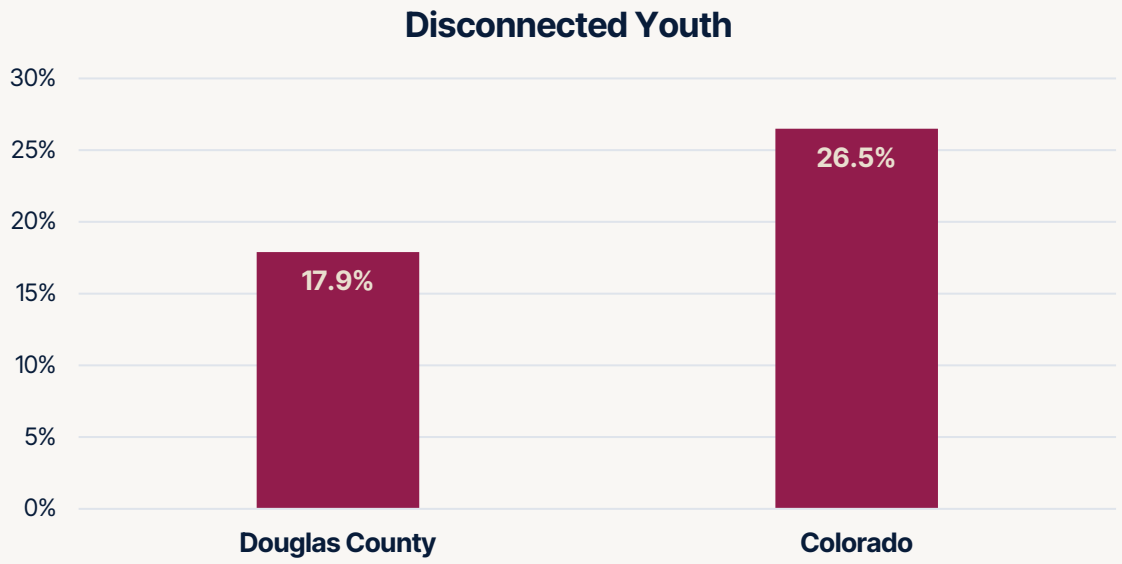
People who are food insecure, who have reduced quality or food intake, may be at an increased risk of negative health outcomes. Studies have shown an increased risk of obesity and chronic disease in adults who are food insecure. Children who are food insecure have been found to have an increased risk of obesity and developmental problems compared to children who are not.[9] **Feeding America estimates for 2023 showed the food insecurity rate in the Hospitals' community as 8.4%.[10]**

Access to public transportation is also an important part of a built environment. For people who do not have cars, reliable public transportation can be essential to access health care, healthy food and steady employment. In the community, 3.5% of the households do not have an available vehicle.

## Social and Community Context

People's relationships and interactions with family, friends, co-workers and community members can have a major impact on their health and well-being.[11] When faced with challenges outside of their control, positive relationships with others can help reduce negative impacts. People can connect through work, community clubs or others to build their own relationships and social supports. There can be challenges to building these relationships when people don't have connections to create them or there are barriers, like language.

**In the community, 17.9% of youth aged 16–19 were reported as disconnected, meaning they were neither enrolled in school nor working at the time.[12]** The percentage of disconnected youth is lower than the state which is 26.5%.




[9] Facts About Child Hunger | Feeding America
[10] Map the Meal Gap 2022 | Feeding America
[11] Social and Community Context-Healthy People 2030 | U.S. Department of Health and Human Services
[12] Healthy Kids Colorado

Further, **18% of seniors (age 65 and older) in the community report living alone and 24% of residents report having limited English proficiency.** All these factors can create barriers to feeling connected in the community.

## Social Determinants of Health

According to the CDC, social determinants of health (SDOH) are the conditions in the places where people live, learn, work and play that affect a wide range of health risks and outcomes. **Social determinants of health are increasingly seen as the largest contributing factor to health outcomes in communities throughout the country.**

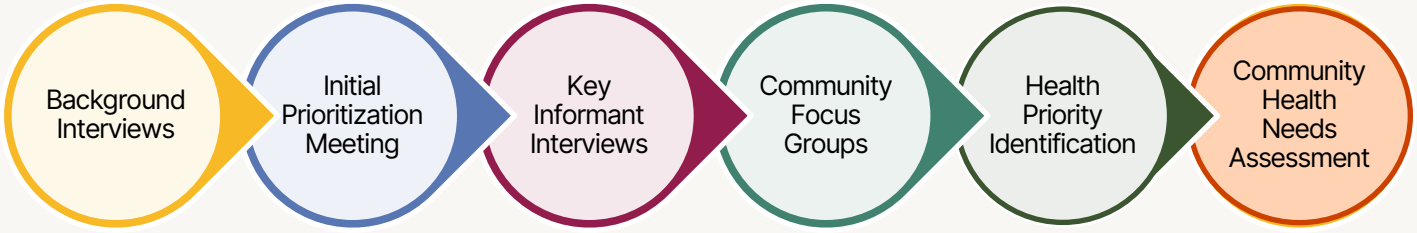
The Hospital categorized and analyzed SDOH data following the Healthy People 2030 model. This approach was chosen so the Hospital could align its work with national efforts when addressing social determinants of health when possible. For the purposes of CHNA, the Hospital will follow this model for reporting any related data.

**The Healthy People 2030 place-based framework outlines five areas of SDOH:**

- **Economic Stability**
  Includes areas such as income, cost of living and housing stability.
- **Education Access and Quality**
  This framework focuses on topics such as high school graduation rates, enrollment in higher education, literacy and early childhood education and development.
- **Health Care Access and Quality**
  Covers topics such as access to health care, access to primary care and health insurance coverage.
- **Neighborhood and Built Environment**
  Includes quality of housing, access to transportation, food security and neighborhood crime and violence.
- **Social and Community Context**
  Focuses on topics such as community cohesion, civic participation, discrimination and incarceration.

# Methods

This section of the report describes the methods used in this assessment. The visual below depicts the specific CHNA process used for Douglas County, followed by a description of the methodology involved in each component of work.




## CHNA Process

### Background Interviews

The Douglas County CHNA process began with a thorough review of data from past AdventHealth Castle Rock and Parker CHNAs, Community Health Improvement Plans (CHIP), Douglas County Health Department's Community Health Assessment (CHA), Public Health Improvement Plan (PHIP) and the Maternal Child Health Landscape Scan, and the recent Men's Mental Health Report from Douglas County. This review of background materials enabled Omni to understand data and community feedback on already identified health priorities to ground project understanding.

> "I would love to see a place for them [people] to get primary care. I think it would **create less strain on our emergency departments** and then ultimately help them be healthier people."
>
> - Background interview participant

Next, three background interviews were conducted with County leadership and AdventHealth leadership to promote further understanding and develop initial priority areas for focused data collection. Nine individuals from AdventHealth Castle Rock and AdventHealth Parker participated in the background interviews with roles ranging from Director and Chief Executive Officers to members of the Care Management team and the hospital Chaplain.

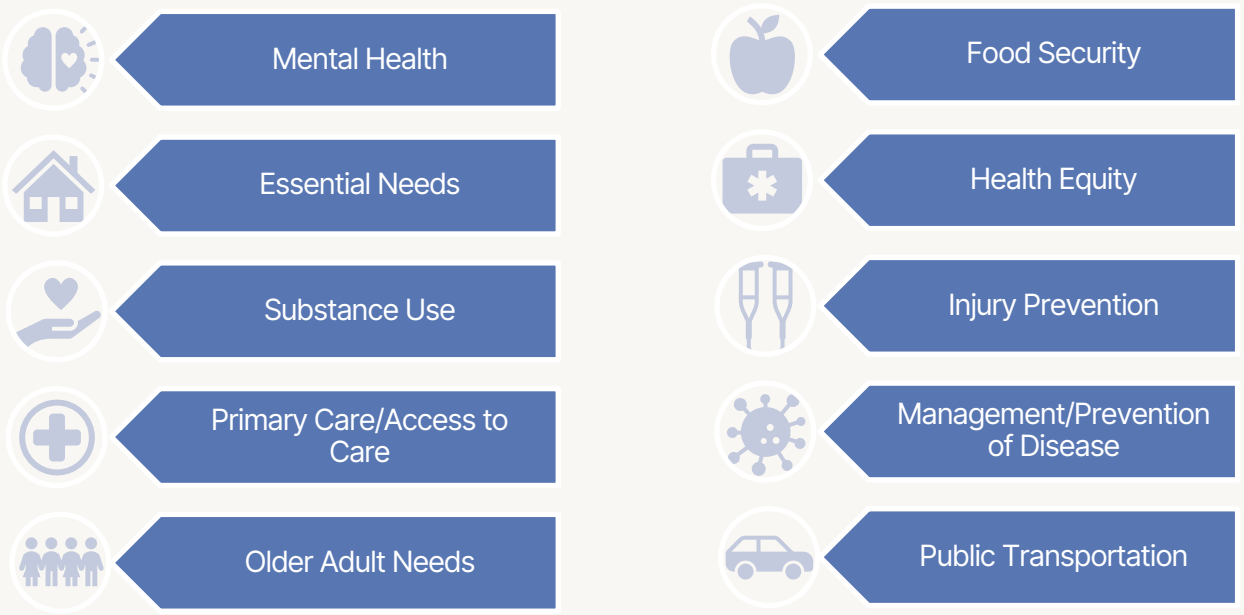
Participants identified three primary areas of community need during the background interviews, which included **mental health, substance use, and primary care/access to care**. Additional priorities participants identified included:

- Essential needs, like housing and food security, especially for people experiencing homelessness

- Increasing public transportation options
- Engagement with the older adult population

## Initial Prioritization Meeting

After the background research and interviews were completed, Omni facilitated a one-hour meeting to review initial data and identify areas of focus for primary data collection. The goal of the meeting was to identify the top five areas where more data collection would be important. With representatives from AdventHealth Castle Rock and AdventHealth Parker, Douglas County Health Department, and local service organizations, 19 individuals participated in the initial prioritization meeting. At the meeting, participants reviewed themes from the initial interviews as well as data from previous reports for Douglas County. Participants then engaged in a prioritization exercise to identify the top five areas of focus for additional data collection. Participants ranked the following 10 priority areas:




Results from the health prioritization exercise indicated that participants prioritized **mental health, substance use, essential needs, primary care/access to care, and senior population needs** as the top five health need areas in Douglas County for which more data collection would be conducted for the 2025 CHNA. These findings were then used to develop the key informant interview and focus group guides.

## Key Informant Interviews

Key informant interviews were conducted with representatives from key organizations and sectors in Douglas County to gain insight into how their work influences overall community health. Key informants provided input on the county's priorities, strengths, and vision, focusing on the people they serve and their services. Omni's research team conducted eight, 60-minute

interviews with informants who represented the following organizations or groups: South East Community Outreach (SECOR) Cares, Douglas County Health Department, Douglas County Housing Partnership, National Alliance on Mental Illness (NAMI) Arapahoe/Douglas Counties, the Douglas County School District, and law enforcement.

## Focus Groups

Community focus groups were also held to gain a deeper understanding of how the CHNA focus areas impact community health. These discussions explored existing barriers to addressing health priorities, as well as the assets and collaborative efforts within the community that can be leveraged to improve health outcomes in Douglas County. Specifically, the focus groups asked questions to further examine the impact of organizational efforts as well as service experiences in Douglas County.

Omni's research team conducted two 90-minute virtual focus groups. The first group focused on organizational perspectives and included five participants representing AllHealth Network, Integrated Family Community Services, You Are Not Alone (YANA), SECOR Cares, and Aging Resources of Douglas County. The second group included four community members who shared their personal experiences accessing services. A third focus group was planned to gather input from the Spanish-speaking community in the County but was ultimately not held due to recruitment challenges.

## Health Priority Identification


Omni researchers facilitated a 2.5-hour "Community Health Improvement Meeting" on May 8, 2025, to review interview and focus group data and to identify the top three health priorities for Douglas County Health Department and AdventHealth Castle Rock and Parker Hospitals to focus on for the next three years. A full summary of key informant and focus group data is included in the section below.

A total of 25 participants, including staff from AdventHealth Castle Rock and AdventHealth Parker, Douglas County Health Department, community nonprofit organizations, and local residents reviewed the data findings from the key informant interviews and focus groups.

Participants also engaged in a Data Gallery Walk where they moved from station to station in small groups, reviewing the data that focused on the five initial priority areas, ranking the priorities from 1-5 on handouts on Importance, Readiness, Changeability, Duplication, and Available Resources, and brainstorming potential solutions for the health priorities.

- **Importance** – How important is this issue to your community?
- **Changeability** – How likely is this issue to change?

- **Readiness** – How ready is your community to start acting on and implementing work to address the issue?
- **Duplication** – Is there already programming, initiatives, and policies in place to sufficiently address this issue?
- **Available resources** – Are there already available resources to capitalize on to begin making changes on this issue?

Next, participants shared their ranking for each area - Importance, Readiness, Changeability, Duplication, and Available Resources - in Mentimeter, a ranking tool that allows participants to share information publicly and in real-time. They debriefed their rankings and further discussed how the priorities built on hospital and health system strengths and what actionable strategies were feasible to implement given available time, readiness, and resources. After the discussion, participants completed a final vote in Mentimeter on their top three health priorities for moving forward. In order of importance, the top three health priorities selected were:

1. **Mental Health**
2. **Essential Needs**
3. **Primary Care/Access to Care**

The three priority areas selected by the Douglas County community for focus over the next three years are described below. This section is followed by a complete summary of data from the key informant interviews and focus groups. Please see Appendix A for key informant and focus group data from Substance Use and Older Adult Needs, which were not selected as top priorities but are reported in the appendix.

## Mental Health

Mental health refers to mental wellbeing, including the impact of mental health on daily activities, feelings of isolation, depressive disorder diagnoses, and suicide attempts and death.

## Essential Needs

Essential needs are the fundamental resources required for individuals and families to maintain stability and quality of life, including access to food, childcare, housing, and

## Primary Care/Access to Care

Primary care/access to care refers to the ability to obtain health care in the community, including barriers associated with availability, price, insurance status, specialty care access, and wait times.

# Key Informant Interview and Focus Group Data

In this section of the report, findings from the key informant interviews and focus groups are reported, organized by topic area. These are the data that informed selection of the health priority areas identified above. For each topic area, findings are organized by key local groups who are impacted by the topic, specific challenges related to the topic, strengths in the community that may be supportive of that topic, and where available, strategies that community members identified that may help address key challenges.

## Mental Health

The first area of focus is Mental Health. Mental health includes the impact of isolation, poor mental health days, diagnoses such as depressive disorder, as well as suicidal behaviors such as self-harm.

### Key Local Groups Impacted

- Youth
- Individuals with low income and those who are unhoused
- Individuals with co-occurring disorders
- Older adults
- Men
- Healthcare workers

> "If I could make one change, **I would make counseling services and mental health services more readily available and easier to access**. Basically, from counselors or mental health professionals that work with anyone from kindergarten all the way up to adults. It's so hard for some of our families to find resources."
>
> - Key informant interview participant

### Participants shared the following challenges and barriers related to **mental health** in the community...

- Lack of providers and long waitlists to access care
- Costly mental health services and a lack of funding, especially for youth mental health
- A perception that processes are inflexible and fail to adapt to individuals' complex needs, particularly for people with disabilities and mental health conditions
- Stigma/fear around mental health and seeking help
- Increased rates of stress/depression/anxiety, especially after COVID-19 and concern for school-aged youth since COVID-19; parental mental health was recognized as a secondary need

- Teacher capacity for working with students with serious mental health needs
- Inadequate staffing and resources at hospitals to support mental health needs

## Community strengths in Douglas County for **mental health...**

- The Community Response Team (CRT)
- Homeless Engagement, Assistance and Resource Team (HEART)
- Strong hospital partnerships
- The Mental Health Collaborative from Douglas County Mental Health Division
- Specialized programing in schools, especially for individuals with intellectual and developmental disabilities (IDD) and autism

> "We've been in the weeds of mental illness for a long, long time, and, you know, healthcare organizations, being that we **still don't have integrated healthcare**... mental healthcare has kind of always been the stepchild of the treatment path."
>
> - Key informant interview participant

## Participants highlighted strategies that the Douglas County community could employ surrounding **mental health...**

To address the community's mental and behavioral health needs, participants highlighted several key strategies that could be implemented. Establishing a dedicated inpatient mental healthcare facility could provide critical 24-hour support. Additionally, expanding access to providers accepting new patients and Medicaid could reduce barriers to care, while affordable, ongoing services, such as counseling and classes, could support both youth and adults.

> "And the fact of the matter is, we have a **system that was built to be reactive and not responsive**. And doing mental health work really is more thoughtful, responsive work. And, you know, within the healthcare system, there has not always been a clear path about how to pay to support the work that needs to be done."
>
> - Key informant interview participant

Participants also noted the need for enhanced provider training for serious mental illness, greater awareness of existing resources like those from the Health Department, and increased collaboration with programs like HEART and the CRT. Additionally, efforts to destigmatize mental health, especially for parents, and more funding for schools to support education, counselors, and trusted adults could further strengthen the system. Collectively, these strategies could create a more accessible, coordinated, and supportive mental health network.

"It's **such a challenge to be able to not only find [mental health services and resources],** but just to have some of those pieces available. For example, if we have a family whose student is suspected of having autism**, you're looking at like eight to 12 weeks, 30 weeks out before they can even be seen by a doctor."** - Key informant interview participant

# Essential Needs

The second area of focus is essential needs. Essential needs are the fundamental resources required for individuals and families to maintain stability and quality of life, including access to food, childcare, housing, and transportation.

## Key Local Groups Impacted

- People experiencing homelessness
- Individuals with low incomes
- Older adults

> "Of course, we **have to have our housing and essential needs met before we can even do anything else**. You have to **have somewhere to rest your head to be productive. You [must] have somewhere to shower and go to the bathroom."**
>
> - Focus group participant

## Participants shared the following challenges and barriers related to **essential needs** in the community...

- While some participants described receiving critical support from community organizations, others faced challenges like judgmental treatment, inflexible processes, and delays
- Participants described public assistance systems as having rigid eligibility rules and a lack of responsiveness, particularly during and after COVID-19
- Limited transportation to access services
- Participants voiced that advocacy efforts can be challenging for community members due to the perception among some community leadership that issues such as poverty and homelessness are not significant problems
- Limited call center hours and staffing shortages
- Participants shared that there can be strict and confusing eligibility thresholds to receive benefits (e.g., SNAP benefits) that often felt restrictive or punitive
- Lack of affordable, transitional, and safe and housing options

> "It's like you get a job and then all of a sudden, now you are having to pay more for rent. So, it's like **when you think you're saving with having a housing voucher, it's kind of taken away from you the minute you get a dollar increase [in wages].** And then, just even with the food stamps, the minute you get a dollar increase, food stamps are done. How can you ever really come up when they're [assistance programs] just looking to take it away?"
>
> - Focus group participant

## Community strengths in Douglas County for **essential needs...**

- SECOR Cares
- Community of Care Network
- Help and Hope Center
- Recreation Centers
- Parker Taskforce
- Catholic Charities
- Douglas County– Homeless Initiative

## Participants highlighted strategies that the Douglas County community could employ surrounding **essential needs...**

Participants mentioned several strategies to improve essential needs for individuals facing homelessness, poverty, and related barriers in Douglas County. These include advocating for increased funding to support organizations addressing basic needs and transportation and expanding access to essentials like clean water and hygiene through mobile services. Further, reducing service penalizations by avoiding one-size-fits-all models and training staff to address barriers was emphasized. Finally, simplifying paperwork across agencies to ease the burden on community members was also shared as a potential strategy.

> "I think **affordable housing is obviously a huge deal,** especially in Douglas County. As a case in point, **hardly any of our teachers can afford to live in Douglas County based on our district's salaries.** And so, the majority of our teachers are living either, you know, in Englewood or Denver, and some other areas that are just a lot cheaper."
>
> - Key informant interview participant

Additional strategies include allowing SNAP benefits to be used at restaurants for those without kitchen access and strengthening workforce development through job training and employer connections. Participants also noted the importance of building relationships with local agencies to enhance emergency rental assistance and eviction prevention, increasing awareness of available resources, and pursuing FEMA funding. Expanding service options to reach diverse populations, including people with disabilities and those without reliable technology, was seen as critical to creating a more inclusive and responsive support system.

## Primary Care/Access to Care

The third area of focus is primary care/access to care. Primary care/access to care refers to the ability to obtain health care in the community, including barriers associated with availability, price, insurance status, access to specialty care, and wait times.

### Key Local Groups Impacted

- Those with co-occurring disorders
- People who are uninsured or underinsured
- Older adult population
- People in crisis
- People without access to transportation

> "What we're seeing and what we know is that **people who are on Medicaid or who do not have health insurance, really have difficulty finding providers that can provide services to them**, because our Medicaid providers are capped at the amount of Medicaid patients they'll take."
>
> - Key informant interview participant

### Participants shared the following challenges and barriers related to **primary care/access to care** in the community...

- Few local providers accept patients who are uninsured or accept Medicaid. This can cause financial strain on hospital emergency systems, especially since there are no safety net clinics in the county
- Long waitlists to access care, resulting in people traveling to nearby counties to see a primary care provider
- A shortage of accessible and timely primary care services for unhoused individuals, creating a reliance on emergency departments
- Few specialty providers and a lack of transportation to medical appointments, especially for older adults
- Lack of accessible care options for people who work regularly scheduled jobs without the flexibility to leave work for appointments
- Lack of transportation

### Community strengths in Douglas County for **access to care/primary care...**

- Wellspring Community offers supportive housing and day programs for individuals with IDD
- Strong existing partnerships with local hospitals
- Publicly available health seminars to educate the community on heath topics such as heart-health awareness, self-breast exams, etc.

- HEART
- CRT
- Care Compact

## Participants also highlighted strategies that the Douglas County community could employ surrounding **access to care/primary care...**

Participants mentioned several strategies to enhance access to care and primary care in Douglas County. One key approach is increasing collaboration among local hospitals to streamline services and improve care delivery. Participants also emphasized the need for hospitals to conduct more outreach to underserved populations, including providing at-home care and referrals to clinics in other counties for those who are uninsured or underinsured. Strengthening care navigation services at both the county and hospital levels was highlighted as especially important for supporting older adults.

> "For folks who are on Medicaid, there are providers in this area, but you know, it is a **three-month waiting list or something like that. When you have people who are in crisis, then it's really difficult.** Or even just the people that, you know, we see every single day that are making difficult decisions about **whether they pay for their medication or go to the grocery store and buy food."**
>
> - Focus group participant

Other strategies included expanding education and awareness about available resources such as the Regional Health Connector program, Valley Hope of Parker, and AllHealth Network. Participants suggested using mobile services to help connect individuals to health insurance and care, as well as offering more flexible payment and eligibility options for people without coverage. Increasing the diversity of providers serving low-income communities and supporting community-based prevention efforts through educational workshops and health tools were also noted. Lastly, participants encouraged hospital leadership to gather community input on service barriers through surveys and listening sessions.

# Recommended Areas for Action

This section of the report summarizes several strategies for action for each of the three main priority health needs areas. These strategies were voiced by participants at the Community Health Improvement Meeting and are discussed in more detail below.

## Mental Health

- Participants emphasized the need for hospitals to serve as resource hubs that connect individuals to appropriate care. However, they acknowledged that it is challenging for hospital teams to be experts in every area. To address this, a multi-disciplinary approach could be adopted, involving specialists who focus on key areas like mental health, essential needs, and the unique challenges of older adults.
- There is a call for more resource navigators and stronger personal connections to care, including "warm handoffs" that create smoother transitions for patients.

> "If you want to be a community hospital, then bring your community back. **Let's bring people back to the hospital for a positive experience."**
>
> - Community Health Improvement Meeting participant

- Building more robust community partnerships is essential, especially with "boots on the ground" staff who can directly engage with and address local mental health needs.
- It is important to actively address stigma, particularly within marginalized populations, to ensure that everyone feels safe seeking care.
- A proactive focus on building resilience and reinforcing upstream protective factors, particularly within school systems, can help prevent mental health crises before they occur.
- Expanding peer-to-peer support models is a promising approach that the community is interested in exploring further. This includes integrating community members with lived experience into workgroups and strategy discussions, ensuring their perspectives are not overlooked.

## Essential Needs

- For hospital patients, incorporating lunch as part of their formal discharge planning could further support essential needs for those struggling with food security.
- Hospital case managers and health navigators could play a critical role in connecting patients to essential resources, including food delivery services, before discharge, ensuring that those struggling to meet their basic needs receive timely support.
- Expand and enhance transportation services for older adults to improve access to healthcare, food, and housing resources, including rental assistance and vouchers and

develop creative strategies to replace services lost due to funding cuts, ensuring continuity of support across the community.

## Primary Care/Access to Care

- Expand care navigation services both within the hospital system and throughout the community to ensure individuals can effectively navigate complex insurance processes and address their health needs. This includes fostering stronger collaborative partnerships between hospital care navigators, community-based care navigators, and case managers.
- Increase funding for community-based organizations that already employ care navigators, enhancing their capacity to support local populations.
- Increase the number of healthcare providers within the Medicaid network to reduce wait times and improve overall access to care for underserved populations.
- Provide additional funding and support for community health centers, ensuring they have the resources needed to meet the diverse healthcare needs of their communities.

# Next Steps

This Community Health Needs Assessment focused on collecting current data to identify three main priority areas in Douglas County, Colorado. Through a structured process, three areas of focus were identified: **mental health, essential needs, and access to care/primary care.**

Building on work completed together for this CHNA, Omni will support Douglas County Health Department with the development of a Public Health Improvement Plan (PHIP) and associated implementation plans, resulting in actionable strategies to guide the county in public health improvement planning over the next three to five years. Omni will facilitate a series of meetings with leadership from the Douglas County Health Department and other community partners to examine the health priorities discussed in this report. The goal of these sessions is to understand the data associated with each of these topics, develop measurable objectives and outcomes with clear targets for improvement, assign responsibilities to groups responsible for implementation, and develop a timeline for implementation. The implementation plan will then be used to inform future programming to improve health in Douglas County.

# Appendix A: Substance Use and Older Adult Needs Data

# Other Focus Group and Key Informant Interview Data

This section of the report includes data from the two strategies that were not selected as top priority areas, which includes substance use and older adult needs.

## Substance Use

Substance use refers to the consumption of any substance, including legal substances like alcohol and tobacco, or illegal substances.

> "Certainly, in substance use, we **need detox centers and things like that. Any kind of overnight care for mental health is pretty skimpy.** Not just here but around the metro area, I think. So, we need resources there."
>
> - Key informant interview participant

### Key Local Groups Impacted

- Youth
- People who do not have housing
- Individuals with co-occurring disorders

### Participants shared the following challenges and barriers related to **substance use** in the community...

- Stigma/fear around seeking treatment or help around substance use
- Lack of 24-hour care for substance use crisis needs and no detox facility
- Lack of providers who provide substance use services within the county
- Long waitlists to access care
- Lack of cross sector collaboration between treatment entities/physical health providers
- Insurance eligibility and cost of care

### Community strengths in Douglas County for **substance use...**

- The Regional Opioid Abatement Council for Douglas County
- The Juvenile Assessment Center (JAC)
- HEART
- CRT
- Strong hospital partnerships
- The Mental Health Collaborative from Douglas County Mental Health Division
- Wellness programing in the school district

### Participants also highlighted strategies that the Douglas County community could employ surrounding **substance use...**

Participants identified several key strategies to address substance use and improve access to substance use care. A primary theme was the importance of destigmatizing substance use to

encourage individuals to seek help without fear of judgement or discrimination. This cultural shift could help foster open conversations about addiction and recovery. Participants also emphasized expanding peer support programs, recognizing the critical role that individuals with lived experience can play in providing guidance and encouragement throughout the recovery process.

> "I think any peer support program that has legitimate training is well worth [the] money, **we should be [funding] to try to intervene in people's lives and try to figure out a way to get them to change their behavior."**
>
> - Key informant interview participant

Most participants also discussed the need for increased availability of detox facilities and inpatient mental health services, reflecting community concern about insufficient treatment infrastructure for those experiencing acute crises. Additionally, participants recommended broader utilization of the Regional Health Connector (RHC) model to strengthen inter-agency coordination, share resources, and improve referrals across systems. To enhance awareness and access, the need for expanded education about existing substance use resources was highlighted, as many community members remain unaware of available services. Furthermore, participants also suggested more referral and care navigation staff within both the Health Department and hospitals to ensure warm handoffs and seamless transitions into treatment and recovery programs. Lastly, enhancing community collaboration with programs such as HEART (Homeless Engagement Assistance and Resource Team) and the CRT (Community Response Team) was viewed by participants as a valuable way to provide holistic, multidisciplinary responses to substance use challenges in Douglas County.

# Older Adult Needs

Older adult needs refer to the needs of older adults, typically defined as individuals aged 65 and older, and encompasses a broad range of physical, mental, social, and environmental factors that influence their health and well-being. These needs often reflect the challenges associated with aging, as well as the systems and services required to support healthy aging in place.

## Key Local Groups Impacted

- Older adults

## Participants shared the following challenges and barriers related to **older adult needs** in the community...

- With limited housing vouchers, a fixed income, and a severe shortage of affordable options, maintaining a large home no longer supports aging in place
- Long waitlists and slow development of new housing communities for older adults
- Limited public transportation to access care specialists, especially for people who can no longer drive
- Low awareness of older adult services/resources
- Isolation

> "I think there's a lot of resources for seniors, but **most seniors still don't know how to access those**, don't understand the system."
>
> - Key informant interview

## Community strengths in Douglas County for **older adult needs...**

- SECOR Cares
- The Older Adult Initiative from Douglas County
- Link on Demand – City of Lone Tree and Highlands Ranch (public transit)
- Highlands Ranch Senior Center

## Participants also highlighted strategies that the Douglas County community could employ surrounding **older adult needs...**

Transportation emerged as a critical issue, with recommendations for expanding accessible transportation options through innovative approaches such as ride-share partnerships or food delivery services, such as Meals on Wheels, for those with mobility limitations. Participants also emphasized the need for greater support and funding for partner organizations that provide older adult transportation programs, such as senior bus services. Additionally, there was a suggestion to sponsor transportation to prevention-focused events tailored specifically for older adults, ensuring equitable access to health education and community engagement opportunities.

Another key strategy was to improve cross-sector coordination among service providers, particularly by co-locating medical and social services to simplify access and reduce the burden on older adults navigating multiple systems. Participants also identified a strong need to increase awareness of existing services available to older adults, as many remain unaware of the available resources and support systems. Finally, there was consensus among participants on the importance of maintaining ongoing community engagement with older adults through listening sessions and participatory opportunities, to ensure that programs remain responsive to their evolving needs and preferences. These strategies collectively aim to create a more age-friendly, inclusive, and supportive environment for older residents of Douglas County.

> "Like at some point our whole county is just going to be a lot of senior citizens, you know? And **as folks get older, they lose access to transportation. They can't drive anymore. They need people to take them to medical appointments.** We have people who need access to come here to get food to just meet those basic needs."
>
> - Key informant interview participant

DOUGLAS COUNTY
HEALTH DEPARTMENT COLORADO

# Public Health Improvement Plan

November 2025

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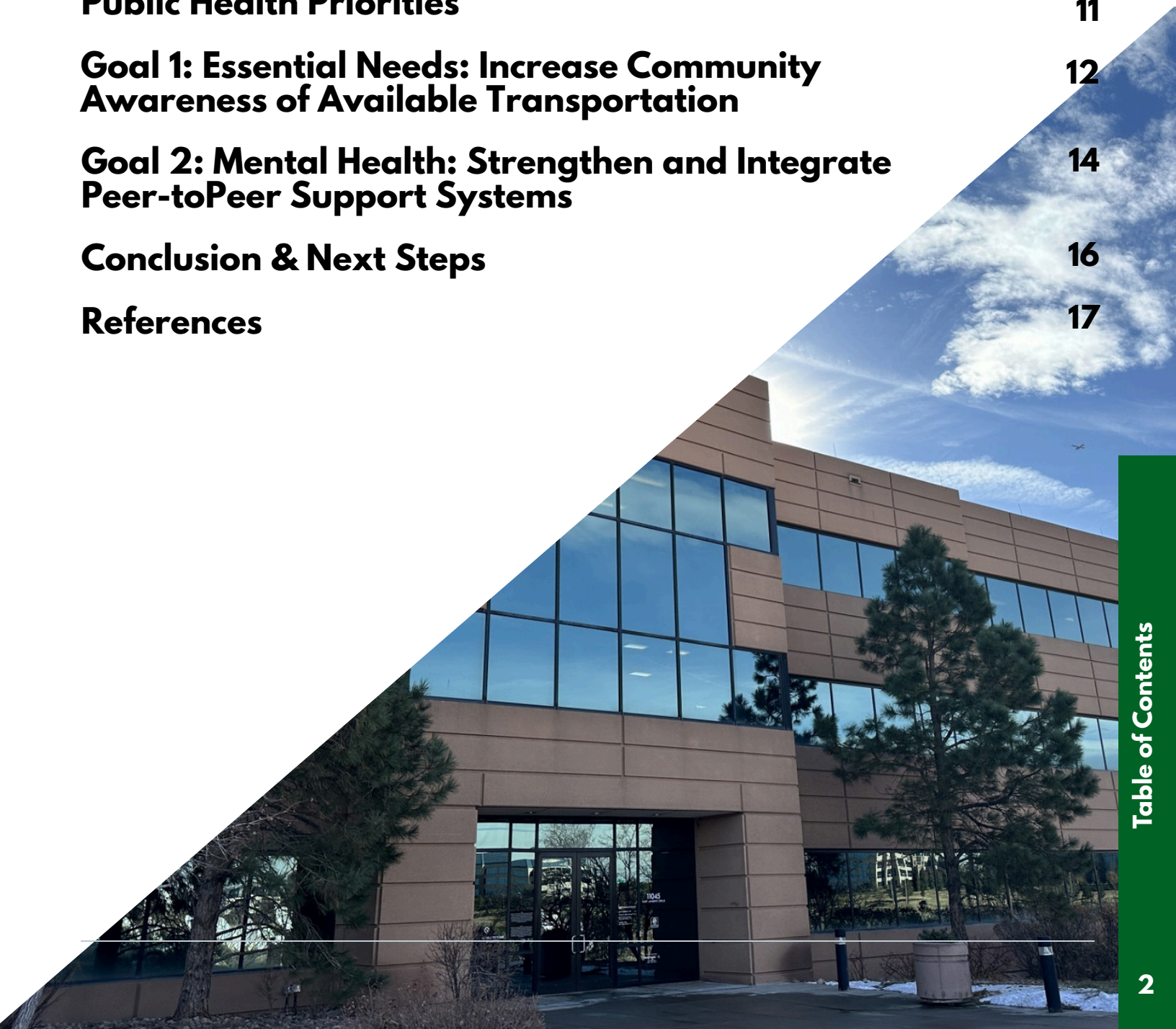


# Executive Summary

Douglas County Health Department (DCHD) is pleased to share our 2025-2028 Public Health Improvement Plan (PHIP), developed in partnership with AdventHealth Castle Rock and AdventHealth Parker. Following the Colorado Health Assessment and Planning System (CHAPS) process, the Community Health Needs Assessment (CHNA) was conducted from January to July 2025 through close collaboration between DCHD and AdventHealth staff, along with input from diverse community partners. This PHIP aligns strategically with the Colorado State Health Improvement Plan (SHIP), AdventHealth's Community Health Needs Assessments, and Douglas County's broader strategic priorities, ensuring coordination across healthcare systems and public health efforts. By integrating these regional and state-level frameworks with local data and community input, this plan creates a unified approach to addressing health priorities and leveraging resources across our region to maximize the impact of Douglas County residents.

# Introduction

Every five years, all public health agencies in Colorado are required to follow the Colorado Public Health Assessment and Planning System (CHAPS) process and create a Public Health Improvement Plan (PHIP) for submission to the Colorado Department of Public Health and Environment's Office of Public Health Practice, Planning, and Local Partnerships.

In 2025, AdventHealth Castle Rock, AdventHealth Parker, and the Douglas County Health Department (DCHD) partnered with Omni Institute (Omni) to conduct Douglas County's Community Health Needs Assessment (CHNA) and this corresponding PHIP for 2025–2028. The CHNA process, conducted between January and July of 2025, included a detailed review of recent data collected to support Douglas County's broader goals for community health, as well as input from residents, community organizations, and healthcare partners.

This report is the resulting PHIP, outlining the process, goals, and strategies that will guide the public health system through 2028. Guided by DCHD's vision—that Douglas County residents have access to opportunities for achieving their healthiest possible lives—and its mission to provide education and evidence-based services that improve community health, this PHIP reflects both the data-driven priorities identified through the assessment and the lived experiences of the residents DCHD serves. By combining community feedback with evidence-based practice, this PHIP offers a responsive roadmap for meaningful improvements in health and well-being across Douglas County.

In July 2020, the Board of Douglas County Commissioners announced its intent to withdraw from Tri-County Health Department (TCHD). The decision was finalized in September 2021, at which point the Board voted to establish the Douglas County Health Department. Shortly thereafter, the Douglas County Board of Health was formed. To ensure uninterrupted public health services during the transition, the

County Commissioners approved an Intergovernmental Agreement with TCHD to continue providing services through the end of 2022 while DCHD built its organizational structure and hired staff. DCHD officially began providing services to the public on June 1, 2022.

Following its establishment, DCHD led its first Community Health Assessment and Public Health Improvement Plan in 2022. Through an extensive public process involving residents, county leadership, and public health professionals, the department identified its initial priority areas: Behavioral Health (including mental health and substance use), Injury Prevention, and Disease Management and Prevention. These priorities informed the development of DCHD's 2023–2026 Strategic Plan, which established the department's mission, vision, and values and emphasized collaboration, education, professionalism, and responsiveness to community needs. In response to evolving community needs, DCHD partnered again with AdventHealth Castle Rock and AdventHealth Parker in 2025 to conduct a new Community Health Needs Assessment. The findings from this process inform the priorities and strategies outlined in this PHIP and will guide DCHD's work over the next three years to better serve Douglas County residents.

# Decision Makers

Members of DCHD worked closely with the Omni facilitators and researchers throughout the CHNA and PHIP processes. For the CHNA, two meetings were held with AdventHealth Castle Rock, AdventHealth Parker, DCHD, and Douglas community members, one virtual and one in person in Douglas County to discuss the community health needs. The first meeting consisted of an initial data review and prioritization process, to narrow health priorities down for further analysis. The second in-person meeting consisted of a data gallery walk to review and discuss data collected during the CHNA reporting process, to identify priority areas, and begin to brainstorm potential goals, strategies, and activities to address these priority areas.

For the PHIP, DCHD leadership met in person twice, to select two priority areas highlighted in the CHNA, and to give feedback on the draft PHIP. In addition, Douglas County Board of Health gave feedback during a virtual meeting and through email on the PHIP. Community members contributed their time, critical insights, and perspectives on health needs in Douglas County, and we thank them for their invaluable contributions.

## CHNA and PHIP Community Participants

- Michael Hill (Executive Director, DCHD)
- Kim Muramoto (Douglas County Board of Health Member, DCHD)
- Dr. Kamran Dastoury (Medical Officer, DCHD)
- Diane Smith (Assistant Director for Douglas County Early Childhood Council)
- Jon Surbeck (Manager, Emergency Preparedness & Disease Surveillance, DCHD)
- Laura Larson (Assistant Director for Community Health, DCHD)
- Skyler Sicard (Assistant Director for Environmental Health, DCHD)
- Andrea Farrow (Environmental Health Supervisor, DCHD)
- Chris Burnett (Quality Improvement Coordinator, DCHD)
- Juvaila Pavlicek (WIC Manager, DCHD)
- Rich Miura (Accounting Supervisor, DCHD)
- Kelly Caldwell (DCHD)
- Mike Gobel (CEO AdventHealth Parker)
- Michelle Fuentes (CEO Castle Rock)
- Tricia Higgens, Bryan Trujillo, Keri Hissong, Matthew Mundall, Erin Day, Leeroy Coleman, Sarah Bixenman, Harmony Furlong, Andrea Catlett, Erica Beard, Jennifer Charles, Monica Kneusel (AdventHealth Parker & Castle Rock)
- Nikki Brooker and Savannah Becerril (You Are Not Alone - YANA)
- Kieth Dunner, Lisa Cardinal, and Katherine Willie (Douglas County Community Members)
- Tiffany Marsitto (Douglas County Health and Human Services)
- Laura-Elena Porras (Doctors Care)
- Christina Rimelspach (SecorCares)
- Nancy Falk (Meals on Wheels)
- Lonnie Martinez and Tim Baster (Reunion Rehab)

# Planning Process

## 1 Review Data and Priority Areas from CHNA

Douglas County Health Department Leadership Team met to review the CHNA data and priority areas and select two priority areas to focus on for the PHIP. In addition, they selected strategy leads, for each priority area.

## 2 Identify Strategies

Once the two priority areas were identified, the strategy leads discussed goals, strategies, activities, and timelines for each priority area.

## 3 Review Draft PHIP

Douglas County Health Department Leadership Team met to review and refine the goals, strategies, activities, and timelines for each priority area.

## 4 Finalize PHIP

The final review was incorporated into the final PHIP, to guide progress over the next 3 years.

# Douglas County Data Snapshot

The data provided a high-level snapshot of relevant indicators on essential needs and on mental and behavioral health for adults and youth in Douglas County. See the corresponding CHNA Report for more information.

## Essential Needs

The neighborhoods where people live have a considerable impact on health and well-being… (An) element of this social determinant of health is the built environment, including transportation…that can promote a higher quality of life. 1

In the (Douglas County) community, 3.5% of the households do not have an available vehicle. 2

### Douglas County 2025 CHNA Key Informant Interview and Focus Group Data

Douglas County 2025 CHNA Key Informant Interview and Focus Group Data

Key informant interviews were conducted with representatives from key organizations and sectors in Douglas County to gain insight into how their work influences overall community health… Community focus groups were also held to gain a deeper understanding of how the CHNA focus areas impact community health.

Essential needs are the fundamental resources required for individuals and families to maintain stability and quality of life, including access to food, childcare, housing, and transportation.

Key Local Groups Impacted

- People experiencing homelessness
- Individuals with low incomes
- Older adults

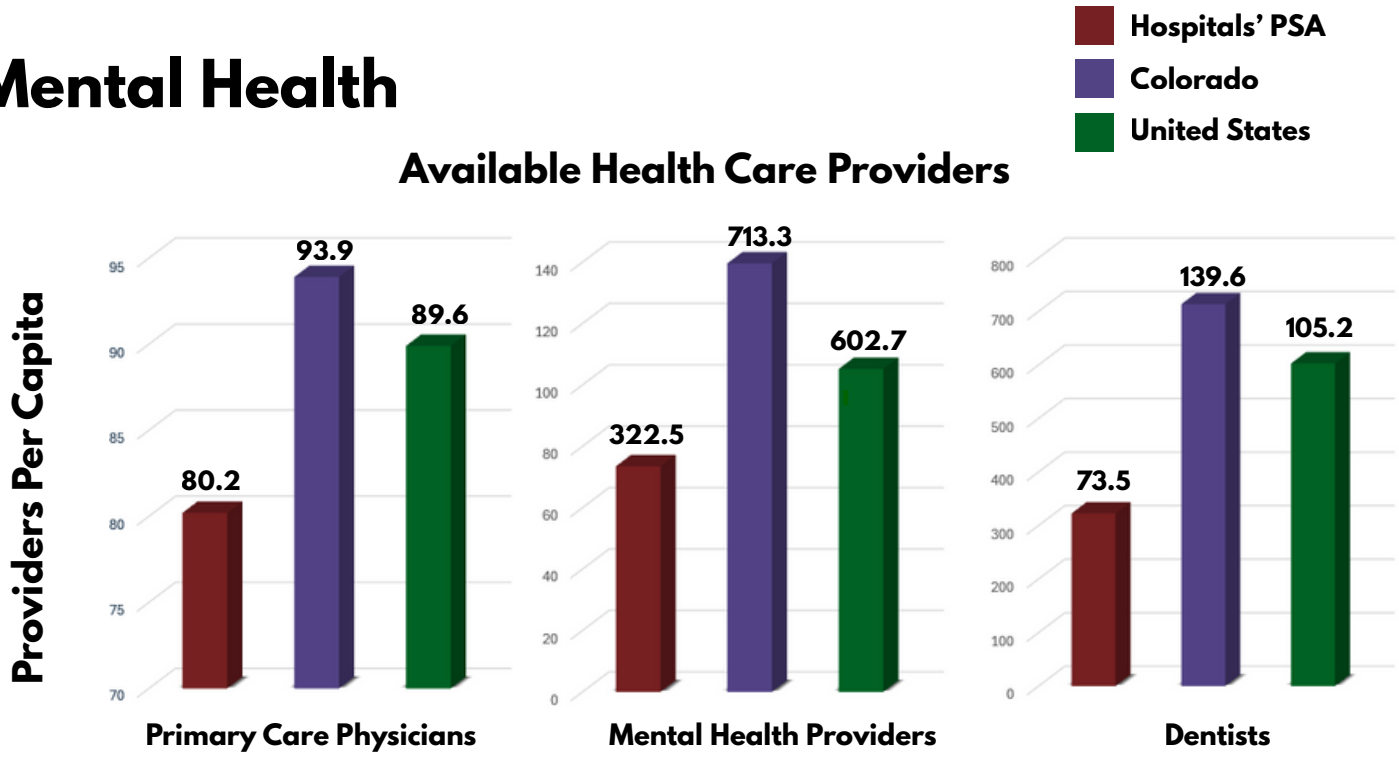
Participants shared the following challenges and barriers related to essential needs in the community

- Limited transportation to access services

Participants highlighted strategies that the Douglas County community could employ surrounding essential needs…

Participants mentioned several strategies to improve essential needs for individuals facing homelessness, poverty, and related barriers in Douglas County. These include advocating for increased funding to support organizations addressing basic needs and transportation… Participants also noted the importance of building relationships with local agencies… (and) increasing awareness of available resources… as critical to creating a more inclusive and responsive support system.

# Mental Health

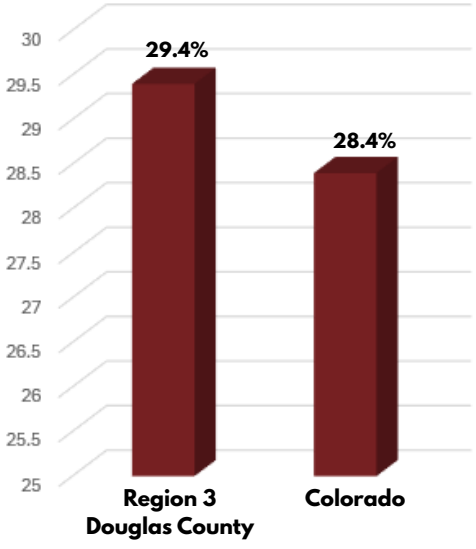



* Hospitals' PSA stands for AdventHealth Castle Rock and AdventHealth Parker Professional Services Agreement [3]

## Social and Community Context

People's relationships and interactions with family, friends, co-workers and community members can have a major impact on their health and well-being. [4] When faced with challenges outside of their control, positive relationships with others can help reduce negative impacts. People can connect through work, community groups or others to build relationships and social supports. There can be challenges to building these relationships when people don't have connections to create them or there are barriers, like language.

**Percentage of students who most of the time or always had poor mental health during the past 30 days**




In the community, **29.4% of youth report that they had poor mental health most of the time or always during the past 30 days.** [5] The percentage is higher than the state which is 28.4%.

Further, **9.9% of residents report speaking a language other than English at home.** [6] These factors can create barriers to feeling connected in the community.

# Public Health Priorities

The Strategies and Activities outlined in this PHIP are aligned with the two goals that have been identified as the priorities for Douglas County. Each goal includes strategies associated with this goal, and activities that Douglas County Health Department can engage in to support achieving this goal in the long term. A proposed timeline is also included to help Douglas County Health Department prioritize activities that will support their long-term success.

## The goals outlined in the 2025-2028 PHIP are as follows:

### Goal 1:
**Essential Needs & Access to Care**

Increase Community Awareness of Available Transportation Resources to Improve Access to Healthcare, Food, and Community Resources (Essential Needs)

## Stategies

1. Enhance and diversify communication methods to reach the community effectively
2. Identify outreach strategies for priority populations
3. Strengthen partnerships and integration across systems
4. Monitor, evaluate, and adapt to address gaps

### Goal 2:
**Mental Health**

Strengthen and Integrate Peer-to-Peer Support Systems to Improve Mental Health and Well-Being Across the Community (Mental Health)

## Stategies

1. Build and strengthen peer engagement networks
2. Expand communication and awareness of mental health resources
3. Develop and institutionalize a community mental health resource hub
4. Develop Outcome Measurements and Impact Goals

# Goal 1:
## Essential Needs & Access to Care

Increase Community Awareness of Available Transportation Resources to Improve Access to Healthcare, Food, and Community Resources (Essential Needs)

Douglas County has a variety of transportation resources available to support residents' mobility and access to essential services. However, due to the county's broad geographic area, promoting and communicating information about these transportation options can be challenging. Below are strategies and corresponding activities designed to enhance community awareness and understanding of the transportation resources available locally.

| Strategy | Year 1 Activities (2025-2026) | Year 2-3 Activities (2026-2028) |
|---|---|---|
| **1** Enhance and diversify communication methods to reach the community effectively | • Develop and test a clear, multilingual one-pager summarizing Regional Transportation District (RTD), LINK on demand (free ride share program in Highlands Ranch and Lone Tree), and other transit options in Douglas County.<br>• Partner with County communications to design materials using accessible language and large print for older adults.<br>• Launch initial outreach visits by health educators to senior centers, food banks, and charitable organizations to distribute materials. | • Conduct annual awareness surveys with residents and service providers.<br>• Update and re-issue materials annually based on community feedback.<br>• Expand outreach to schools, churches, and employers with transit-dependent workers.<br>• Embed transportation resource info into provider discharge planning, social service intake, and county newsletters. |
| **2** Identify outreach strategies for priority populations | • Identify community partners who can support outreach to populations of focus including older adults, people with English as a second language, and individuals who identify as Hispanic/Latino. | • Create custom outreach with resources/information these populations need including translated resources.<br>• Distribute resources through community partner channels. |

# Goal 1 Continued:
## Essential Needs & Access to Care

| Strategy | Year 1 Activities (2025-2026) | Year 2-3 Activities (2026-2028) |
|---|---|---|
| **3**<br>Strengthen partnerships and integration across systems | • Compile a comprehensive partner list (hospitals, older-adult serving organizations, food banks, churches, community centers) and develop formalized partnerships for coordinated communication.<br>• Engage community leaders and cultural liaisons for outreach to Latino and other underrepresented groups. | • •Integrate transit information into hospital discharge and case-management systems.<br>• Support joint campaigns with the local hospitals highlighting success stories (e.g., "How I got to my doctor using Link on Demand"). |
| **4**<br>Monitor, evaluate, and adapt to address gaps | • Develop a baseline awareness and access survey for residents served by medical providers and community-based organizations, including those partners outlined in this strategy.<br>• Create feedback loops with community partners to capture gaps in transit access or awareness.<br>• Document communication barriers identified during outreach (e.g., language, digital literacy). | • Use evaluation data to prioritize underserved zones (e.g., rural southern Douglas County).<br>• Partner with RTD on route expansion advocacy.<br>• Reassess community needs annually to evolve focus beyond transportation (e.g., essential-needs domains). |

# Goal 2:
## Mental Health

Strengthen and Integrate Peer-to-Peer Support Systems to Improve Mental Health and Well-Being Across the Community (Mental Health)

Douglas County has a strong foundation of mental health and suicide prevention efforts supported by numerous community partners. However, residents experiencing mental health or substance use challenges often face barriers connecting to available supports. This includes limited opportunities for peer support engagement from individuals with lived experience. The following strategies and activities aim to strengthen peer involvement, enhance awareness, and create sustainable pathways for connection, belonging, and access to behavioral health resources across Douglas County.

| Strategy | Year 1 Activities (2025-2026) | Year 2-3 Activities (2026-2028) |
|---|---|---|
| **1** Build and strengthen peer engagement networks | • Recruit and onboard individuals with lived experience (mental health & substance use) into suicide prevention and mental health subcommittees.<br>• Create regular opportunities for feedback from individuals with lived experience.<br>• Hold monthly coordination meetings with County Communications. | • Develop a Peer Navigation Program modeled on best practices in veteran, peer mentoring, and You Are Not Alone (YANA) programs.<br>• Create clear onboarding, training, and participation guidelines for peer members.<br>• Create regular feedback opportunities for peers to shape county initiatives. |
| **2** Expand communication and awareness of mental health resources | • Partner with County Communications to launch a mental health awareness campaign.<br>• Integrate mental health and substance use messaging with feedback from individuals with lived experience.<br>• Highlight recovery and lived experience stories of substance use and suicide survivors and family to reduce stigma. | • Run annual focused campaigns for perinatal families, men, youth/transition-aged youth, veterans/first responders, and older adults.<br>• Integrate mental health communication into schools, workplaces, and community events.<br>• Use peer messengers and trusted local leaders to deliver information. |

# Goal 2 Continued:
## Mental Health

| Strategy | Year 1 Activities (2025-2026) | Year 2-3 Activities (2026-2028) |
|---|---|---|
| **3** Develop and institutionalize a community mental health resource hub | • •Identify categories of key resources (crisis lines, peer groups, treatment providers, suicide prevention, family supports).<br>• Map existing platforms (“Nobody’s Perfect,” through the National Association of Mental Illness Arapahoe/Douglas Counties (NAMI-ADCO), You Are Not Alone (YANA), OwnPath, and Colorado Access) to find partnership overlaps.<br>• Support the evolution and integration of mental health resources within the county’s existing centralized resource hub. | • Maintain a digital resource hub through the county, updated quarterly.<br>• Integrate with hospital discharge systems and social service referrals.<br>• Connect to future Peer Navigation Program for seamless linkages |
| **4** Develop Outcome Measurement and Impact Goals | • Establish baseline data on suicide rates, help-seeking behavior, and mental health service utilization.<br>• Identify key indicators to measure the impact of peer and community-based strategies.<br>• Collaborate with partners to align data collection methods. | • Track and analyze long-term outcomes such as reductions in suicide rates, emergency mental health crises, and unmet behavioral health needs.<br>• Evaluate peer program effectiveness using participant feedback and data dashboards.<br>• Develop and publish an annual Mental Health Outcomes Report.<br>• Evaluate utilization rates of the digital resource hub. |

# Conclusion & Next Steps

The Public Health Improvement Plan marks an important effort towards improving health in the Douglas County community over the next three years and beyond. With goals centered around improving access to essential needs and mental health for all members of the community, DCHD is committed to implementing activities that improve health in DouglasCounty. The implementation of this PHIP will continue to be guided through the ongoing work of DCHD in collaboration with community partners. The next steps required for successful implementation of this PHIP include reviewing the proposed timelines and making any adjustments to reflect a realistic process. From there, DCHD will identify community partners to support each goal area and begin conversations about implementing strategies.

The PHIP will be widely distributed to ensure accessibility and transparency with the community. The Plan will be made available on the DCHD website, shared through email distribution to community partners, presented to the Douglas County Board of Health for public review, and directly distributed to key partner organizations throughout Douglas County. This multi-channel approach ensures that residents, healthcare providers, community organizations, and other partners have access to the Plan and can engage in its implementation and ongoing evaluation.

DCHD will monitor and evaluate progress on this PHIP through systematic data collection, collaborative partnerships, and structured progress reviews. The next step in this process is the development of a comprehensive Strategic Plan that will establish specific, time-bound goals and implementation timelines for achieving the priorities outlined in this PHIP. Each goal area includes measurable objectives tracked through established community health indicators, partner reports, and surveillance data. Progress will be reviewed quarterly by the DCHD Leadership Team and summarized in annual public reports shared with the Douglas County Board of Health, community partners, and Douglas County residents. These evaluation findings will drive data-informed adjustments to strategies, resource allocation, and partnership initiatives, ensuring continuous improvement, transparency, and accountability throughout the 2025-2028 planning cycle and beyond.

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