1861 WELD COUNTY, CO

Weld County Department of
Public Health and Environment

COMMUNITY HEALTH IMPROVEMENT PLAN

2026 - 2028



This report was produced by the Weld County Department of Public Health and Environment. Our vision is that everyone in Weld County has the opportunity to live their healthiest lives. Our mission is to serve Weld County by cultivating partnerships to promote public health and environmental quality through the delivery of relevant, innovative, and cost-effective services.

Authors and contributors to this report:

Emily Pickens, MPH
Olivia Egen, DrPH, MPH
Cody Speece, MPH

Comments, questions, and requests for additional information:

Emily Pickens, MPH
Public Health Initiatives Manager
Weld County Department of Public Health and Environment
1555 N 17th Avenue
Greeley, Colorado 80631
weldhealtheducation@weld.gov

Published October 2026



TABLE OF CONTENTS

Executive Summary....4
Key Terms....5
Overview....6
CHAPS Framework....7
Prioritization Process....8
Priority Health Issues....9
Timeline....10
CHIP Structure and Implementation....11
Priority Health Issues....12
- Healthcare Access....13
- Mental Health....16
- Chronic Diseases....20

Plan Alignment....23
Acknowledgments....24
Appendices....25
- Appendix A - Sources....25
- Appendix B - Capacity Assessment....27
- Appendix C - Prioritization Summary Report....32
- Appendix D - Healthcare Access Issue Brief....36
- Appendix E - Mental Health Issue Brief....41
- Appendix F - Chronic Diseases Issue Brief....45

EXECUTIVE SUMMARY

The Weld County Department of Public Health and Environment (WCDPHE) is pleased to present the 2026 - 2028 Community Health Improvement Plan (CHIP). The CHIP follows a strategic process to address key priority health issues that emerge during the community health improvement process. This cycle occurs every three years.

The process began in spring 2025 with the launch of the Weld County Community Health Survey (CHS). Over 2,800 usable responses were received, providing valuable, community-level data on numerous indicators related to the overall health and well-being of Weld residents. The CHS Key Findings Report was published in February 2026, sharing important data with community partners and the public.

Beginning in April 2026, WCDPHE staff facilitated a series of meetings with community partners to identify priority health issues. During the first meeting on April 28, partners helped narrow the list of potential issues from nine to five. In the second meeting on May 20, the group identified the top three priorities: healthcare access, mental health, and chronic diseases. This entire process relied heavily on the input and guidance of community partners.

In June 2026, workgroups began a collaborative process to develop the goals, objectives, and evidence-based strategies that will be used to address each priority health issue. This action plan is the key component of the CHIP.

WCDPHE is committed to working alongside our partners to improve the well-being and quality of life for Weld County residents. We would like to thank them for their valuable contributions to this community-driven plan.

Sincerely,

Olivia Egen, DrPH, MPH
Community Health Division Director

KEY TERMS

Term	Acronym (if applicable)	Definition
Community Health Assessment	CHA	A process using qualitative and quantitative methods to collect and analyze data to help local public health systems understand population health status, identify key needs and priorities, and guide community health improvement
Community Health Improvement Plan	CHIP	A long-term, systematic action plan used to address specific public health problems and priorities identified by the CHA
Community Health Survey	CHS	A random sample survey collected every three years to understand resident health status and health-related behaviors
Health Disparities	-	The differences in health outcomes between two groups
Public Health Equity	-	The fair and just opportunity for every person to be as healthy as possible
Social Determinants of Health	SDOH	The factors other than health behaviors and genetics that strongly influence individual health
Thriving Weld Coalition	-	A group of educators, leaders, non-profits and other agencies working towards a Weld County that has healthy, connected, thriving communities where all people have equitable access to resources that improve quality of life
Thriving Weld Steering Committee	-	Representatives from North Colorado Health Alliance, North Range Behavioral Health, WCDPHE, and United Way of Weld County that provide strategic guidance to support the Thriving Weld Coalition

OVERVIEW

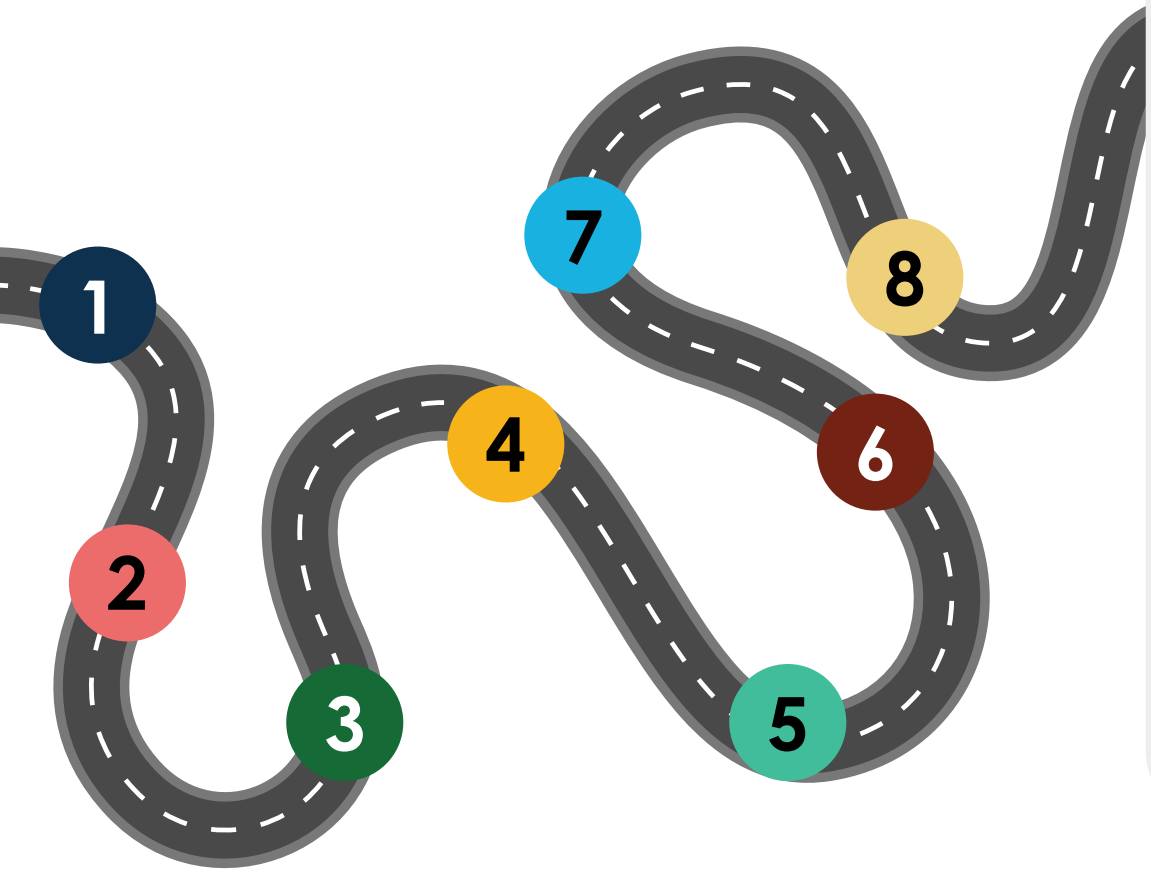
The CHIP describes a three-year collaborative strategic planning effort to address community health issues. These issues were identified through findings from the CHS, review of secondary data sources, and considerations of national and state public health priorities. The activities and collaborative efforts of WCDPHE and community partners are reflected in this report.

Weld County's CHIP is a shared responsibility of Thriving Weld - a collaboration between WCDPHE and over 100 partner organizations across the county. WCDPHE and partners utilize the CHIP to improve the health and well-being of all residents by advancing an intentional, integrated, and collective approach to foster lasting, meaningful change.

While the CHIP is a community-driven and collectively owned health improvement plan, WCDPHE is charged with providing administrative support, tracking and collecting data, and preparing the plan. The CHIP has been an integral part of the community health improvement process in Weld County since the initial five-year CHIP in 2012. Now, this process is completed on a three-year cycle to incorporate new challenges, needs, activities, and outcomes that reflect the current community. The CHIP is reviewed and revised annually, in collaboration with key agencies and community workgroup members. Progress reports will be published and shared on an annual basis.

CHAPS FRAMEWORK

Weld County uses the Colorado Health Assessment and Planning System (CHAPS) framework for community health assessment and planning. The framework has eight phases that provide guidance for carrying out CHA and CHIP activities. The framework was developed in 2010 in response to the 2008 Public Health Act, requiring all local public health agencies to complete a CHA and CHIP on a three to five year cycle. CHAPS is used by the Colorado Department of Public Health and Environment (CDPHE) and local public health agencies.



CHAPS PHASES

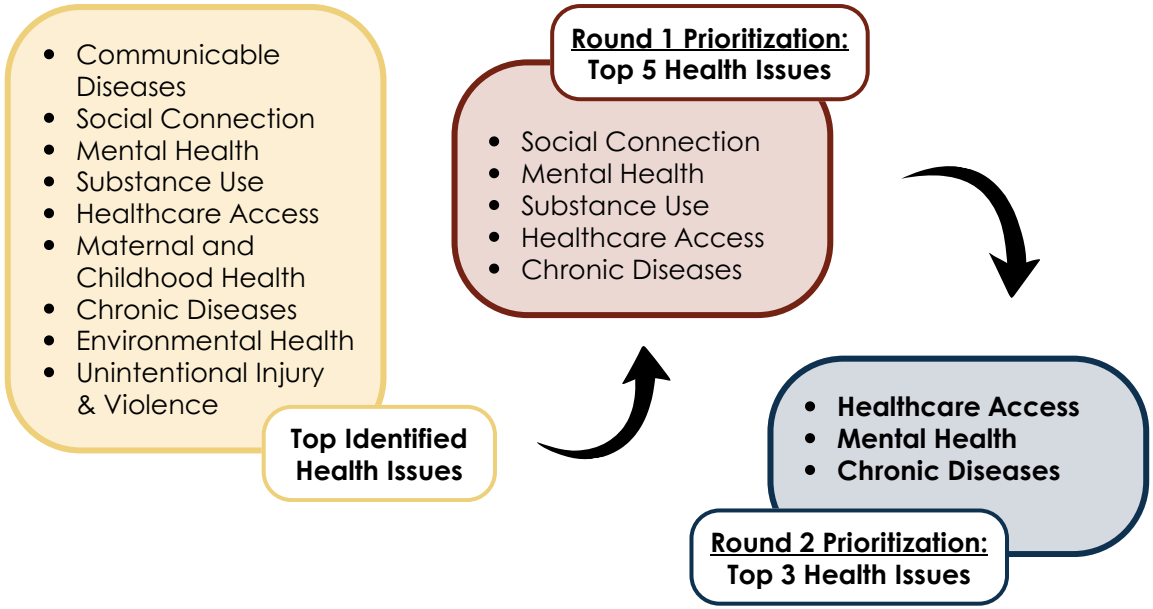
1. Plan the process
2. Equity & community engagement
3. Conduct a community health assessment
4. Assess capacity
5. Prioritize issues
6. Develop a plan
7. Implement, promote, and monitor
8. Participate in statewide public health improvement opportunities

PRIORITIZATION PROCESS

It would be impossible to address all health issues identified in the community health improvement process at the same time and see measurable improvement. Addressing a smaller number of issues in a coordinated, rigorous manner is more effective than uncoordinated efforts aimed at multiple problems. Identifying a few priorities allows our community to concentrate resources to achieve the greatest impact on key issues. Weld County stakeholders considered key issues presented across two prioritization meetings and worked to select the top priorities through a voting process. Voting occurred at public meetings, following data presentations with key indicators and trends from the 2025 CHS to ensure local data was incorporated throughout the prioritization process.

Healthcare access, mental health, and chronic diseases were ultimately chosen as the three priority health issues for the 2026 - 2028 Weld County CHIP.

Each priority health issue has its own CHIP workgroup. Group members work together to develop the goals, objectives, and strategies that form their action plan. During meetings, members report out on action items and collaborate to implement evidence-based strategies to accomplish shared goals.



The remainder of this report will focus on the three priority health issues, including their focus areas, related barriers, and strategies to overcome them. Each priority health issue has its own action plan. For more details about the full prioritization process, please see Appendix C which includes the *Prioritization Process Summary* document.

PRIORITY HEALTH ISSUES

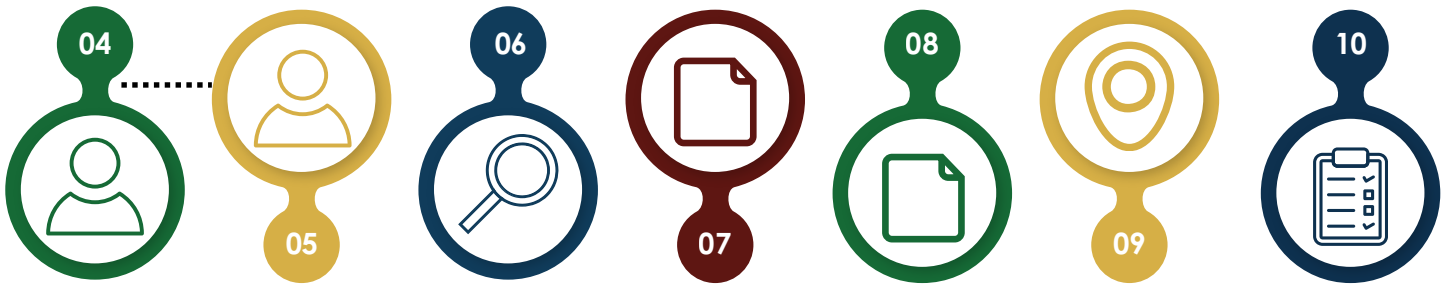
A literature review was conducted to determine key components, focus areas, and best practices related to the three priority health issues. This information was used to develop a strategy map for each issue, with up to five focus areas and related best practices. These maps were presented to each workgroup to further narrow down the focus area of each group, with the exception of chronic diseases. The information below shows the focus areas under each priority health issue. Details and strategy maps can be found in the appendices of this report.

Priority Health Issue	Workgroup Focus Areas		
Healthcare Access	Access to health insurance coverage	Healthcare workforce	
Mental Health	Upstream prevention	Social connection	Community engagement
Chronic Diseases	Physical activity social support	Cardiovascular disease education	Access to diabetes programming
	Chronic disease and aging	Physical environments	

TIMELINE

Below is the timeline of major activities leading to the creation of the 2026-2028 CHIP. Planning began in the spring of 2026 and progressed through the fall as each group worked to finalize their action plans.

The CHIP is a key piece of the broader community health improvement process, which also includes assessment and prioritization processes. These pieces lay the foundation for a successful CHIP, in which partners acknowledge the feasibility of addressing certain issues as well as the resources required to implement the necessary strategies, programs, and initiatives to bring about meaningful change.



April 2026

CHIP Prioritization Round 1

May 2026

CHIP Prioritization Round 2 at Thriving Weld Quarterly Meeting

June 2026

CHIP Priority Areas shared with Thriving Weld

Literature Review & Workgroup Recruitment

July 2026

Workgroup Recruitment

Initial Action Planning Meetings

August 2026

Thriving Weld Quarterly Meeting

Continued Recruitment & Action Planning

September 2026

Finalize Action Plans & Identify Data Points

October 2026

Finalize Action Plans & Data Points

Publish CHIP

2026 - 2028

CHIP Implementation

CHIP STRUCTURE AND IMPLEMENTATION

Thriving Weld Steering Committee

The Thriving Weld Steering Committee is an integral piece of the community health improvement process. They provide strategic guidance to support the development and implementation of the Weld County CHIP. Key member responsibilities are to guide vision and strategy, cultivate community engagement, support aligning workgroup activities, advance policy and systems plans, and mobilize resources. These agencies include North Range Behavioral Health, North Colorado Health Alliance, United Way of Weld County, and WCDPHE.

Thriving Weld Coalition

The Thriving Weld Coalition includes partners from municipal government, businesses, healthcare, education, non-profits, mental and behavioral health, and the general public. Since the initial CHIP was published in 2012, Thriving Weld membership has grown significantly. The coalition began with around 35 partners and has since grown to include more than 100 organizations. The entire coalition meets on a quarterly basis to remain engaged, learn, and grow the movement to ensure Weld County is home to healthy, connected, thriving communities where all people have equitable access to resources that improve quality of life.

CHIP Implementation

No single person or organization could implement the CHIP alone to achieve our shared goals. Instead, those involved in the CHIP development are responsible for determining the specific actions they and their organization will take. Each workgroup developed an action plan, which includes the agencies committed to implementing the necessary strategies to successfully meet our collective objectives. Workgroups will monitor and track their progress and annual reports will be published throughout the CHIP cycle, highlighting key successes, opportunities, and any changes made to workgroup action plans.



PRIORITY HEALTH ISSUES

HEALTHCARE ACCESS

Having access to necessary healthcare services helps residents support and maintain their overall health and well-being. Healthcare access is more than just seeing a healthcare provider when you are sick. It also includes factors like access to health insurance and understanding your coverage, making appointments within a reasonable timeframe at locations that aren't too far from home or work, and receiving preventive care like health screenings.

Focus Areas

Each CHIP workgroup completed a prioritization process where they utilized data from the CHA and partner agencies to determine the main two to three areas they wanted to focus on within their priority health issue. For healthcare access, the two focus areas are health insurance access and healthcare workforce.

Key Data

In 2025, more than **6% of Weld residents were uninsured**, representing 17,020 adults. The most common reasons were cost, disenrolled/dropped from Medicaid, lost/changed job, employer does not offer coverage, and no longer eligible due to age or income. In 2022, very few residents reported Medicaid disenrollment as a reason for being uninsured. In 2025, it was the **second most common answer**. Additionally, nearly **1 in 2** (47%) residents reported they were **always or usually worried about health insurance becoming too expensive**.

Navigating the Action Plan

The action plan depicted on the following page(s) includes the goals, objectives, and evidence-based strategies used by the CHIP workgroup to enact change. It is reviewed and updated annually to reflect changes, accomplishments, and opportunities. The target metrics for outcome objectives in the action plan were determined using a trend analysis tool from the National Center for Health Statistics.

Healthcare Access CHIP Action Plan

Focus Area: Health Insurance Access

Goal 1 | Develop a more comprehensive understanding of the local healthcare system and identify opportunities for meaningful impact.

Objective 1.1 | By May 31, 2027, conduct a landscape analysis to assess countywide needs, assets, resources, and capacity as it relates to healthcare access, including input from all major healthcare entities.

Data Source	Metric	Baseline Value	Target Value	Agencies Responsible
Thriving Weld partners	*# landscape analysis*	*0 (2026)*	*1 (2027)*	*WCDPHE*

- **Strategy 1:** Build or leverage community partnerships to obtain data and context necessary to successfully conduct a landscape analysis
- **Strategy 2:** Host and facilitate meetings to gather appropriate data and context
- **Strategy 3:** Develop and publish landscape analysis report to guide future healthcare access priorities, strategies, and actions

Objective 1.2 | By December 31, 2027, identify opportunities to leverage partnerships and resources to support the North Colorado Health Alliance's Community Response Strategy Menu to address insurance access in Weld County.

Data Source	Metric	Baseline Value	Target Value	Agencies Responsible
Thriving Weld Website	*# opportunities identified*	*0 (2026)*	*2 (2027)*	*WCDPHE, NCHA, UCHealth, Banner Health, NCMS, Intermountain Health, Centennial AHEC, NoCO Health Sector Partnership*

- **Strategy 1:** Leverage results from the landscape analysis to support NCHA's Community Response Strategy Menu opportunities
- **Strategy 2:** Identify opportunities to measure, collect and analyze data related to health insurance access

Focus Area: Healthcare Workforce

Goal 2 | Support efforts to improve local infrastructure to increase the number of healthcare professionals serving Northern Colorado.

Objective 2.1 | By May 31, 2027, identify opportunities to increase involvement with/support of the Northern Colorado Health Sector Partnership.

Data Source	Metric	Baseline Value	Target Value	Agencies Responsible
Thriving Weld Website	*# opportunities identified*	*0 (2026)*	*2 (2027)*	*WCDPHE, NCHA, UCHealth, Banner Health, NCMS, Intermountain Health, Centennial AHEC*

- **Strategy 1:** Leverage results from the landscape analysis to support NoCO Health Sector Partnership workforce-related initiatives

Healthcare Access CHIP Action Plan (continued)

Objective 2.2 | By December 31, 2028, increase the supply of Registered Nurses in Weld County.

Data Source	Metric	Baseline Value	Target Value	Agencies Responsible
Weld County Workforce Development	*# registered nurse jobs in Weld County*	*1,458 (2025)*	*1,534 (2028)*	*WCDPHE, Centennial AHEC, NoCO Health Sector Partnership*

- **Strategy 1:** Partner with local agencies working to increase health workforce capacity to identify opportunities for collaboration or support
- **Strategy 2:** Support Northern Colorado Health Sector Partnership strategic planning efforts to increase local health workforce capacity

Objective 2.3 | By December 31, 2028, increase the supply of physicians in Weld County.

Data Source	Metric	Baseline Value	Target Value	Agencies Responsible
Weld County Workforce Development	*# physician jobs in Weld County*	*335 (2025)*	350 *(2028)*	*WCDPHE, Centennial AHEC, NoCO Health Sector Partnership*

The strategies for Goal 2 Objective 2.3 are the same as those listed for Objective 2.2 with the addition of strategy 3 below

- **Strategy 3:** Develop partnerships with the UNC College of Osteopathic Medicine to determine opportunities to assist student development and improve healthcare access

Objective 2.4 | By December 31, 2028, increase the number of medical assistants in Weld County.

Data Source	Metric	Baseline Value	Target Value	Agencies Responsible
Weld County Workforce Development	*# medical assistant jobs in Weld County*	495 *(2025)*	*530 (2028)*	*WCDPHE, Centennial AHEC, NoCO Health Sector Partnership*

The strategies for Goal 2 Objective 2.4 are the same as those listed for Objective 2.2

MENTAL HEALTH

Mental health affects people's ability to participate in everyday activities. It can also impact how connected they feel to their community and those around them. Having poor mental health and/or feeling lonely over long periods of time can also impact someone's physical health. It is important for community members to have access to mental health treatment and supportive services. The mental health priority area of the CHIP will be implemented by the Healthy Mind and Spirit Workgroup, who has been working diligently to improve the mental health and well-being of Weld County residents since the 2012 CHIP cycle.

Focus Areas

Each CHIP workgroup completed a prioritization process where they utilized data from the CHA and partner agencies to determine the main two to three areas they wanted to focus on within their priority health issue. For mental health, the three focus areas are **upstream prevention, social connection, and community engagement.**

Key Data

In 2025, **30%** of adult residents reported having a professional diagnosis of a mental health condition, including depression, anxiety, or other mental health conditions. More than **1 in 4 (27%) residents are lonely** and around **12% report they are socially isolated**. Residents who reported having fair or poor health or had frequent mental distress had **higher rates of loneliness and social isolation** compared to countywide averages.

Navigating the Action Plan

The action plan depicted on the following page(s) includes the goals, objectives, and evidence-based strategies used by the CHIP workgroup to enact change. It is reviewed and updated annually to reflect changes, accomplishments, and opportunities. The target metrics for outcome objectives in the action plan were determined using a trend analysis tool from the National Center for Health Statistics.

Mental Health CHIP Action Plan

Focus Area: Upstream Prevention

Goal 1 | To enhance protective factors for positive mental health outcomes by focusing on upstream prevention and early detection.

Objective 1.1 | By December 31, 2028, reduce the percentage of residents experiencing anxiety, depression, or another mental health problem.

Data Source	Metric	Baseline Value	Target Value	Agencies Responsible
Weld County Community Health Survey	*% residents reporting experiencing anxiety, depression, or another mental health problem*	*30.3% (2025)*	*26.4% (2028)*	*WCDPHE, North Range Behavioral Health, UNC, Centennial AHEC*

- **Strategy 1:** Improve population monitoring of mental health outcomes to tailor interventions and track disparities
- **Strategy 2:** Support programming around the social determinants of mental health
- **Strategy 3:** Identify and implement initiatives or programming that support adult emotional regulation/social emotional learning skill building

Objective 1.2 | By December 31, 2028, reduce the percentage of residents reporting frequent mental distress.

Data Source	Metric	Baseline Value	Target Value	Agencies Responsible
Weld County Community Health Survey	*% residents reporting frequent mental distress (defined as 14+ days of poor mental health in past 30 days)*	*11.5% (2025)*	*9.3% (2028)*	*WCDPHE, North Range Behavioral Health, UNC, Centennial AHEC*

The strategies for Goal 1 Objective 1.2 are the same as those listed for Objective 1.1

Objective 1.3 | By December 31, 2028, increase the percentage of residents who stated they needed mental health care and then sought out counseling or treatment.

Data Source	Metric	Baseline Value	Target Value	Agencies Responsible
Weld County Community Health Survey	*% residents who answered yes to needing mental health care and also sought out counseling or treatment*	*63.4% (2025)*	*66.1% (2028)*	*WCDPHE, North Range Behavioral Health, UNC, Centennial AHEC*

- **Strategy 1:** Improve knowledge of barriers to accessing mental health care through focus groups and share results with community partners
- **Strategy 2:** Collaborate with North Range Behavioral Health to increase access by embedding a licensed counselor on the WCDPHE Mobile Unit to provide navigation assistance for mental health services

Mental Health CHIP Action Plan

Focus Area: Social Connection

Goal 2 | To foster supportive social networks that prevent feelings of loneliness or disconnect from others.

Objective 2.1 | By December 31, 2028, maintain or reduce the rate of residents experiencing loneliness.

Data Source	Metric	Baseline Value	Target Value	Agencies Responsible
Weld County Community Health Survey	*% residents experiencing loneliness*	*27.2% (2025)*	*27.2% (2028)*	*WCDPHE, North Range Behavioral Health, High Plains and Clearview Library Districts, UCHealth, Local communities*

- **Strategy 1:** Provide resources and support to individuals and organizations to increase connection
- **Strategy 2:** Support programming such as Dude Talk Dinners and Coffee Break Project that bring meaningful connection opportunities to groups and/or regions at higher risk
- **Strategy 3:** Seek opportunities to pair therapies with outdoor activities and opportunities for connection for adults
- **Strategy 4:** Secure funding to increase capacity to provide evidence-based trainings and programming

Objective 2.2 | By December 31, 2028, maintain or reduce the rate of residents who report they are socially isolated.

Data Source	Metric	Baseline Value	Target Value	Agencies Responsible
Weld County Community Health Survey	*% residents saying they rarely or never get the social and emotional support they need (social isolation)*	11.8% *(2025)*	*11.8% (2028)*	*WCDPHE, North Range Behavioral Health, High Plains and Clearview Library Districts, UCHealth Aspen Club*

The strategies for Goal 2 Objective 2.2 are the same as those listed for Objective 2.1

Objective 2.3 | By December 31, 2027, and every year thereafter, Healthy Mind and Spirit workgroup members will provide meaningful contributions to Acts of Connection programming (i.e. co-facilitating workshops, coordinating, connecting, etc.).

Data Source	Metric	Baseline Value	Target Value	Agencies Responsible
Healthy Mind and Spirit Meeting Minutes; Acts of Connection Sign Ins	*# members providing meaningful contributions (i.e., facilitating workshops, coordinating, connecting)*	11 *(2025)*	*16 (2027)*	*WCDPHE, North Range Behavioral Health, UNC, Centennial AHEC, Local communities*

- **Strategy 1:** Increase capacity to provide trainings by hosting an Acts of Connection train-the-trainer event
- **Strategy 2:** Increase the number of community businesses/organizations participating in promoting, hosting, and/or supporting Acts of Connection or other social connection initiatives

Mental Health CHIP Action Plan (continued)

Focus Area: Community Engagement

Goal 3 | To foster an informed, empowered, and engaged community to reduce mental health stigma and increase awareness.

Objective 3.1 | By December 31, 2028, reduce the percentage of Weld County residents who did not seek mental health care when they needed it because of stigma.

Data Source	Metric	Baseline Value	Target Value	Agencies Responsible
Weld County Community Health Survey	*% residents who did not seek mental health care when needed because they were concerned it might cause family, friends, neighbors, and others to have a negative opinion of them*	16.7% *(2025)*	13.9% *(2028)*	*WCDPHE, North Range Behavioral Health, High Plains Library District, AIMS Community College, UNC, Local communities*

- **Strategy 1:** Launch an education/media campaign focused on protective factors to prevent negative mental health outcomes
- **Strategy 2:** Host or attend community engagement events to normalize discussions on mental health

Objective 3.2 | By December 31, 2027, maintain or increase the percentage of Weld County high school students who can manage their stress.

Data Source	Metric	Baseline Value	Target Value	Agencies Responsible
Healthy Kids Colorado Survey	*% Weld County high school students who agree or strongly agree their stress level is manageable most days*	*57.8% (2025)*	*57.8% (2027)*	*WCDPHE, North Range Behavioral Health, High Plains Library District, AIMS Community College, UNC*

- **Strategy 1:** Continue expanding opportunities for Acts of Connection workshops/programming in schools and youth-predominant spaces

Objective 3.3 | By December 31, 2028, provide mental health training to community partners and residents.

Data Source	Metric	Baseline Value	Target Value	Agencies Responsible
WCDPHE or NRBH Tracking Log	*# individuals receiving training*	*0 (2025)*	*150 (2028)*	*WCDPHE, North Range Behavioral Health*

- **Strategy 1:** Provide evidence-based trainings such as MHFA, QPR, and COMET to organizations and non-traditional community members
- **Strategy 2:** Increase the number of community businesses/organizations participating in offering onsite or virtual mental health training and/or incentivizing participation in said training or related programming
- **Strategy 3:** Secure funding to increase capacity to provide evidence-based trainings and programming

CHRONIC DISEASES

Chronic diseases are health issues that last a long time, often do not resolve on their own, and usually cannot be completely cured. Common examples are heart disease, type 2 diabetes, and Alzheimer's disease. Many chronic diseases can be prevented or controlled through early intervention and healthy lifestyle changes.

Focus Areas

In 2026, WCDPHE received a three-year Local Public Health Agency Chronic Disease Pilot grant from CDPHE. Community partners participated in an assessment process that identified 5 focus areas, including **physical activity social support, cardiovascular disease education, access to diabetes programming, chronic disease and aging, and physical environments**. Staff and community partners agreed it would make the most sense to align the chronic disease grant with the CHIP action plan for the chronic disease priority health issue. Aligning these two plans ensures we are working collaboratively towards clear, well-defined, and attainable goals.

Key Data

In 2025, **half of Weld County adults reported having one or more chronic conditions**. 1 in 3 reported having high blood pressure. 1 in 3 also reported having high cholesterol. 1 in 10 residents reported having been diagnosed with diabetes. Around 80% of those with diabetes take medication to manage it. Nearly 15% of residents have been told they have pre-diabetes, meaning their blood sugar levels are elevated but not high enough to cause diabetes.

Navigating the Action Plan

The action plan depicted on the following page(s) includes the goals, objectives, and evidence-based strategies used by the CHIP workgroup to enact change. It is reviewed and updated annually to reflect changes, accomplishments, and opportunities. The target metrics for outcome objectives in the action plan were determined using a trend analysis tool from the National Center for Health Statistics.

Chronic Diseases CHIP Action Plan

Focus Area: Physical Activity Social Support

Goal 1 | To increase education and awareness around opportunities for residents to connect with one another while being active.

Objective 1.1 | By December 31, 2028, increase access to community-based physical activity opportunities.

Data Source	Metric	Baseline Value	Target Value	Agencies Responsible
WCDPHE Evaluation Plan	*# sustainable community-based physical activity opportunities*	*0 (2025)*	*5 (2028)*	*WCDPHE, Area Agency on Aging, Community centers, CSU Extension, UCHealth, NCHA*

- **Strategy 1:** Build or leverage community partnerships to increase access to physical activity opportunities and social connection
- **Strategy 2:** Share culturally appropriate educational materials on the benefits of social support and shared physical activity experiences with at least eight local organizations
- **Strategy 3:** Assist with recruiting, training, and mentoring community champions in rural communities to independently facilitate ongoing opportunities for physical activity and social connection

Focus Area: Cardiovascular Disease Education

Goal 2 | To equip residents with tools to improve their cardiovascular health.

Objective 2.1 | By June 30, 2027, and annually thereafter, conduct regional cardiovascular health education workshops.

Data Source	Metric	Baseline Value	Target Value	Agencies Responsible
WCDPHE Evaluation Plan	*# cardiovascular workshops per year*	*0 (2025)*	*6 (2028)*	*WCDPHE, Area Agency on Aging, Community centers, CSU Extension, Local communities, UCHealth*

- **Strategy 1:** Work with community partners to implement cardiovascular health education workshops with a minimum of one per region
- **Strategy 2:** Establish and maintain partnerships with at least two community organizations to integrate simplified, culturally tailored cardiovascular education messages into existing partner programming and outreach activities

Chronic Diseases CHIP Action Plan (continued)

Focus Area: Access to Diabetes Programming

Goal 3 | To ensure residents are aware of resources to prevent or manage diabetes.

Objective 3.1 | By December 31, 2028, collaborate with healthcare partners to implement evidence-based prediabetes screening, provider education, and standardized referral pathways to WCDPHE's Heart of Weld National Diabetes Prevention Program for eligible patients.

Data Source	Metric	Baseline Value	Target Value	Agencies Responsible
WCDPHE Evaluation Plan	*# established referral pathways*	*0 (2025)*	*4 (2028)*	*WCDPHE, Area Agency on Aging, CSU Extension, UCHealth*

- **Strategy 1:** Increase adoption of diabetes prevention and education programs that reach underserved populations by collaborating with community partners serving rural residents, Hispanic/Latino communities, low-income households, younger adults, and seniors.

Focus Area: Chronic Disease and Aging

Goal 4 | To improve early identification and care navigation for older adults and their caregivers.

Objective 4.1 | By December 31, 2027, and annually thereafter, improve early identification and care navigation for adults ages 65+ through increasing access to education, dementia risk screenings, and linkage to appropriate resources at community events.

Data Source	Metric	Baseline Value	Target Value	Agencies Responsible
WCDPHE Evaluation Plan	*# community events per year*	*0 (2025)*	*2 (2028)*	*WCDPHE, Area Agency on Aging, CSU Extension, UCHealth*

- **Strategy 1:** Identify existing evidence-based training opportunities on dementia awareness from reputable agencies/entities.
- **Strategy 2:** Work with community partners to identify opportunities to train other agencies, associations, businesses, and groups on dementia awareness and referral protocols.
- **Strategy 3:** Strengthen social connectedness and support for older adults with chronic conditions or dementia by partnering with community agencies to host informal, low-barrier gatherings and conduct brief risk checks that help identify needs and connect participants to appropriate aging and dementia services.

Please note: the physical environments focus area will not be implemented until 2027, after this initial report is published. Objective 5 and its related strategies will be developed prior to implementation and will be updated to reflect progress in later CHIP Annual Report documents.

PLAN ALIGNMENT

It is important to consider alignment with existing public health improvement plans or efforts at the state and national level. Below, you can see how WCDPHE's CHIP priority areas align with Colorado's State Health Improvement Plan and the Center for Disease Control and Prevention's Healthy People 2030 initiative.

Weld County CHIP Focus Area	CDPHE State Health Improvement Plan	Healthy People 2030
Healthcare Access	*Healthcare access is not a focus of the 2025 - 2029 Colorado State Health Improvement Plan. However, healthcare access is referenced in regards to other plan focus areas such as substance use, environmental health/extreme heat, and communicable disease control*	**Focus Area: Health Care Access and Quality** Goal: Increase access to comprehensive, high-quality health care services *Strategies: Increase proportion of adults who get recommended preventive health care; Reduce proportion of people who can't get medical care when they need it; Reduce proportion of people without a usual source of care*
Mental Health	**Focus Area: Suicide Prevention** Goal 1: Meet specific community needs, focusing on populations experiencing greater rates of suicidal despair, attempts, and fatalities by suicide *Strategies: Provide community helper trainings like MHFA, QPR, and COMET*	**Focus Area: Mental Health** Goal: Improve mental health *Strategies: Increase proportion of children and adolescents who get appropriate treatment for anxiety or depression; Increase proportion of adults with depression and/or serious mental illness who get treatment; Reduce the suicide rate*
Chronic Diseases	**Focus Area: Healthy Eating and Active Living** Goal 1: Increase the prevalence of Colorado adults who are at a healthy weight *Strategies: Increase access to National Diabetes Prevention Programming*	**Focus Area: Overweight and Obesity** Goal 1: Reduce overweight and obesity by helping people eat healthy/get physical activity *Strategies: Increase number of eligible people completing diabetes prevention programs*

ACKNOWLEDGEMENTS

WCDPHE expresses gratitude to the individuals and organizations who participate in the Thriving Weld coalition and CHIP workgroups. Their input and commitment to collaboration are essential to our success. They helped identify priority health issues, select evidence-based strategies, and have guided how valuable resources should be focused.

A special thank you to the members of the Thriving Weld Steering Committee. This report would not have been possible without their expert guidance.

Thriving Weld Steering Committee

Dr. Dannon Cox, *University of Northern Colorado*
Hannah Groves, *North Colorado Health Alliance*
MJ Jorgensen, *North Colorado Health Alliance*
Ty Lamm, *United Way of Weld County*
Aisha Meza, *North Colorado Health Alliance*
Micaela Sanchez, *North Range Behavioral Health*
Katie Schmidtmann, *North Range Behavioral Health*
Kelly Schwindt, *North Colorado Health Alliance*
Lyle SmithGreybeal, *United Way of Weld County*
Dr. Mark Wallace, *North Colorado Health Alliance*





APPENDIX A

Sources

SOURCES

1. Healthy People 2030. (2026). *Social determinants of health.* https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health
2. Centers for Disease Control and Prevention (2024). https://www.cdc.gov/healthequity/index.html
3. World Health Organization. (2026). *Health equity*. https://www.who.int/health-topics/health-equity#tab=tab_1



APPENDIX B

Capacity Assessment

CAPACITY ASSESSMENT

A public health capacity assessment measures the ability of an agency, partners, and systems to deliver or ensure public health and environmental health services, programs and activities, and to address local health issues. We assessed the capacity of the public health system in Weld County in two ways:

1 - Capacity to address identified health issues
2 - Capacity to perform foundational capabilities and implement core public health services

1

Capacity to Address Identified Health Issues

Reviewed and assessed capacity during the CHIP health issue prioritization process to gain community feedback regarding the size, seriousness, disproportionate impact, ability to change, and relevance of priority health issues. This information was used to narrow the number of health issues from nine to three. During the prioritization process, participants were prompted to consider their agency's individual capacity to address each issue as well as the capacity of the overall community - weighing available resources, staffing, interest, and other influential factors.
Additional details about this process can be found in Appendix C.

2

Capacity to Perform Foundational Capabilities and Implement Core Public Health Services

Assessed the agency's capacity to perform foundational capabilities and implement core public health services based on the 2008 Colorado Public Health Act. It is important to assess internal capacity to determine any areas that need to be addressed before committing to other priority public health issues. This process also assists agencies with their strategic plan and/or quality improvement planning efforts. Review the following page for more information about the Foundational Capabilities and Services.
Detailed results of the internal capacity assessment can be found on pages 30 and 31.

FOUNDATIONAL PUBLIC HEALTH CAPABILITIES AND SERVICES

The 2008 Colorado Public Health Act established the core public health services that local public health agencies must provide or ensure. As of January 1, 2020, state statute also requires public health agencies to ensure the provision of seven Foundational Capabilities and five Foundational Services.

Colorado Foundational Public Health Capabilities

Foundational Capabilities are the cross-cutting capacities and expertise needed to support foundational services of any public health program.

1 - Assessment and planning
2 - Communications
3 - Policy development and support
4 - Partnerships
5 - Organizational competencies
6 - Emergency preparedness and response
7 - Health equity and the social determinants of health

Colorado Foundational Public Health Services

Foundational Services are the subset of services in each public health program area that are foundational to building and maintaining healthy communities.

Maternal, Child, Adolescent & Family Health



Environmental Health



Communicable Disease Prevention, Investigation & Control



Access to and Linkage with Care



Chronic Disease, Injury Prevention & Behavioral Health Promotion

Core Public Health Services: Foundational Capabilities							
	Assessment & Planning	**Communications**	**Policy Development and Support**	**Partnerships**	**Emergency Preparedness & Response**	**Organizational Competencies**	**Health Equity & the Social Determinants of Health**
Personnel & FTE	7 personnel; 5.25 FTE	13 personnel; 3.75 FTE	5 personnel; 2 FTE	25 personnel; 4 FTE	4 personnel; 2.50 FTE	10 personnel; 7.25 FTE	50 personnel; 4 FTE
Areas of Strength	Weld conducts triannual survey for CHA; SME across staff; Ongoing QI efforts	SME across staff; PIO & IT teams provide support & manage systems; Weld-specific branding & style guides; Strong networks to disperse content	SME across staff + doctoral-level; Relationships with state agencies, county leadership, partners to support policy development	CH Division staff all support this service; Established partnerships	Department-wide training drill (2026); OEM supports (4 FTE); Partners (Serve 6.8 & Red Cross); SME across staff	SME staff including fiscal team & Admin Manager; Other depts. support	Internal workgroup focused on staff development; Clinic & preventive services provide safety net
Areas of Challenge	Difficult to hire data analysts; 3-year CHA/CHIP cycle - more frequent to align with healthcare systems; Funding uncertainty	Difficult to get messages to community with changing media engagement; Fewer outlets for ads & messages to public	Policy development is limited by centralized County lobbying efforts	Geographically large with many municipalities; Difficult to identify partners & community champions in smaller cities/towns	Difficult to coordinate across large geographical area & culturally/ linguistically diverse population; Coordination with healthcare facilities	System inefficiencies; Weld has many employees/ Departments - need to build in additional time for cross-Dept. support	Some staff don't see their work as public health equity, even if it reduces disparities
Ranking*	High	Moderate to High	Moderate to High	Moderate to High	Moderate to High	Moderate	Moderate
Other		Many languages spoken		CHW team supports Latino/Hispanic-focused partnerships	Seasonal transitory population with little or no means to communicate critical information to; Lack of ESF-8		Conducts BARHII Organizational Self-Assessment

**Capacity rankings included: Basic, Basic to Moderate, Moderate, Moderate to High, and High*

Core Public Health Services: Foundational Services					
	Communicable Disease Prevention & Control	**Environmental Public Health**	**Maternal, Child, Adolescent, & Family Health**	**Chronic Disease, Injury Prevention, & Behavioral Health Promotion**	**Access to & Linkage with Health Care**
Personnel & FTE	15 personnel; 10 FTE	38 personnel; 37 FTE	14 personnel; 13 FTE	27 personnel; 23 FTE	10 personnel; 7 FTE
Areas of Strength	Diverse team with background in lead poisoning prevention, zoonotic & communicable disease; Strong partnerships with clinic and CDPHE; Robust clinic services including STI/HIV, TB, & immunizations	Program specialists (vs generalists); SME across staff; Depth in programs; Regional water quality laboratory	Strong MCH programming in NFP, HCP, Lighthouse, & social work/ navigation; SME across staff	SME across staff; CHW team focused on chronic disease; Significant grant support for services	Robust safety-net clinic services, Mobile Health Unit, & partnerships improve access to preventive care for underserved populations; Navigation, care coordination, & outreach connect residents to services
Areas of Challenge	Difficulty setting & enforcing public health orders; Uncertainty in federal and state funding	Extensive travel for inspections; Balance between industry and public health; Linguistically diverse population	Uncertainty in federal & state funding; Limited community resources/ services to connect people to	Geographically large county with many municipalities; Can be difficult to establish presence and relationships outside of Greeley	Limited availability of affordable health care, transportation barriers & geographic disparities; Funding uncertainty
Ranking*	Moderate to High	Moderate to High	Moderate to High	Moderate to High	Moderate to High
Other				WCDPHE Mobile Unit brings chronic disease screenings to Weld residents	Healthcare access selected as a 2026-2028 CHIP priority area

**Capacity rankings included: Basic, Basic to Moderate, Moderate, Moderate to High, and High*



APPENDIX C

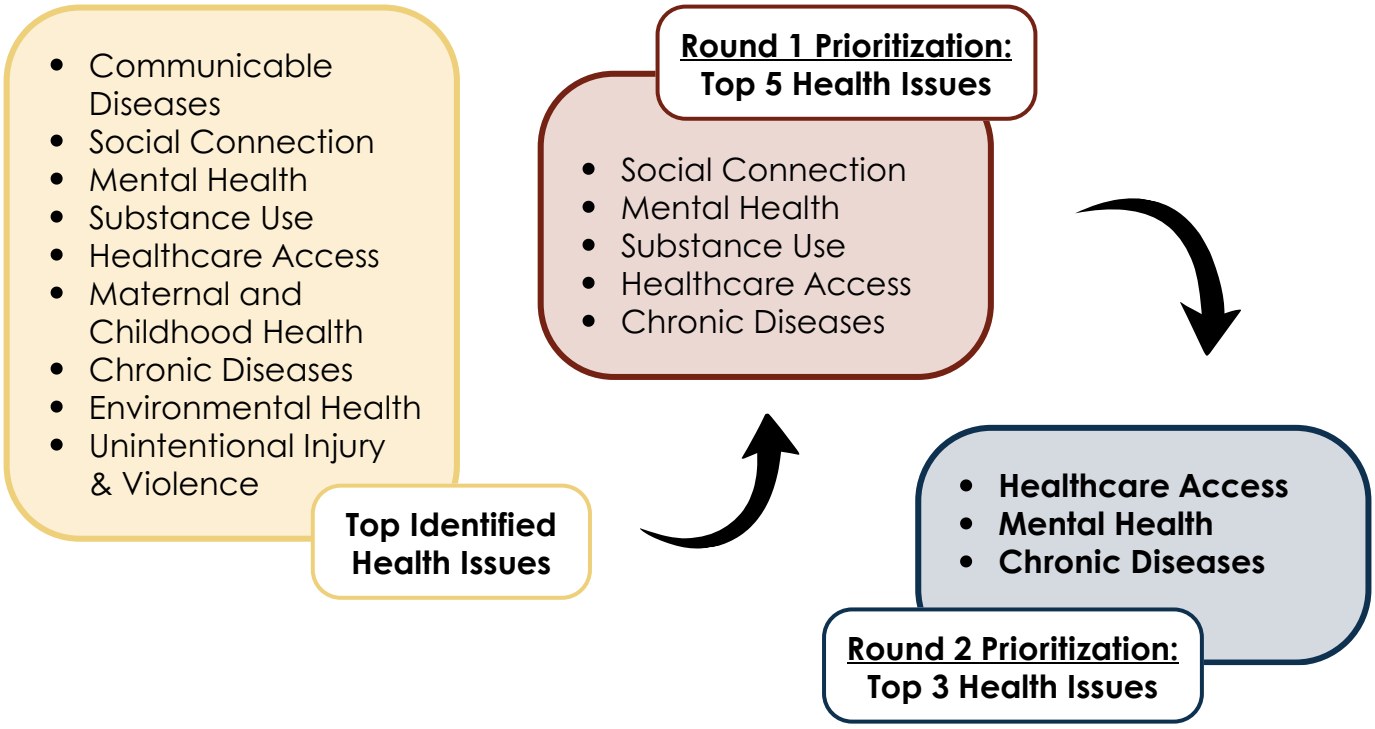
CHIP Prioritization Process Summary Report

SUMMARY REPORT

CHIP ISSUE PRIORITIZATION PROCESS

OVERVIEW

Thank you to everyone who participated in the Community Health Improvement Plan (CHIP) issue prioritization process. On April 28, 2026, multi-sectoral partners narrowed the number of health issues from ten to 5. On May 28, 2026, community partners gathered for the Thriving Weld Quarterly Meeting and further narrowed issues to the top three: **Healthcare Access, Mental Health, and Chronic Diseases.**



A Note on the Calculations:

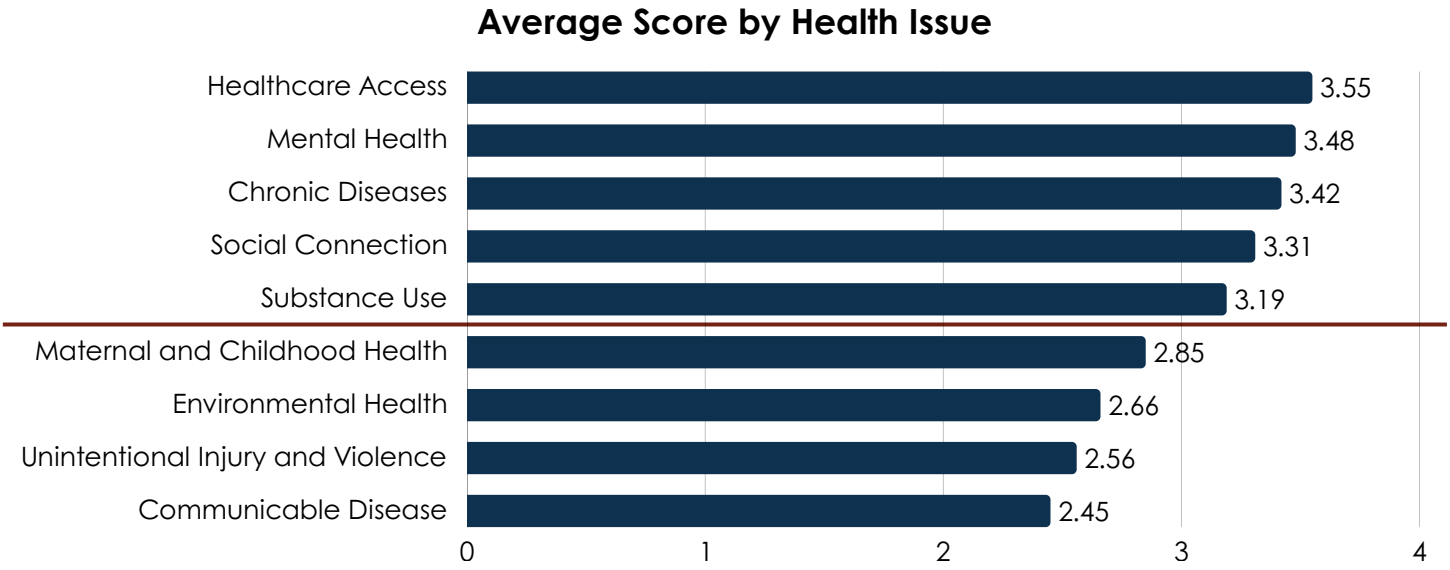
For each health issue, each criterion (size, seriousness, disproportionate impact, ability to impact, and relevance) was averaged. Then, all criteria for that health issue were averaged for a final, overall score. Scales used during voting were as follows:

High Importance = 4
Moderate Importance = 3
Low Importance = 2
Not Important = 1

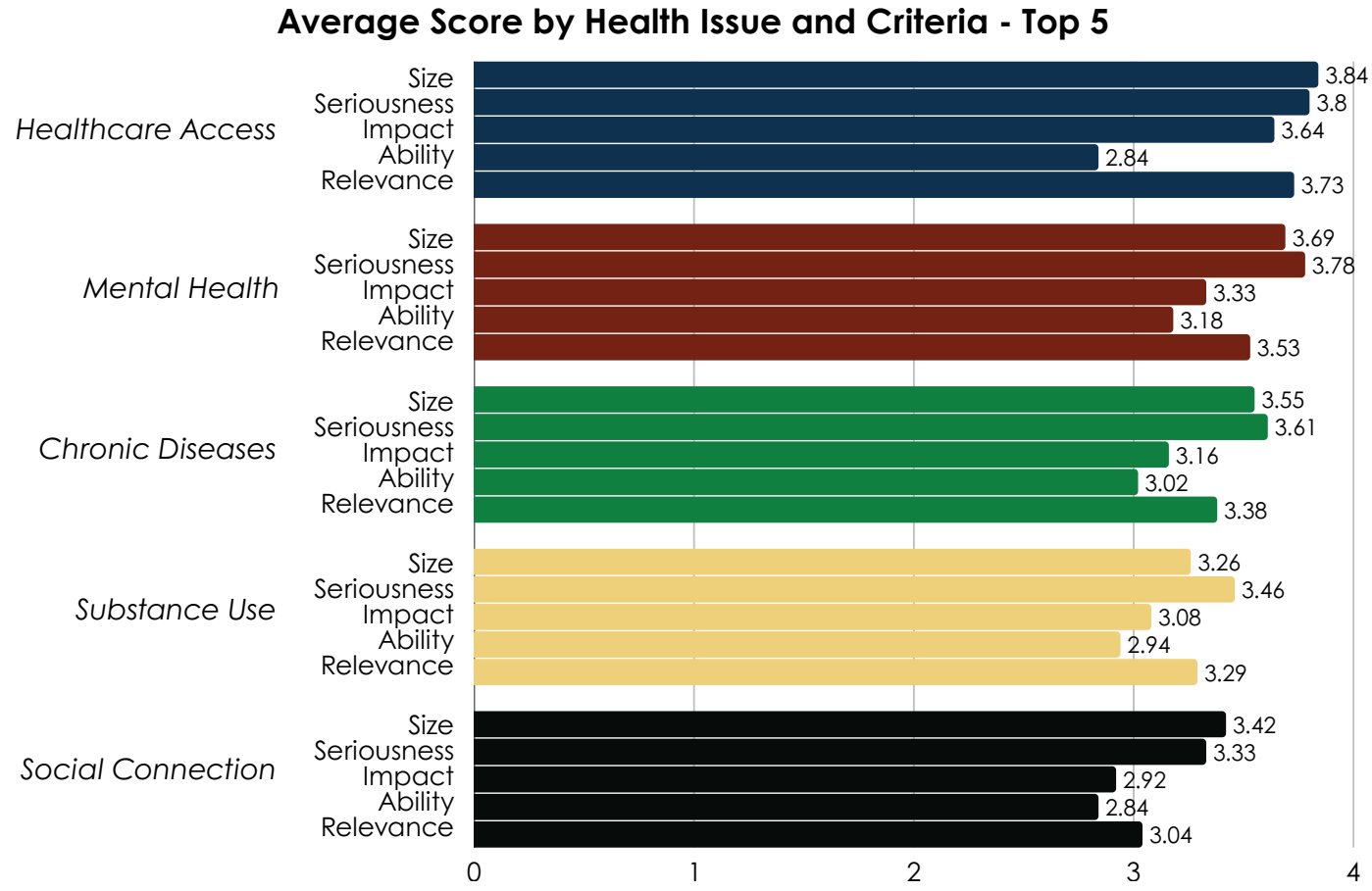
The *Average Score by Health Issue and Criteria - Top 5* graph on the next page shows the average scores for each criterion within each of the top 5 health issues.

PRIORITIZATION PROCESS DATA

After the first prioritization meeting, issues were scored to identify the top 5 priority health concerns for further investigation and discussion.



The second round of prioritization focused on narrowing the number of issues to 1-3 key health concerns to serve as the focus of the 2026-2028 CHIP.



NEXT STEPS

Healthcare Access, Mental Health, and Chronic Diseases will be the focus of the 2026-2028 Weld County CHIP. We need your help as we initiate **next steps**. This includes **forming a Healthcare Access workgroup and developing action plans** for each of the three priority areas. Mental Health will remain under the existing Healthy Mind and Spirit workgroup. The previous Healthy Eating and Active Living workgroups will be combined to address chronic diseases. Initial action planning meetings will begin in July.

Contact us to join a workgroup and please share this information with your colleagues who may be interested.

Thank you for your time and expertise! Your assistance throughout this process is sincerely appreciated.

1. Join a workgroup - *consider being a founding member of the Healthcare Access group!*
2. Share data and workgroup information with passionate folks in your network

PROJECTED CHIP TIMELINE

April 2026
CHIP Prioritization Round 1

May 2026
CHIP Prioritization Round 2 at Thriving Weld Quarterly Meeting

June 2026
CHIP Priority Areas shared with Thriving Weld

Literature Review & Workgroup Recruitment

July 2026
Workgroup Recruitment

Initial Action Planning Meetings

August 2026
Thriving Weld Quarterly Meeting

Continued Recruitment & Action Planning

September 2026
Finalize Action Plans & Identify Data Points

October 2026
Finalize Action Plans & Data Points

Publish CHIP

2026 - 2028
CHIP Implementation



APPENDIX D

Healthcare Access Issue Brief and Strategy Map

HEALTHCARE ACCESS

ISSUE BRIEF & STRATEGY MAP

BACKGROUND

Having timely and easy access to necessary healthcare services helps residents support and maintain overall physical, social, and mental health status. Barriers to access include:

- Cost of care
- Being uninsured, underinsured, or insurance not covering services
- Location and geographic access
- Appointment wait times and availability
- Limitations to time off of work
- Transportation

COMMUNITY HEALTH SURVEY DATA

Health Insurance

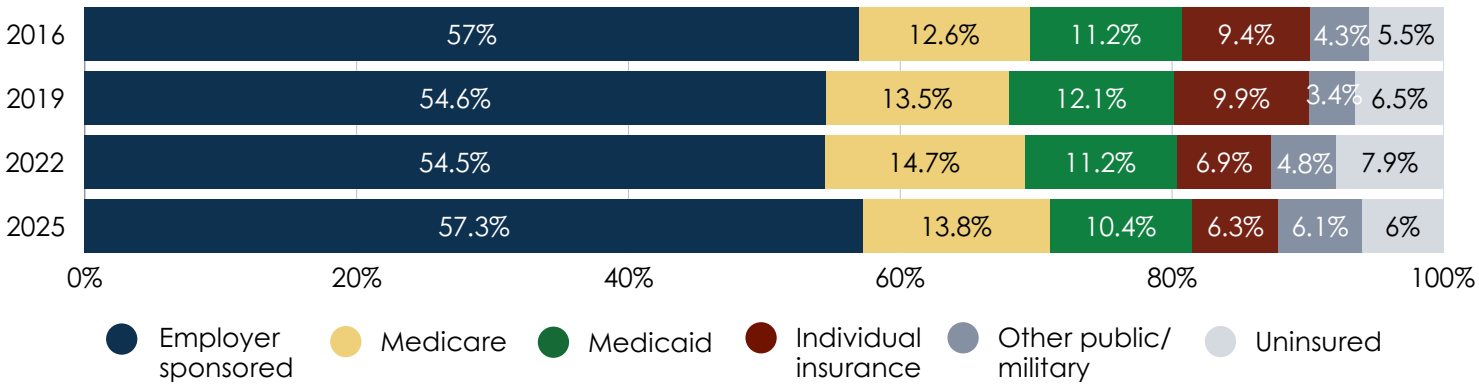
In 2025, more than **6% of Weld residents were uninsured,** representing 17,020 adults. The most common reasons were cost, disenrolled/dropped by Medicaid, lost/changed job, employer does not offer coverage, and no longer eligible due to age or income.

Note: In 2022, very few residents reported Medicaid disenrollment as a reason for being uninsured. In 2025, it was the **second most common answer.**

Though uninsured rates declined significantly for Weld Hispanic/Latino residents in 2025, disparities remain. **Uninsured rates were 4x higher in Weld Hispanic/Latino residents** compared to White non-Hispanic/Latino residents.

Nearly **1 in 2** (47%) Weld County adults reported they were **always or usually worried about health insurance becoming too expensive**.

Adult Health Insurance Coverage by Insurance Type



Delayed Care

Reasons for Delaying or Going Without Needed Care	
Cost	50%
No convenient/available appointment	38%
Not able to take time off work	20%
Problem not covered by insurance	19%
No insurance	15%
Couldn't find a provider who accepts my insurance	13%
No provider in my area	8%
Transportation	8%
Could not find childcare	5%

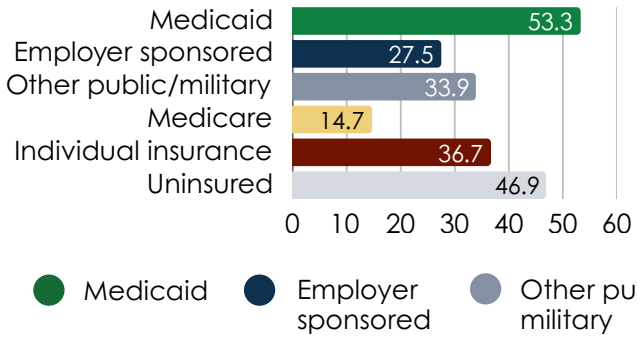
Nearly **1 in 3** Weld residents delayed or went without needed health care in the past year.

Uninsured residents (47%) delayed or went without care more often than those with insurance (30%).

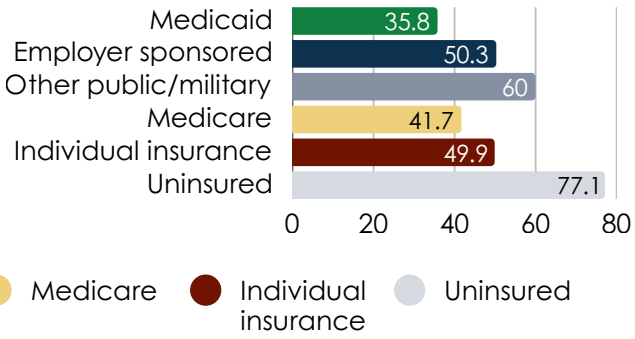
More residents ages 18-34 (44%) delayed or went without care compared to residents ages 35-54 (31%) and 55+ (21%).

Even residents with insurance reported putting off needed care.

% Delayed Care by Insurance Type



% Delayed Care Due to Cost by Insurance Type





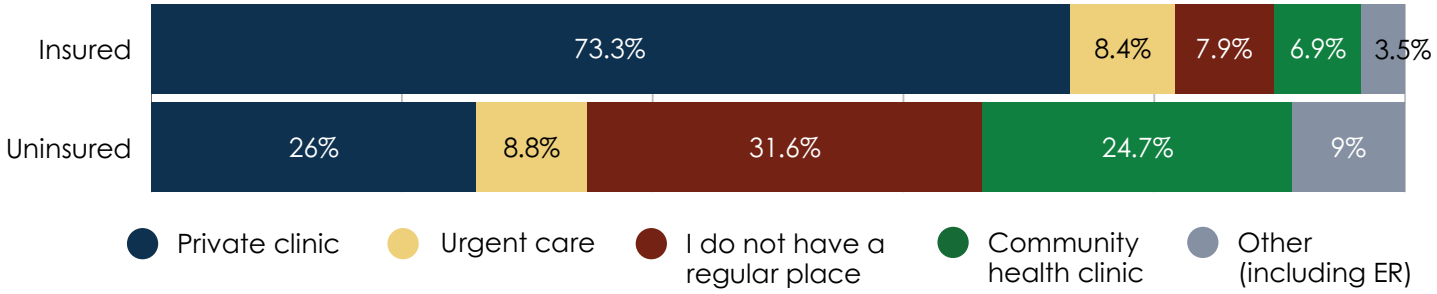
Emergency Room Visits

Of the 22% of residents who visited the ER in the past year, around **1 in 3 believed they could have been treated by a regular doctor** if one was available.

Regular Care Location

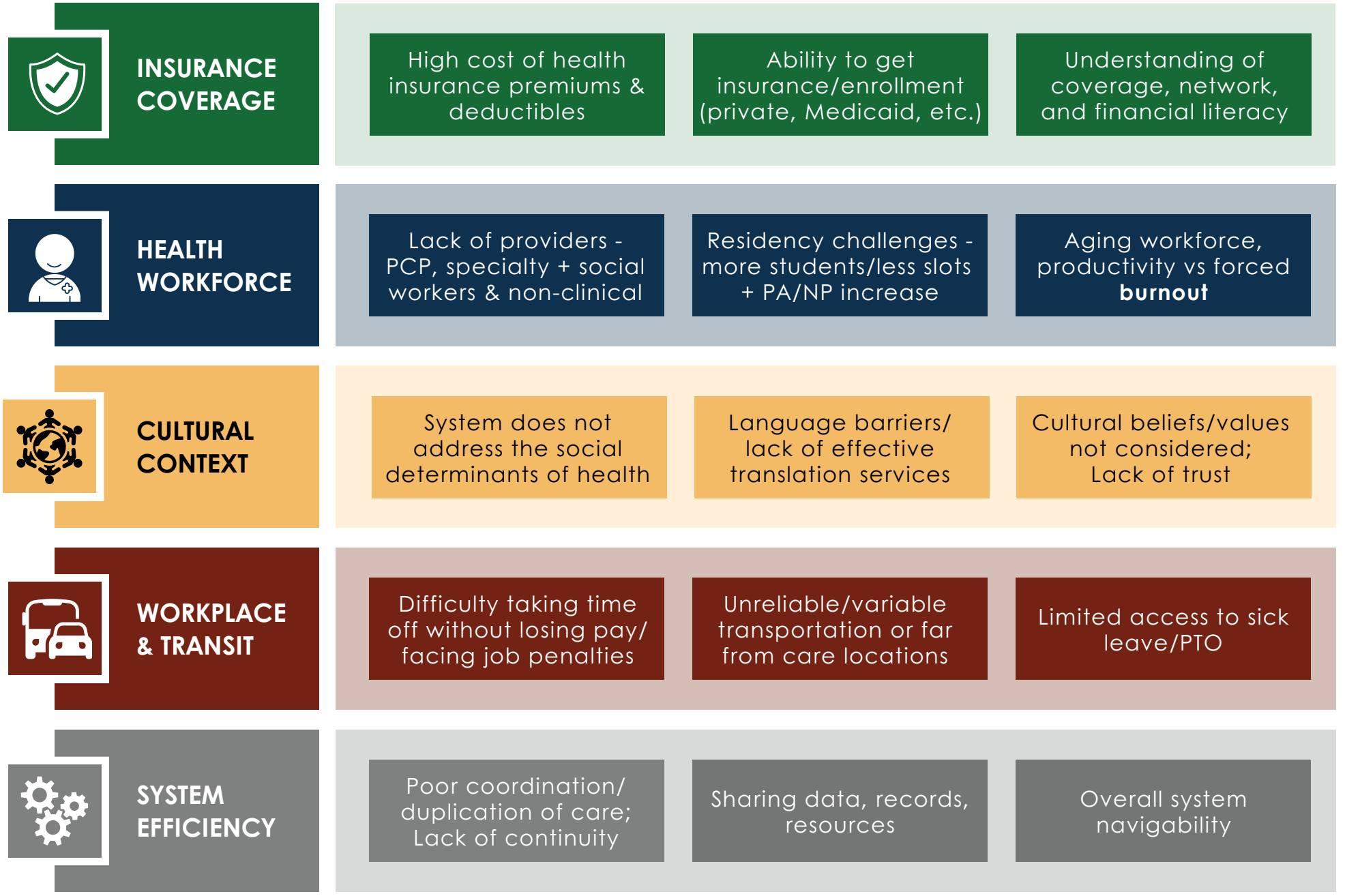
Around 1 in 10 residents (9.4%) do not have a regular place to receive care. Of those who do, private clinics, urgent care, or community health clinics are most common, but can vary.

Regular Care Location by Insurance Status



HEALTHCARE ACCESS KEY BARRIERS

Cost *was largely identified as the greatest barrier to accessing healthcare. It impacts each section below.*





01

Health Insurance:
Access to insurance, cost of insurance, insurance coverage

- Utilize community health workers to provide insurance enrollment assistance/outreach
- Enhance health insurance literacy by developing easy to understand benefit summaries
- Simplify enrollment process, use clear plan comparison tools to reduce confusion

02

Health Workforce:
Provider availability in prevention, primary care, specialty care, and supportive care functions

- Partner with academic institutions to streamline career pathways and support transitions into the workforce
- Prevent burnout by encouraging integration of well-being programs and training supervisors in supportive management

03

Cultural Context:
Addressing the social/ structural factors that make care less affordable and/or accessible to many communities, including discrimination

- Utilize interpreters/translation services
- Incorporate culture-specific attitudes and values in health promotion tools
- Provide linguistic assistance past clinical encounters (i.e. scheduling, billing, all written materials)
- Provide regular training to increase cultural awareness, knowledge, skills

04

Transportation & Workplace:
Ability to access appointments, including without losing significant wages/employment

- Integrate tools (i.e., telehealth and mobile clinics) to expand reach to underserved areas
- Ensure services reach geographic areas that are easily accessible for at-risk groups
- *Employers* provide frequent education to staff about benefits to maximize utilization and offer flexible scheduling to accommodate appointment schedules

05

System Efficiency:
Ability to operate with few errors and support collaboration to improve patient outcomes

- Modernize and standardize workflows across departments to reduce errors
- Streamline systems communication (i.e. appointments, reminders, provider scheduling)

Education, awareness, and outreach are also key tactics to be incorporated in each strategy bucket above.



APPENDIX E

Mental Health Issue Brief and Strategy Map

MENTAL HEALTH

ISSUE BRIEF & STRATEGY MAP

BACKGROUND

Mental health affects people's ability to participate in everyday activities. It can also impact how connected they feel to their community and those around them. Having poor mental health and/or experiencing chronic loneliness can also impact someone's physical health. It is important for community members to have access to mental health treatment and supportive services to manage symptoms and improve health outcomes.

COMMUNITY HEALTH SURVEY DATA

Loneliness and Social Isolation

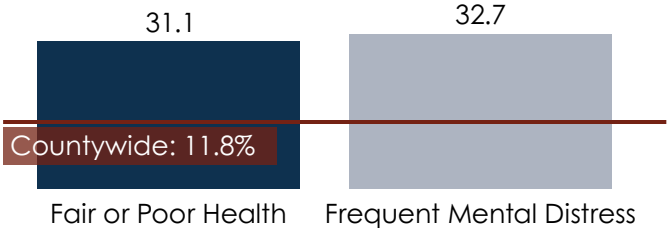
More than 1 in 4 (27%) Weld residents are lonely. Around 12% report they are socially isolated. Loneliness and social isolation are linked to poor mental and physical health.

Residents ages 18-34 experience the **highest rates of loneliness** (37%) compared to other age groups. Low-income residents report significantly **higher rates of loneliness** (43.5% vs 24.2%). Residents with 4 or more chronic conditions also have significantly **higher rates of social isolation** (18.7% vs 9.45%).

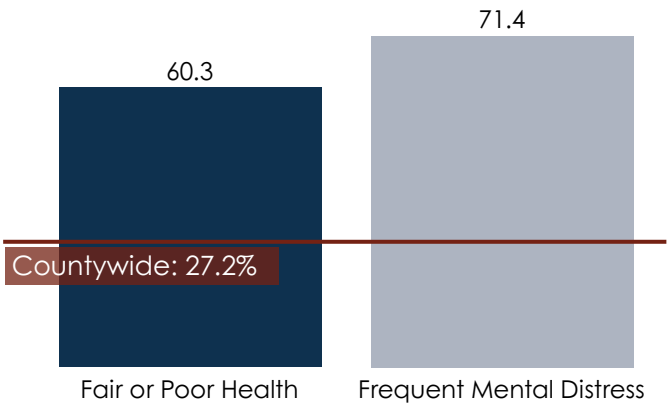
Male residents have significantly **higher rates of social isolation compared to females**, while female residents had significantly **higher rates of loneliness.**

Residents who *reported fair or poor health* or had *frequent mental distress* had **higher rates of loneliness and social isolation** compared to countywide averages.

% of Residents Experiencing *Social Isolation* with Concurrent Physical/Mental Health Problems



% of Residents Experiencing *Loneliness* with Concurrent Physical/Mental Health Problems



Mental Health Outcomes

In 2025, **30%** of adult residents reported having a professional diagnosis of a mental health condition, including depression, anxiety, or other mental health conditions.

More female residents (39%) report having depression, anxiety, or other mental health problems compared to males (21%).

The crude suicide rate in Weld County is 18 per 100,000 population. This has *remained the same since 2022*. Around 5% of Weld high school students (1 in 20) attempted suicide in the past 12 months. 1 in 10 (10.7%) seriously considered suicide in the past 12 months.

In 2024, the suicide rate was nearly **4x higher for male residents** compared to female residents.

Middle school-aged students in Colorado report higher rates of suicide attempts and serious thoughts of suicide compared to their high school-aged peers.

Access to Care

Reasons for Delaying or Going Without Needed Mental Health Services	
Cost	50%
Did not have time to seek treatment	48%
Insurance won't cover/pay enough	44%
Did not know where to go to get services	44%
Had a hard time getting an appointment	30%
Concerned others would have a negative opinion	17%
Concerned seeking treatment might negatively impact their job	14%
Other	27%

In 2025, more than **1 in 4** (26.3%) Weld residents reported needing mental health services or counseling.

1 in 3 did not get the care they needed.

Around 69% of insured Weld County adults have coverage for behavioral or mental health services. 12% do not and 19% are unsure.

Youth Resiliency

According to the 2025 Colorado Healthy Kids Survey, many mental health and resiliency indicators are improving statewide and among Weld County* high school students:

- **58%** agree or strongly agree their stress level is manageable most days
- **76%** (3 in 4) felt they had an adult they could go to for help with a serious problem
- **92%** usually or definitely felt safe at school
- **64%** agree or strongly agree they belong at their school
- **27%** most of the time or always had poor mental health during the past 30 days

**Though past Weld County data is limited, these indicators show improvement.*



01 **Upstream Prevention:**
Identify and reduce risk factors and focus on early detection

- Improve population monitoring of mental health outcomes to tailor interventions and track disparities
- Support programming around the social determinants of mental health
- Develop initiatives that emphasize protective factors, such as emotional regulation, identity, and connection

02 **Access and Integrated Care:**
Embed mental health services in non-traditional settings to improve access and reduce stigma

- Improve mobile outreach to include mental health services
- Support school-based health centers and counseling services
- Address cost barriers associated with mental health care

03 **Social Connection:**
Foster supportive social networks to combat feelings of being alone or disconnected from others, leading to poor mental health outcomes

- Implement peer support programs
- Integration of social prescription in physical and mental healthcare
- Community events/workshops that cultivate a strong sense of belonging and connectedness
- Creating built/physical environments that foster safety, community, and physical activity

04 **Community Engagement:**
Cultivate a sense of connectedness, improve awareness, reduce stigma, and empower communities to engage in efforts

- Encourage data sharing of mental health outcomes and population monitoring
- Mental health promotion and education
- Partner with community champion organizations to reach underserved and susceptible groups

05 **Workforce and Training:**
Strengthen professional capacity and foster training among non-specialist community members

- Strengthen professional capacity in prevention, specialty care, and supportive roles (health support workers/peer support)
- Train teachers, responders, and others to recognize warning signs/crisis and provide support



APPENDIX F

Chronic Diseases Issue Brief and Strategy Map

CHRONIC DISEASES

ISSUE BRIEF & STRATEGY MAP

BACKGROUND

Chronic Disease Grant

The Chronic Disease Prevention Pilot Grant aims to help build community capacity, change social norms, and foster community readiness and support for Chronic Disease Prevention and Management.

Strategy Selection Process

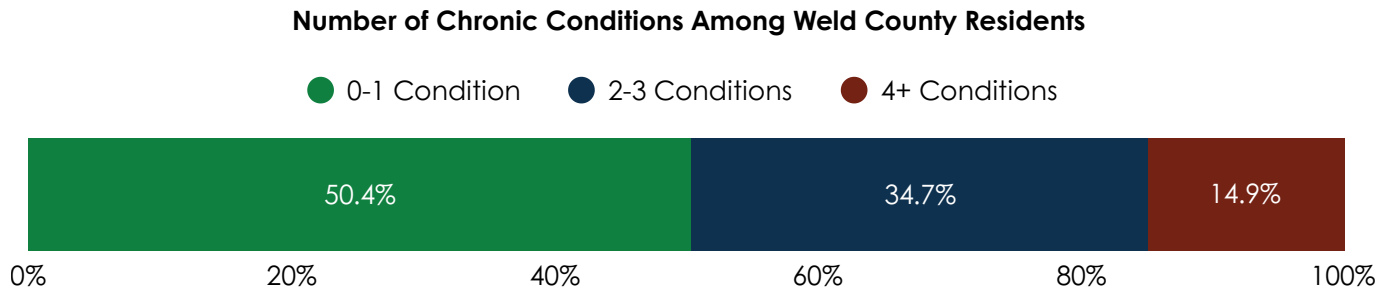
WCDPHE and community partners participated in a chronic disease community assessment from April to June 2026. During this process, attendees learned more about the grant, reviewed local chronic disease indicators, and prioritized strategies identified by the Colorado Department of Public Health and Environment (CDPHE). A prioritization process narrowed these evidence-based strategies from 25 to 18 then continued until the final 5 were identified. *See the strategy map on page 2 for details.*

COMMUNITY HEALTH SURVEY DATA

Chronic Diseases

In 2025, half of Weld adults reported having one or more chronic conditions.

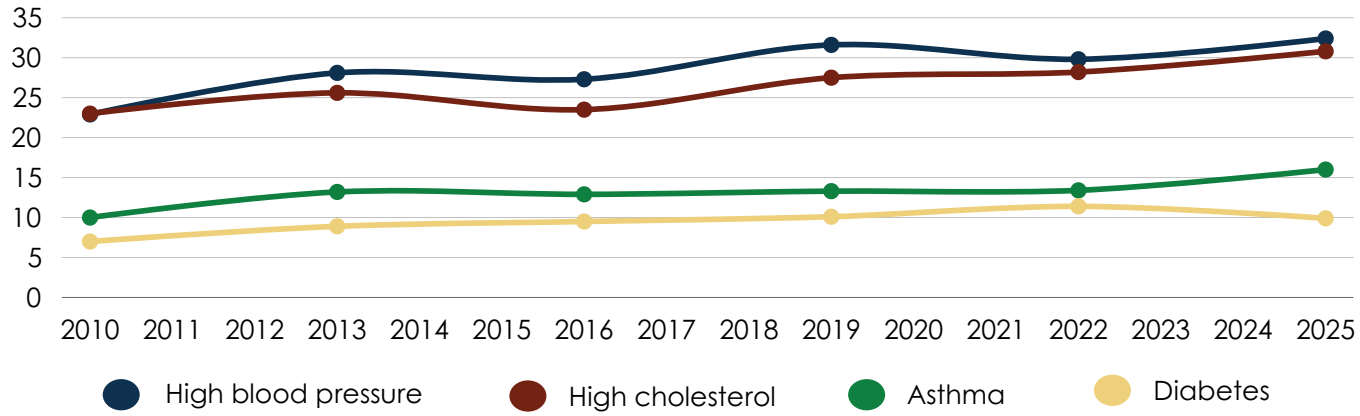
- 1 in 3 reported having high blood pressure
- 1 in 3 reported having high cholesterol
- 1 in 10 had been diagnosed with diabetes



Common Chronic Diseases

Common chronic diseases among adult Weld County residents include heart disease, high blood pressure, diabetes, high cholesterol, and asthma.

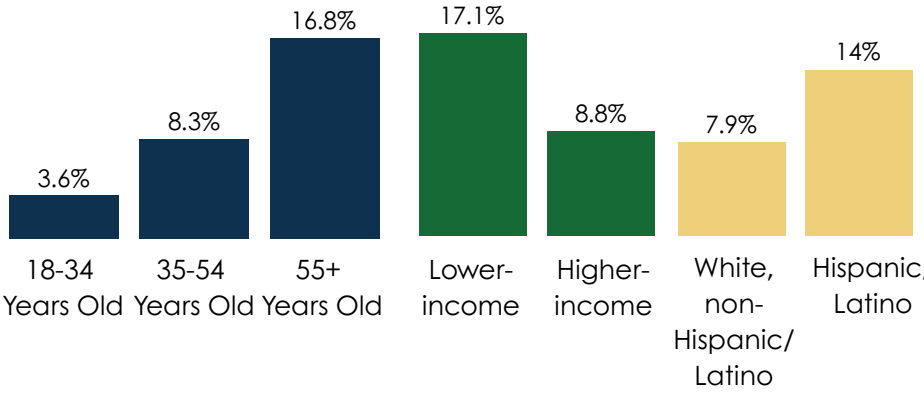
Percent Trends in Chronic Conditions, 2010-2025



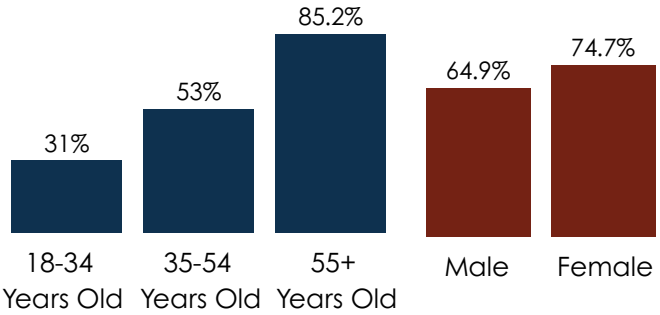
Chronic Diseases Disparities

Some groups of Weld County adults experience chronic diseases at a significantly higher rate than the general population - this is also called a *disparity*. **Disparities were found based on income, age, and ethnicity**.

% With a Diabetes Diagnosis by Demographic Groups



Out of Residents With a High Blood Pressure Diagnosis: % Taking High Blood Pressure Medication by Demographic Groups



% with Heart Disease Diagnosis by Demographic Groups

8.5%

Lower-Income Residents

(compared to 4.4% of those with higher incomes)

7.3%

Male Residents

(compared to 2.9% of female residents)

STRATEGY MAP

01 **Physical Activity Social Support:** Increase social supports for physical activity

- Promote community-based programs encouraging participation in activity and social connection
- Educate about benefits of social supports and shared activity experiences
- Identify and train community champions to lead culturally tailored physical activity groups

02 **Cardiovascular Disease Education:** Advance educational efforts to increase understanding of risk factors

- Host culturally appropriate community workshops and education
- Expand screening access in underserved communities
- Conduct community outreach and promotional campaigns

03 **Access to Diabetes Programming:** Increase access to National Diabetes Prevention (DPP) Programs and Diabetes Self-Management Education and Support (DSMES) programs

- Partner with clinics to increase screening and referrals to DPP
- Promote adoption and implementation of programs that reach underserved populations
- Deliver DPP locally

04 **Chronic Disease and Aging:** Provide support for addressing co-occurring chronic diseases within an aging population

- Strengthen early identification and care navigation for older adults with multiple chronic conditions/possible cognitive decline
- Connect individuals and families to appropriate resources (e.g., respite care, day programs, dementia services)
- Expand services for older adults with chronic diseases (e.g., DPP class, physical activity)

05 **Physical Environments:** Promote access to stable and healthy housing, nutritious foods, and safe and connected neighborhoods

This strategy will begin in year two