

HEALTH DISPARITIES GRANT PROGRAM

Final Evaluation Report | Funded Agencies

FISCAL YEARS
2012-2015



COLORADO
Department of Public
Health & Environment



Acknowledgements

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Funded Agencies

Health Disparities Grant Program
Fiscal Years 2012 - 2015

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Since 2005, Colorado's Health Disparities Grant Program (HDGP) has been supporting programs and initiatives across the state to address the prevention, early detection and treatment of cancer, cardiovascular and pulmonary diseases in underrepresented populations. The statute that created the program emphasizes a focus on racial and ethnic minorities and underserved/under-represented populations.

Between 2012 and 2015, 13 communities implemented practical, evidence-based projects and reached more than 250,000 underserved individuals in 23 counties.

The communities served represented the following demographics:

| Race or ethnicity (as categorized by the U.S. Census Bureau) | Percent of Colorado population according to 2010 Census Bureau | Percent of populations reached through the Health Disparities Grant Program |
|--|--|--|
| White, Non-Hispanic | 70 | 25 |
| Hispanic | 22 | 54 |
| Black or African American | 5 | 8 |
| Asian and Pacific Islander | 2 | 6 |
| American Indian | 4 | 7 |

* Source: Colorado State Demography Office.

Projects were designed to address cancer, cardiovascular and pulmonary diseases, and some grantees addressed a combination of these. Using a variety of strategies including health education, clinical activities and policy change, 69 percent of the agencies focused on reducing risk factors to decrease obesity, while 61 percent performed patient navigation and case management activities. Fifteen percent of agencies also worked collaboratively across sectors to improve health outcomes for their community members. Some projects implemented one or more of the priorities to ensure a variety of approaches to address chronic disease for underserved people. Of the 13 funded agencies, 54 percent addressed screening for clients and 35 percent implemented screening services through in-house activities. In 2012 a still unknown percentage of the services were consistent with the Patient Protection and Affordable Care Act (Obamacare) and referred clients to available patient-centered, clinical and/or primary health care services.

All agencies were required to evaluate their programs, describe assessment activities and present progress toward planned outcomes. Many of the agencies exceeded the standard evaluation requirement by

maintaining sophisticated systems to manipulate and aggregate data. Agencies that screened clients for chronic disease collected demographic information, tracked the number of clients screened and monitored health levels (e.g. blood pressure measurements, lipids, Hemoglobin A1 C and body mass index).

This final evaluation report documents project progress and outcomes, and includes responses from each agency as required by HDGP Program Rules, 6 CCR 1014-5.



Project Title: Talking Circles for People who are Homeless in Metro Denver

Disease Category: Crosscutting (Cancer, Cardiovascular and Chronic Pulmonary diseases)

Year 1 (FY 12-13): \$149,138

Year 2 (FY 13-14): \$198,851

Year 3 (FY 14-15): \$198,851

3-Year Total: \$546,840

Project Priority: Patient Navigation/Case Management Services

Intended Population: Native American/American Indian

Counties Served: Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Jefferson

3-Year Population Reach: 515

Project Summary: The Colorado Coalition for the Homeless (CCH) implemented the three-year project addressing health disparities of homeless Native American adults in Metropolitan Denver. The project conjoined Native and western medicine by: 1) continuing CCH hosted Talking Circles and 2) continuing Patient Navigation/Case Management to increase access to health care and treatment services, and 3) hosting Talking Circles to address access to health care, encourage health screening and provide referrals to treatment services. Clients are screened for health care eligibility. The Patient Navigator/Community Health Worker lead clients through the Colorado PEAK application process to support enrollment for food, cash and medical assistance.

The information below is a response to the HDGP Program Rules 6CCR1014-5 Final Evaluation Report questions as required.

a Key Accomplishments

The Talking Circles for People who are Homeless in Metro Denver project surpassed planned goals to recruit and maintain Native American participation in the project. The following results were achieved.

- Total project attendance: **515**
- Talking Circle Ceremonies held: **497**
- Patient Navigation/Community Health Work (PN/CHW) contacts: **2,760**
- Number of PN/CHW referrals for prevention and early detection: **284**
- Number of participants' follow up to health care services: **230**

- Number of participants enrolled in health care benefits: **417**
- Number of providers trained in cultural competency: **65**
- Number of participants provided with permanent, supportive housing: **24**

b People Served and Services Received

Talking Circles were hosted weekly at four strategic sites frequented by homeless and at-risk Native Americans. The project served a total of 515 individuals. The Patient Navigation/Case Management process and group activities were successfully attended. Eighty-one percent of the participants worked with the Patient Navigator/Case Manager to access transportation, referral, crisis intervention, individual and family counseling, outreach, housing attainment and retention and benefit acquisition. Health access assistance included education to increase the ability to be self-sufficient and manage individual health care needs.

c State-Level Evaluation

CCH participated in the state-level evaluation studies regarding the impact of the overall Health Disparities Grant Program spearheaded by the Community Epidemiology & Program Evaluation Group (CEPEG). CCH provided detailed project information to CEPEG regarding Community Health Worker job descriptions and navigator roles. CEPEG completed initial and follow-up interviews and the preliminary report, available through the Office of Health Equity.

d Evaluation Results

The project conjoined Native and western medicine by hosting culturally specific Native American Talking Circles and providing health education. It was learned it is important to use an innovative outreach strategies to encourage and engage the homeless Native American population. CCH project employees were sensitive to the barriers which traditionally have inhibited access for the intended population, and demonstrated understanding and acceptance with all cases. Weekly attendance was consistently high in the Talking Circle ceremonies, and the project maintained a high percentage of follow up contacts and referrals to health care providers. This data showed evidence of trust between the intended population and the project staff.

e Measures and Methods to Determine Effectiveness

Measures and data variables included participation numbers and project events completed. Data elements included:

- Total Talking Circle Ceremonies held;
- Total duplicated and unduplicated attendance;
- Number of Patient Navigator/Community Health Worker (PN/CM) contacts;
- Number of PN/CM referrals to health care services;
- Number of Participants enrolled in health care benefits;
- Number of providers trained in cultural competency;

- Number of Participants provided with permanent, supportive housing.

Program staff members directly delivering project services met regularly with CCH’s Native American Services Program Manager and also the CCH Director of Native American Services to review progress, assess effectiveness and evaluate process.

The method for determining program progress included the analysis of client data. Demographic and project participation data for each client was regularly recorded through a spreadsheet and entered into the Homeless Management Information System (HMIS). The Director of Evaluation and Quality Assurance managed program data spreadsheets and analyzed the data elements. Effectiveness was determined by comparing the numbers of clients with improved access to health care, follow up referrals and enrollment in the talking circles.

Project results, progress and lessons learned were disseminated to CCH staff, the CCH management team and the board of directors. Feedback was shared with these partners to ensure project improvements could be made and that positive impacts on the intended population could be maximized. It was discovered through an analysis of project data that limited resources should be addressed and that staff should be well trained and supported.

f Sustainability

CCH has committed to sustaining central elements of the project. There were positive impacts on the intended population and the culturally competent programming was found beneficial to Native American clients. Both general funds and increased Medicaid revenue is needed to sustain the project

and the agency will continue to seek additional state and federal grant funding.

Additionally, the CCH Native American Services Program Manager will engage broader partners for support, such as the Denver Indian Center, Denver Indian Health and Family Services and Denver Indian Family Resources. CCH project staff will continue to present on the Talking Circle Project and Native American services at national conferences, and is occasionally supported by independent donations.

g Impact on Intended Population

The following story exemplifies one of the many successes realized by this Project: A 60+ year-old Lakota female client began attending Talking Circle ceremonies. She was homeless living in motels, shelters and outside. She became very connected to the circle and was a strong presence offering her stories of pain and trauma. She often would complain that her doctors “didn’t care; I’m just a number.” After some time, her attendance with medical appointments was sporadic and unsatisfying to her. The Patient Navigator/Community Health Worker connected with the woman and collaborated with Housing First to help the client find an apartment. The client continued to attend Talking Circle Ceremonies and ultimately reported, “I feel heard when I come to circle.”

h Approach to Cultural Competence

CCH employees are trained in cultural competence. Employees are trained in health care navigation and group education to address and engage a

highly marginalized homeless Native American people. The Patient Navigator/Community Health Worker created a bridge to mainstream services and increased access to integrated and comprehensive primary and behavioral care. The Talking Circles for People who are Homeless in Metro Denver project involves understanding the complex and holistic needs of people experiencing homelessness, and

seeking to provide integrated services such as emergency, transportation and housing assistance as an additional means of increasing health outcomes. Native American project staff also provided both structured and informal cultural competency education to health care providers within CCH's Stout Street Health Center.



Project Title: Community Heart Health Actions for Latinos at Risk

Disease Category: Cardiovascular disease

Year 1 (FY 12-13): \$43,576

Year 2 (FY 13-14): \$50,034

Year 3 (FY 14-15): \$50,047

3-Year Total: \$143,657

Project Priority: Patient Navigation/Case Management Services
Risk Factor Reduction/Obesity

Intended Population: Latino/Hispanic community

Counties Served: Denver

3-Year Population Reach: 964

Project Summary: The Colorado Prevention Center’s (CPC) Community Heart Health Actions for Latinos at Risk (CHARLAR) project included education and health navigation services to address cardiovascular disease and diabetes screening. Counseling and behavior change support was provided to vulnerable, older adult Latinos in Northwest Denver. Promotoras worked with community members using specialized training in health education for Denver area residents. The project focused on health care access and community resources, and included a 12-week education program. Clients worked with Promotoras to navigate health services and received counseling. Health screenings including cholesterol, blood pressure, glucose, and body mass index were available, and clients were referred to local community clinics as needed.

The information below is a response to the HDGP Program Rules 6CCR1014-5 Final Evaluation Report questions as required.

a Key Accomplishments

Project goals included enhanced and comprehensive care to address cardiovascular disease (CVD) and diabetes prevention with the Latino population. The project achieved its goal by increasing health care access and community resources. Clients obtained biometric assessments including blood glucose, blood pressure measurements, cholesterol and body mass index. Counseling and education were critical components of the screening process and each client met with a health professional to assess status. Clients attended a 12-week health education class, received ongoing telephone follow-up calls and participated in the navigation process. Other project objectives included easier access and satisfaction in health services. Clients also were empowered to pursue and achieve personal health goals.

b People Served and Services Received

A total of 964 individuals were served during the project's three-year period. The target population was Latino adults over the age of 40 who reside in Denver. Participants received health screening, comprehensive risk assessments, and counseling from a health professional. The counseling sessions included education about cardiovascular disease and diabetes, risk factors for developing these conditions, strategies to reduce disease risk and ways to better manage chronic conditions.

c State-Level Evaluation

CPC Community Health participated in the state-level evaluation studies regarding the impact of the overall Health Disparities Grant Program spearheaded by the Community Epidemiology & Program Evaluation Group (CEPEG). The Colorado Prevention Center provided detailed project information to CEPEG regarding Community Health Worker job descriptions and navigator roles. CEPEG completed initial and follow-up interviews for the preliminary report available through the Office of Health Equity.

d Evaluation Results

Project participants have shown favorable results as indicated by a variety of measures. The number of days per week that participants did either moderate or vigorous exercise increased by approximately one day. Participants' average daily intake of fruits and vegetables increased by slightly more than one serving per day. Among those participants identified as having an elevated cardiovascular disease risk factor at

baseline (n=498), there were reductions observed of lipoprotein cholesterol (LDL) (114 mg/dL to 111 mg/dL), fasting blood glucose (114 mg/dL to 108 mg/dL) and systolic blood pressure (139 mmHg to 134 mmHg).

The project maintained successful participant recruitment, retention and positive feedback. Community members agree the Community Heart Health Actions for Latinos at Risk project is needed in Denver. The project's initial eligibility was limited to individuals aged 55 and older, but after learning of the high demand among younger adults, the minimum age was lowered to 40 years old. One of the most important lessons learned was the necessity of building and maintaining strong relationships with the community and surrounding service partners.

e Measures and Methods to Determine Effectiveness

The CHARLAR project evaluation process was structured using a single group, pre- and post-test design. Surveys were administered at the health-screening events and throughout the 12-week program. Surveys captured demographic and socioeconomic information, in addition to lifestyle data such as levels and frequency of physical activity and diet. In addition to survey data, body mass index, blood glucose, cholesterol levels, triglyceride levels and fasting blood glucose were measured. Improvements in these measures were analyzed, shared with clients, and used for project planning. An ACCESS database was used as the electronic system to store and manage client data. Database information was then transferred to SAS for aggregation, and to provide statistical, categorical and variance analysis, showing measurements of the spread between numbers in the data sets and health improvements among the intended population.

The pre- and post-test evaluation design captured behavioral data sets. Biometrics and analysis of unique physical and other traits related to cardiovascular disease and diabetes risk were used in counseling and screening as strategies to determine project effectiveness. Socio-demographic data was collected, including geographic and socioeconomic information as pertinent characteristics. Analysis of socio-demographic information allowed CPC to ensure that the people served were those affected by health disparities.

CPC is preparing a manuscript on the CHARLAR program to be submitted to a peer-reviewed scientific journal. Two separate abstracts highlighting various aspects of programming have been accepted for presentation at the American Public Health Association (APHA) Conference and Public Health in the Rockies (PHiR) conference. The project results will continue to be communicated to a community advisory committee as a community leadership group whose members are graduates of the CHARLAR program. Sharing project success and findings facilitates community-based knowledge, engagement in the data and ownership of the project.

f Sustainability

CPC is excited and grateful to have been selected as a Health Disparities Grant Program grantee and continue work for another three years. In addition to funding provided through this program, the agency will pursue other sources for the CHARLAR program. CPC is working with a business consultant to explore funding models and achieve improved financial sustainability.

g Impact on Intended Population

The majority of participants are Spanish-speakers, of which a large proportion was born in Mexico. Many (approximately 50 percent) lack health insurance. The intended population faces many barriers regarding accessing chronic disease prevention and management services, especially those that are culturally and linguistically appropriate. The CHARLAR program impacted the intended population by increasing access to medical care and the ability to live a healthier lifestyle.

Personal impact on a client was conveyed in the following testimonial:

“I have gone to my doctor, but it just seemed like she was just going through the motions with me, and I was not getting the message. After seeing the CHARLAR doctor during our first visit, I spent quality time and walked away feeling like he really cared about me. I knew I needed to do something about my blood work as they were all high, after going through this program, my blood work is perfect, I am not high or low in any area except my HDL, and it has gone from 29 to 38... I will be recommending this program to everyone.”

h Approach to Cultural Competence

Cultural competence was a focus of all CHARLAR activities. The Project’s Community Health Workers are members of Denver’s Latino communities and share many of the same life experiences as the clients. Project materials provided to clients are delivered in a culturally and linguistically

appropriate manner. The Community Advisory Committee (CAC) furthered goals to address cultural competence and provided critical community knowledge. The CAC members worked with CPC as invested leaders in Northwest Denver. The CAC members provided feedback to CHARLAR staff from the perspective of the Latino/Hispanic perspective on all aspects of the project and helped to ensure activities and improvements were aligned with the needs of the community.



Project Title: DPS Students & Families Healthy Choices**Disease Category:** Cardiovascular disease

Year 1 (FY 12-13): \$173,094

Year 2 (FY 13-14): \$173,092

Year 3 (FY 14-15): \$140,000

3-Year Total: \$486,186

Project Priority: Risk Factor Reduction/Obesity**Intended Population:** African American/Black, Asian American/Pacific Islander, Latino/Hispanic, Native American/American Indian and White/Caucasian communities**Counties Served:** Denver**3-Year Population Reach:** 2,994

Project Summary: The DPS Students & Families Healthy Choices project offered comprehensive, culturally competent, community-based after-school activities and classes for children and families in Northwest Denver. Project activities aimed to reduce obesity and obesity-related factors, encourage fitness and promote healthy lifestyle choices. The classes focused on fitness, weight loss and nutrition at the Skinner Neighborhood Center and Northwest feeder schools. Participation was intended to promote healthier lifestyles and increased fitness levels for students and their families.

The information below is a response to the HDGP Program Rules 6CCR1014-5 Final Evaluation Report questions as required.

a Key Accomplishments

Project participants and activities were tracked through an on-line database used to manage participation and engagement. Overall project results were measured in terms of number of events, numbers of attendees, as well increased skills, positive attitudes and behavior changes that led to better health outcomes. Most participants reported an improvement in personal physical activity behaviors and regimens. Post-retrospective survey data indicating increased skills and positive attitudes were also used to determine an improvement in health outcomes.

b People Served and Services Received

The Students & Families Healthy Choices project served a total of 2,994 people over three years. Cooking programs and events were offered at five schools and included fitness, nutrition and gardening. Gardening-related events were offered at three different sites, and all were instructed by qualified school staff, in conjunction with providers such as Denver Diggs and Denver Urban Gardens. All other services and events were fitness related and available to students and adults of the surrounding communities.

The population served was diverse and included: 51 percent Latino/Hispanic, 28 percent White/Caucasian, 11 percent two or more races, African 6 percent American/Black, 2 percent Native American/American Indian, and 2 percent Asian American / Pacific Islander populations. Ninety-two percent of the participants were school-age youth (6-18 years old), and 8 percent comprised the young adult and adult demographic, 18-55 years old. Eighty-five percent of the individuals served were of low socioeconomic status.

c State-Level Evaluation

N/A

d Evaluation Results

A retrospective electronic survey to assess the program outcomes was administered to participants in June 2015. This survey consisted of two identification and nine perception questions, and

was designed by the program officer and research analyst. Fifty-three responses were collected - 24 from students and 29 from adults. Survey findings divided by key health-related topics are below.

Healthy lifestyles data

Sixty-four percent of the adults and 63 percent of the students indicated that since participating in the program, their “awareness of the importance of healthy behaviors” had improved, suggesting a positive impact for about two-thirds of respondents. The most common behaviors were improved exercise habits, gardening, and healthy nutrition. Eighty-one percent of adults and 92 percent of students indicated they started drinking more water after participating in the project, while more than 50 percent of all respondents reported eating more fruits, vegetables and lean meat.

Fitness data

Over the course of the three-year grant period, participants attended fitness programs. The following classes were offered each year:

- 1** swimming session
- 3** basketball sessions
- 5** cardio sessions
- 4** soccer sessions
- 3** Zumba sessions
- 4** running sessions
- 2** yoga sessions
- 1** tennis session
- 1** wrestling session
- 10** miscellaneous fitness sessions.

Approximately 116 families participated in gardening-related activities four times a year, and over 200 students and family members participated in cooking and nutrition activities. The courses were evidence-based and led by health experts in their area.

Eighty-six percent of the adults and 71 percent of the students reported that since participating in the project, personal physical activity had improved. They also indicated that soccer, futsal (a modified form of soccer), basketball and Zumba had made them more active. Eighty-three of the adults and 58 percent of the students reported they felt more physically fit. This remarked enthusiasm could be a direct result of increased physical activity opportunities.

Program diffusion data

Seventy-nine percent of the adults reported to “have shared anything [they] learned with friends and family,” compared to 50 percent of the students. This difference was attributed to students who might be more reluctant to share information spontaneously. Ninety-six of the adults reported they “would recommend the program to friends” and 79 percent of students indicated they would too. This data indicated strong project satisfaction, fulfilling a community desire. An average of 998 participants were involved in the project each year.

e Measures and Methods to Determine Effectiveness

The strategies used to determine the impact on health disparities includes behavior changes showing that participants are internalizing and using the curriculum. Project success is inherent in participant self-reported data and testimonies of increased healthy habits. Seventy-nine program participants reported an improvement in personal

physical activity behaviors and regimens. An increase in healthy eating also was reported including 60 percent more vegetables, 58 percent more fruits and 87 percent in drinking water intake. And finally, 71 percent reported feeling more physically fit. Project results will be used as evidence to demonstrate the need for comprehensive, culturally competent, community-based after-school activities and classes for children and families in Northwest Denver.

f Sustainability

It is vital to recognize healthy lifestyle programming in the Northwest Denver community is not only important, but there also is a community need and desire for such programming. The department consciously wrote healthy lifestyles programming into a grant to fund Colfax Elementary for the next five years, as well as other schools in Northwest Denver that were not part of this cohort. Two of the five program sites will continue to offer healthy lifestyle related programs afterschool for students and in the evening for families and adults. A small tuition portion will sustain these programs with ample scholarship opportunities for those that cannot afford it.

g Impact on Intended Population

The project served a geographic area of Denver where the population is approximately 50 percent Hispanic/ Latino, 86 percent are considered to have low-socioeconomic status and 75 percent of the individuals are considered school-aged. Project participants reflect similar Denver demographics,

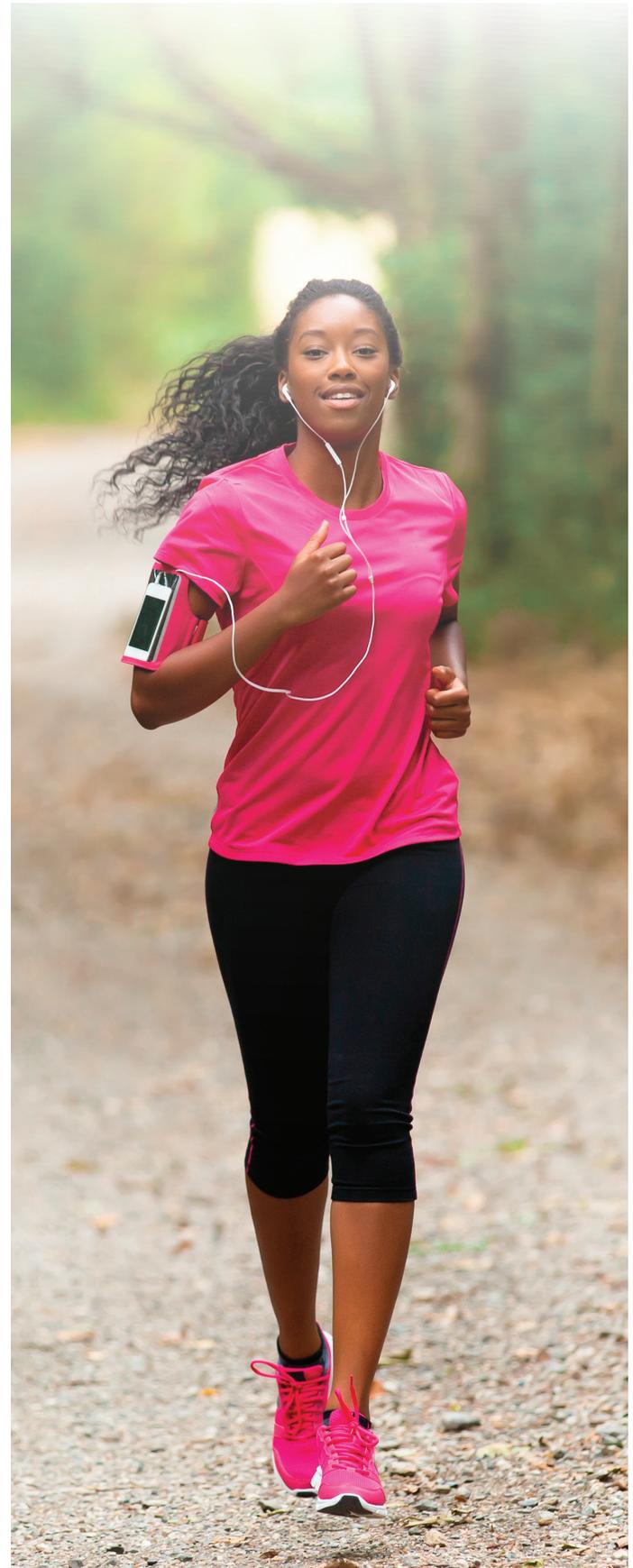
indicating the majority of participants were individuals of the groups intended to be served.

The boundary defined in the grant was from Colfax Ave to I-70, and Sheridan Ave to I-25. Population data was collected from Berkeley, Sunnyside, Highland, West Highland, Sloan Lake and Jefferson Park neighborhoods, as the geographic boundary.

Approach to Cultural Competence

The project was designed to address Latino/Hispanic in Northwest Denver. Surveys were administered to families and students prior to implementation in order to determine highly desirable program offerings for the targeted population. Cultural considerations also were made for addressing those living in Denver and considered of low-socioeconomic status. The most important cultural considerations were made in addressing 75 percent of the population considered school-aged.

Communication via surveys and marketing materials were created in both Spanish and English. Culturally diverse project instructors were chosen, including those who have bilingual skills and competence. Project activities also were linked to cultural aspects and traditions. Gardening and cooking programs were designed around ingredients common in Central and South America, and physical activity components included traditionally popular Latino sports such as soccer and futsal (a modified form of soccer).



Project Title: Increasing Moderate to Vigorous Physical Activity (MVPA) in DPS P.E.**Disease Category:** Cardiovascular disease

Year 1 (FY 12-13): \$199,150

Year 2 (FY 13-14): \$228,831

Year 3 (FY 14-15): \$228,831

3-Year Total: \$656,812

Project Priority: Risk Factor Reduction/Obesity**Intended Population:** African American/Black, Asian American/Pacific Islander, Latino/Hispanic, Native American/American Indian and White/Caucasian communities**Counties Served:** Denver**3-Year Population Reach:** 72,000

Project Summary: The Increasing Moderate to Vigorous Physical Activity (MVPA) project increased physical activity levels among 72,000 students by improving the physical education (PE) program. The Denver Public Schools implemented evidence-based SPARK curriculum (<http://www.sparkpe.org>) for students. The project enforced a 2010 DPS policy requiring students be engaged in moderate to vigorous physical activity (MVPA) a minimum of 50 percent of PE class time.

The information below is a response to the HDGP Program Rules 6CCR1014-5 Final Evaluation Report questions as required.

a Key Accomplishments

The ultimate project goal was to increase moderate to vigorous physical activity (MVPA) and teacher effectiveness using the Physical Education Observation Form (PEOF) in DPS physical education classes. The System for Observing Fitness Instruction Time (SOFIT) was conducted, involving evaluations of physical educators prior to and following SPARK and other continuing education courses. SOFIT assisted project staff in making determinations about whether MVPA and PEOF improved as a result of specific SPARK training, and facilitated needed improvements.

Project activities contributed to the goal of improving physical instruction overall. During the 2014-2015 school year, the program provided eight

nutrition, physical activity and wellness trainings for families in the Elyria, Globeville and Swansea neighborhoods. The education focused on healthy eating habits in an attempt to reduce obesity and improve overall health. In the 2013-2014 school year Colorado Action for Healthy Kids parent training sessions were conducted in September 2013 (healthy communities), February 13 (parent advocacy training), February 23 (parent wellness training), and January/February 2014 (Smith Elementary fitness training).

b People Served and Services Received

The grant served approximately 72,000 DPS K-12 students and 213 physical education teachers. Of the 72,000, 96 percent of the project participants were high school, and 4 percent were middle and elementary school students. In addition to the student activities, 13 parent training sessions in schools were completed to focus on the importance of family health, fitness and nutrition.

c State-Level Evaluation

N/A

d Evaluation Results

A total of 180 physical education teachers were observed under the System for Observing Fitness Instruction Time (SOFIT). A total of 116 teachers attended SPARK physical education curriculum training. Participating teachers were provided with equipment that would aid students in increasing

moderate to vigorous physical activity and ideas for improving instruction. Networking through SPARK training events was a beneficial way for teachers to share what is working for them and to gain help with challenges. It became apparent and important that teachers involved in the project also improved personal MVPA of SPARK.

e Measures and Methods to Determine Effectiveness

Questions addressed through evaluation included

- at spring measurement, are teachers able to achieve (or maintain) 50 percent of class time spent in moderate to vigorous physical activity (MVPA)? and
- does an increased amount of professional development (PD) increase the percent of class time spent in MVPA?

Data results included the number of hours spent in physical education opportunities overall, including the annual Summer Institute and a Monday night series. The percent of class time spent in MVPA was collected from teachers using SOFIT. The data was analyzed through an evaluative process, involving systematic data collection and independent observers. Data variables were consistent with the project goals to increase the hours of professional development provided to teachers, and increase student MVPA participation. A total of 72,000 DPS K-12 students and 213 physical education teachers were reached.

The System for Observing Fitness Instruction Time (SOFIT) measures energy expenditure during classroom-based physical activity. The system involves observation tools and techniques designed to assess the programming design and levels of

activity. The system process for the Increasing Moderate to Vigorous Physical Activity project involved visual and physical observation methods, and both teachers and students were assessed. The system compared variables like body weight with indirect calorimeters and ideal predictions.

The SOFIT study procedures were explained to each child and classroom teacher before the assessment, and demographic data such as gender and age were recorded. Once the data was collected, descriptive statistics were calculated for the students. Teachers received improvement findings to use in classroom instruction. Teachers were presented with SOFIT scores, adaptive strategies and improvement results to enhance classroom physical education programming.

Results from the SOFIT observations and attitudinal surveys were shared with the teachers as direct feedback to improve technique and scores.

f Sustainability

DPS plans to continue the work of this project through making continuous improvements to teaching effectiveness through educational opportunities. The Summer Institute will continue for two years, through 2017. DPS also plans to continue the learning communities, Monday night physical education workshops, SPARK activities and the equipment resource center. Additional funding will be pursued to support the SOFIT evaluation processes for elementary, middle and high schools.

g Impact on Intended Population

A total of 72,000 students were reached through physical education classes and parent training sessions, and over 300 parents were reached overall. A total of 265 parents participated in the DPS parent institute and physical education activities designed to promote lifelong fitness.

The project impacted the intended population by improving the health of the DPS student community and parents. Professional development for the physical education teachers directly impacts students in the classroom, and was a beneficial resource for teachers. The most important impact on the intended population was improved physical education for students, enhanced teaching practices in the classroom, and exposure and training for parents to pursue exercise and improve individual and family health.

h Approach to Cultural Competence

Cultural competence considerations were made through project design. DPS considers disparities in obesity and levels of physical activity to be attributed to numerous socio-ecological factors, including environment, poverty, education, background, social and cultural factors. Ethnic minority and low-income families do not always have safe streets where they can walk or bike. Fees for recreation centers and fitness clubs often do not feel within reach. Groceries stores can be sparse, and there is limited access to fresh and affordable healthy foods. One-hundred percent of the participants were self-reported to be of low-socio-economic status.

Cultural competence also was addressed through professional development and education activities with teachers. Teacher surveys addressed cultural responsiveness and encouraged teachers to address each student as unique and with accommodation. Students were surveyed and asked to express how they felt cultural disparities are being addressed by teachers.



Project Title: ¡Estoy Sano!

Disease Category: Cardiovascular disease

Year 1 (FY 12-13): \$141,827

Year 2 (FY 13-14): \$215,776

Year 3 (FY 14-15): \$215,776

3-Year Total: \$573,379

Project Priority: Risk Factor Reduction/Obesity

Intended Population: Latino/Hispanic, White/Caucasian

Counties Served: Eagle

3-Year Population Reach: 4,000

Project Summary: The ¡Estoy Sano! project promoted nutrition and healthy food access through a collaboration between Eagle County Public Health and community partners. The project provided culturally competent programming intended to reduce obesity risk factors and decrease cardiovascular disease in the Eagle County Latino/Hispanic population. A major objective of the project was to plan healthy food access and review supporting policies. Project staff worked with the Latino Health Leadership Group to increase engagement among Spanish speaking residents and provide insight on barriers. Components of the project included Expanded Food and Nutrition Education Program (EFNEP) courses, nutrition and healthy living awareness, cooking shows aired on ECO TV 18, and community engagement to address opportunities for healthy eating and active living.

The information below is a response to the HDGP

Program Rules 6CCR1014-5 Final Evaluation Report questions as required.

a Key Accomplishments

Nutrition Education: ¡Estoy Sano! provided nutrition education for the intended population through the Tomando Control program classes in collaboration with the local community food pantry at the Vail Valley Salvation Army (VVSA). The project also integrated nutrition education into existing curriculum for Eagle County Schools' 3rd graders. ¡Estoy Sano! increased participation and retention of Spanish speakers in the Expanded Food and Nutrition Education Program (EFNEP) by 50 percent.

Nutrition Awareness through the Media: Nutrition awareness campaigns were not available to the

Spanish speaking community prior to ¡Estoy Sano!. The project leveraged multiple media outlets through Spanish language channels and increased awareness in the media by 100 percent. Weekly health tips were aired on La Nueva Mix, and 44 cooking and nutrition education shows were provided. Other components of the awareness campaign included the 5-2-1-0 nutrition campaign that promotes five servings of fruits and vegetables per day, two hours or less of recreational screen time, one hour or more of physical activity and zero sugar-sweetened beverages.

Healthy Food Access and Policy: The Produce for Pantries campaign created a system for fresh produce to be donated directly to the food pantries. This campaign increased produce donations at the VVSA food pantry by 20 percent. Healthy foods became more accessible to SNAP (Supplemental Nutrition Assistance Program) recipients and enabled a local farmers market to encourage healthy food purchases. More than \$1,000 of healthy foods were purchased at the farmers market in 2014, a 100 percent increase since the start of the project. Policy work included a PhotoVoice project to identify barriers prohibiting healthy eating and active living for Latino/Hispanic residents. A total of 18 community members were featured through the public display of 50 photos and captions.

State-Level Evaluation

¡Estoy Sano! was selected for evaluation by the Community Epidemiology and Program Evaluation Group (CEPEG). A total of 418 adults responded to a door-to-door survey (convenience sample) between October 2013 and April 2014. The primary question included: What proportion of the population is aware of and applies ¡Estoy Sano! media components? One-third

of respondents reported having heard of the ¡Estoy Sano! program and health tips on La Nueva Mix Spanish language radio station, while 9 percent percent of respondents viewed the cooking show on ECO-TV18. It was recommended the frequency of radio health tips be increased and ways to disseminate the cooking show be expanded. The second evaluation question was: How does the population define healthy eating, and what are the corresponding knowledge and behaviors? The respondents value healthy eating, and nearly half of the respondents indicated that fruits and vegetables are part of a healthy eating definition. However, a large majority of participants were unaware of the daily fruit and vegetable intake of five servings per day. The recommendation was made to increase awareness and knowledge of healthy eating, such as the recommended daily fruit and vegetable consumption goals that are part of the 5-2-1-0 campaign.

People Served and Services Received

The intended population of ¡Estoy Sano! was Spanish-dominant Latinos living in the Eagle River Valley of EC (I-70 corridor, Vail through Dotsero). Latino/Hispanic individuals comprise about 30 percent of Eagle's population (approximately a total of 15,700 people). The project reached 25 percent of the county's Latino/Hispanic population, approximately 4,000 people. Programmatic elements reached a total of 4,000 people through direct and indirect activities.

Evaluation Results

Nutrition Education: Approximately 180 adults were reached through classes and participation was most successful when recruitment came from within

the community. It was discovered that training community members to teach nutrition classes maximized participation. Modifications to effectively reach and retain the intended population will be pursued, such as providing groceries for ‘make at home’ meals, providing child care, and flexibility on class times and locations will also be increased.

Nutrition Awareness through the Media: The media was utilized to increase nutrition awareness. The Spanish Language radio station helped to increase reach, and aired 75 different health tips weekly. A total of 44 cooking shows aired on local TV and provided online, and monthly nutrition columns were published in the local Spanish language newspaper. The local Spanish language radio station, La Nueva Mix, is one of most effective ways to reach the Spanish speaking population.

Healthy Food Access and Policy: Healthy food access efforts reduced the complexity of accessing healthy foods in the community. Despite increased efforts, some venues (farmers market, food pantry) maintain barriers in price and access for the Latino/Hispanic community. Many lessons learned regarding barriers to healthy food access were gained through the Latino Health Leadership Group and conversations with community members and leaders.

e Measures and Methods to Determine Effectiveness

Nutrition education was measured by the number of people participating in classes offered, and the data was captured through class sign-in sheets. Nutrition awareness indicators were measured in participation numbers and numbers of nutrition education materials disseminated at community outreach events. Indirect reach was devised through listener and viewer rates. The number of tokens

distributed for Supplemental Nutrition Assistance Program (SNAP) recipients as cash at the farmers market was documented. Demographic information regarding SNAP recipients was collected. Stories captured by community members participating in the PhotoVoice project also were used to understand cultural nuances and health needs of the Latino/Hispanic population in Eagle County.

The effectiveness and impact on health disparities by the ¡Estoy Sano! program was determined by the participation and reach, strategies specifically designed to be relevant for the Spanish-speaking Latino population, and health education opportunities not available before in Eagle County. ¡Estoy Sano! increased direct nutrition education, awareness and media programming by 25 percent.

Results from ¡Estoy Sano! evaluations project findings have been shared with other Eagle County Government departments and community organizations such as Eagle County’s Maternal and Child Health, the Healthy Communities Coalition, and the Colorado State University Extension, Vail Valley Salvation Army, Catholic Charities, etc. Results have been shared during Eagle County Board of Health meetings, which are televised. Final evaluation and project reports are available at www.estoy sano.com.

f Sustainability

Many of the ¡Estoy Sano! program elements will continue. The cooking show, health tips on ECO-TV18, the Healthy Communities Coalition, and collaboration with key leaders and organizations dedicated to increasing opportunities the Latino community. Guidance from the Latino Health

Leadership Group will continue to advance health, maintain community engagement and reduce cardiovascular disease.

g Impact on Intended Population

The intended population of the ¡Estoy Sano! project was Spanish-dominant Latino community members in the Eagle River Valley. Prior to the grant, ECPHE had limited trusting relationships with members from this community and no programs directly developed for the predominantly Latino/Hispanic population. The nutrition awareness campaigns and education programs were developed to meet the needs of this community and the individuals. Resources such as child care, training for members of the community and materials in Spanish were critical to for individuals to participate in the healthy living initiative. The PhotoVoice project, photographs and captions were displayed in two public libraries and illuminated policy changes that could improve food access/healthy living needs. This project empowered individuals to have their voices heard in the community.

h Approach to Cultural Competence

The Latino Health Leadership Group (LHLG) was comprised of select members of the community and culturally-appropriate strategies were utilized. Efforts to address cultural effectiveness in programming were examined. For example, a series of focus groups among Spanish speaking community members critiqued various nutrition education and media components and provided recommendations to adapt cultural components. The LHLG and the Community Liaison hired to work with the Latino/

Hispanic population were also important project elements to build trust with the residents and ensure cultural considerations were addressed.



Project Title: Promoting Access, Prevention and Coordinated Care**Disease Category:** Crosscutting (Cancer, Cardiovascular and Chronic Pulmonary diseases)

Year 1 (FY 12-13): \$142,636

Year 2 (FY 13-14): \$218,278

Year 3 (FY 14-15): \$218,278

3-Year Total: \$579,192

Project Priority: Patient Navigation/Case Management Services**Intended Population:** African American/Black, Asian American/Pacific Islander, Latino/Hispanic, Native American/American Indian and White/Caucasian communities**Counties Served:** Adams, Arapahoe, Boulder, Broomfield, Douglas, Denver, Jefferson**3-Year Population Reach:** 2,087

Project Summary: The Promoting Access, Prevention and Coordinated Care project provided quality accessible and affordable health services. The overarching goal was to reduce health disparities for low-income, uninsured and select minority populations. The project established effective and efficient links between community efforts and health prevention, including early detection of cardiovascular disease and identification of associated health precursors. The project connected comprehensive primary care with diagnosis and treatment and continuity of care for underserved individuals.

The information below is a response to the HDGP Program Rules 6CCR1014-5 Final Evaluation Report questions as required.

a Key Accomplishments

Project goals were met through conducting health education, screening, referral and enrollment activities. Over three years, Inner City Health Center (IHC) screened and educated 2,087 individuals, representing 140 percent of the projected goal and referred 1,061 individuals, representing 126 percent of the initial estimate. The following is an example of how results were achieved. An uninsured client named Frank comes to the clinic after being screened the previous year. He received education about his heart health, and was told that it was critical for him to see a doctor. After working with a physician and making a number of lifestyle changes, he was at a healthy body mass index level, his blood pressure was normal, and he conveyed that IHC had “saved my life.”

b People Served and Services Received

A total of 2,087 individuals were provided free screening and cardiovascular health education by licensed professionals at 95 events. Clients at the events with abnormal screening results were referred to ICHC. The project implemented client follow-up with 1,061 individuals through the patient navigation process. An annual symposium and a Heart Health Fair were held to ensure community participation, education, free resources and clinical health services.

c State-Level Evaluation

ICHC participated in the Community Epidemiology Program Evaluation Group's (CEPEG) Independent Evaluation for Patient navigator and community health worker program components. The CEPEG Preliminary report 2014 is available upon request through the Office of Health Equity.

d Evaluation Results

The Promoting Access, Prevention and Coordinated Care program was successful in connecting community members to health resources. It was important to place more emphasis on navigating at-risk individuals to the clinic. In addition, providing closer and more accessible services was a crucial benefit. ICHC became more cognizant of challenges related to patient recruitment from community members and discovered diverse ways to increase client enrollment. As a result of this discovery and the implementation of diverse strategies to recruit underserved individuals,

project participation increased by 35 percent in the third year.

e Measures and Methods to Determine Effectiveness

A primary objective of the project was to provide preventative screening services and navigation to a health care home for underserved individuals. Client demographic data including race and ethnicity, insurance status, and other factors were tracked to ensure reach to predominantly underserved communities with populations experiencing disparities. Client statistics were monitored monthly, including attendance in health education and screening opportunities. Screening results were analyzed and abnormal test results were addressed with clients. Many clients who maintained an interactive treatment plan and made decisions about their own health care were critical variables to the project's success. Two key indicators of the project's success were increased access to clinical services and positive health outcomes reported by clients.

Preventative screening, education, and navigation into a health care home were provided to low-income, minority, and un/under-insured community members and those who would not have otherwise received services. The ICHC intended to increase reach to low-income individuals and strategically pursued organizations that could assist in this effort. Churches, food banks and other key community partners identified and referred those suffering from health disparities. Direct engagement with community leadership broadened the depth of service relationships and built trust and legitimacy in working with the intended population.

Progress analysis and data results were used internally and with external partners. They were

shared with internal staff to improve processes and outcomes. Results and improvements also were shared with external community partners involved in health screening efforts. Promotions such as the Heart Health Event and the annual symposium were opportunities to communicate and address improvements to address cardiovascular disease and health services for the intended population.

f Sustainability

The ICHC is considering numerous options for increasing the number of patients enrolled in screening. Sustainability planning involves new ways to reach the intended population. A mobile medical clinic will be pursued and available at community events. This resource will provide on-site screening and diagnosis, and increased client enrollment in clinic services. The ICHC will increase community engagement and enhance connections with partners so they can provide financial resources and services to underserved individuals. The agency will also continue to partner with the Congregational Health Ministry that helps recruit and serve the underserved populations. The ICHC expects that client revenue will increase by 60 percent in fiscal year 2015-2016, due to increased Medicaid and Medicare dollars, and a 3 percent health services fee increase.

g Impact on Intended Population

The ICHC believes one of the most effective means of positively impacting clients is the simple act of providing accessible screening, education and care. Services were delivered in a respectful manner and in a way that values each client and recognizes his/

her needs. Approximately 75 percent of the clients screened are underserved minorities, including 60 percent aging and/or low-income and/or uninsured or Medicaid individuals. The project was successful in providing key chronic disease services to these priority populations and provided a conduit for services in accessible community settings.

h Approach to Cultural Competence

The ICHC in practice and policy does not discriminate against anyone in employment offered or services rendered. The multinational, multiethnic, multilingual staff ensures that clients feel comfortable. The ICHC maintains a long history of community outreach to Denver populations who experience disparities, and is experienced with minority communities. The agency performs extensive work with many ethnicities, clients enrolled from diverse community events, and has focused on predominantly African-American/Black individuals.



Project Title: Clinica Tepeyac Health Disparities**Disease Category:** Cardiovascular disease

Year 1 (FY 12-13): \$120,337

Year 2 (FY 13-14): \$171,873

Year 3 (FY 14-15): \$134,000

3-Year Total: \$426,210

Project Priority: Risk Factor Reduction/Obesity**Intended Population:** African-American/Black, Latino/Hispanic and White/Caucasian communities**Counties Served:** Adams, Arapahoe, Jefferson**3-Year Population Reach:** 3,023

Project Summary: The Clinica Tepeyac Health Disparities project provided low-income Latinos with chronic disease education, healthy living opportunities and diabetes screening. The project ensured access to nutrition and exercise programming, including low-cost food ingredients to encourage healthy eating and cooking. The project was intended to reduce disparities in cardiovascular disease among Denver's working poor, providing them with health assets that may otherwise be unavailable. Participants were enrolled in an electronic client registry making it easier for them to be engaged in their individual health data, and empowered to manage outcomes.

The information below is a response to the HDGP Program Rules 6CCR1014-5 Final Evaluation Report questions as required.

a Key Accomplishments

The overarching goal of the Clinica Tepeyac Health Disparities program was to implement evidence-based strategies regarding the prevention and early detection of cardiovascular disease. This was achieved by implementing screenings, health classes, an electronic health registry, and health status and client navigation/coaching activities.

b People Served and Services Received

La Clinica Tepeyac promised to reach a total of 400 low income Latino people annually and enroll them in the electronic health registry to track their health outcomes, provide on-line client portal access to help them track their health outcomes and better

manage their own health. This was achieved through screening, health education classes, electronic health registry and client navigation/coaching activities. The total number of people reached through the Health Disparities Program over the three year period is 3,023.

State-Level Evaluation

N/A

Evaluation Results

Screening outcomes achieved: Eighty-nine percent of the goal to screen American Diabetes Association (ADA) expo 2,200 participants, was met. The project showed health screenings at community events are successful.

Classes outcomes achieved: A total of 847 classes were held and 3,023 unduplicated clients participated. Across the three years, classes increased from 133 to 297 to 417, respectively. ‘Word of mouth’ expanded the project and increased participants. The project learned that educational classes are an asset to impacting community health and the overall experience was positive. Health education increased knowledge and promoted positive behavior changes. Health education within the community also promoted meeting people where they are, which is critical to individual empowerment and the opportunity to self-manage health outcomes.

Electronic Health Registry outcomes achieved: The goal was to enroll approximately 850 project participants in the electronic health registry

per year and/or community programs and health activities. Clinica Tepeyac surpassed this expectation by enrolling a 3,023 clients in the electronic health registry over the three-year period. The project showed that the electronic registry engaged clients, created strong processes and better coordination of care. Clinica Tepeyac will continue to use this tool to enhance client experience and manage health data and outcomes.

Health Status outcomes achieved: Seventy-nine percent of participants in the disease education classes reported intent to improve health behaviors including diet, exercise and increased confidence in disease management. This work highlighted the need to focus on evaluation efforts to accurately highlight client health behavior and confidence.

Patient Navigation/Coaching outcomes achieved: The goal was to reach 600 clients and Clinica Tepeyac surpassed this expectation by providing patient navigation/coaching to 920 (153 percent) clients. There were 920 (100 percent) clients who created a personal health plan, with a total of 542 (59 percent) clients reaching their desired goals. Clients’ improved understanding of individual health conditions, self-directed care, and healthier lifestyle decisions necessary to achieve improvements in health indicators like Hemoglobin A1 C and blood glucose management.

Major accomplishment (one example): A success story includes a client who began participation in year 1 of the grant. She is a 47-year-old Latina who has seven children and three grandchildren. She was diagnosed as pre-diabetic and was 50 pounds overweight, suffering from extreme exhaustion. The Health Promotions team (Promotoras) identified the health issues during clinic in-reach. The team determined that diabetes and exercise education was needed and was provided to improve the

client's health outcomes and lifestyle choices. The free program helped her set health goals, pursue exercise and integrate healthy habits into daily living. After taking the diabetes class, the client was open to exercise and in 2013 began to change her lifestyle. Two years later she has lost 30 pounds, her A1C was significantly low, and members of her family now exercise with her. Education and exercise have changed her life. She is motivated to continue living a healthy lifestyle.

e Measures and Methods to Determine Effectiveness

The number of ADA expo participants screened in the Latino Zone was 1,966. The number of participants documented on sign-in sheets for classes was 3,116. The number of clients enrolled and tracked through the electronic registry was 3,613. The number of participants documented on the sign in sheet for classes geared to improved health status was 355. There were 191 that self-reported increase of knowledge. The number of clients receiving coaching/navigation was 920. The number of clients creating a personal health plan was 920. The total number of clients reaching goals set in personal health plans was 542.8 (59 percent).

One-hundred percent of screening event participants received education and counseling through the screening process. Data was collected on 51 percent of the client population. Clinica Tepeyac provided 847 classes to 3,116 clients and community members providing free educational and preventative opportunities. Seventy-nine percent of people reported the intent to improve health status after participating in classes. Patient navigation/coaching created health plans with 100 percent of clients they served and 59 percent reached their health goals.

Progress measures were used to manage deliverables, improve and enhance programming. Class attendance sheets were used to manage participant retention in educational and prevention classes. An outreach protocol was developed to encourage participants to complete classes. Retention analysis resulted in program and class redesign. Thoughtful analysis about how the classes were structured resulted in the creation of a continuum of care and improved participants' experience. Findings regarding personal health coaching were shared internally and the quality management team discussed changes needed at the annual conference of Colorado safety net clinics. Event and class improvement planning is crucial. There also should be a permanent process to enhance operations and address cardiovascular disease projects moving forward.

f Sustainability

This grant provided Clinica Tepeyac with an opportunity to implement effective strategies for reducing health disparities in the Latino community. It provided strong infrastructure, data collection tools and an evaluation model, providing a strong programmatic infrastructure. Although the funding has ended, the clinic plans to sustain and advance the program.

g Impact on Intended Population

Clinica Tepeyac served clients who were at or below 200 percent of federal poverty level, uninsured, primarily Spanish-Speaking living in Adams, Arapahoe, Denver or Jefferson counties. The clients served were of low socio economic status and

experienced racial and aging barriers. Their risk factors for obesity were reduced by screening 1,966 participants. Seventy-nine percent of participants in the disease education classes reported intent to improve health behavior via diet and exercise and reported increased confidence in disease management. One-hundred percent of the project participants created a personal health plan, while 59 percent reported having reached their health goals.

Approach to Cultural Competence

Clinica Tepeyac used the Center for Disease Control and Prevention’s obesity disparities toolkit to enhance the pre-existing cultural competency best practices. For 21 years, the agency has worked to understand the Latino community, paying careful attention to the impact of health conditions. For several years, Clinica Tepeyac has been learning about obesity-related disparities, rates of obesity and obesity-related social norms. The intent of this health disparities project was to ensure a working framework to view and address culture as related to obesity through a health equity lens. The project analyzed healthy eating and active living approaches to identify and test cultural metaphors as related to the Latino population.



Project Title: **Vida Sana: Uniting for Health Equity of Hispanic/Latinos**
Coalición Para Mejorar La Salud De Nuestra Comunidad Latina

Disease Category: Crosscutting (Cancer, Cardiovascular and Chronic Pulmonary diseases)

Year 1 (FY 12-13): \$133,603
 Year 2 (FY 13-14): \$187,382
 Year 3 (FY 14-15): \$187,215
 3-Year Total: \$508,200

Project Priority: Collective Action for Collective Impact
 Patient Navigation/Case Management
 Risk Factor Reduction/Obesity

Intended Population: Latino/Hispanic and White/Caucasian Communities

Counties Served: Larimer

3-Year Population Reach: 5,230

Project Summary: The Vida Sana project provided evidence-based programming toward the prevention of—and early detection of—cancer, cardiovascular disease and diabetes in racially and ethnically diverse communities. The project goal was to improve access, resources and physical activity opportunities to reduce health disparities. The project was implemented in three Fort Collins neighborhoods and included a Promotora navigation process for clients. The project aimed to serve a significant number of low income clients and addressed needs such as built environment and social determinants of health concepts minority populations in Fort Collins and eight surrounding communities. The project promoted collaborative planning with the community and key leaders.

The information below is a response to the HDGP Program Rules 6CCR1014-5 Final Evaluation Report questions as required.

a) Key Accomplishments

The Vida Sana project addressed obesity risks by providing daily passes for underserved individuals through the Northside Aztlan Community Center. The project provided a total of 70,719 daily passes over the three-year project. By year three, there was an 8.56 percent increase in the demand for recreation center passes. Promotoras working with clients and providing navigation services fostered trusting relationships with clients in the Fort Collins communities. The Promotoras made 2,247 referrals to follow-up care. Within the program’s first year, the Promotoras completed 753 referrals with a referral follow through rate of 405. In the third year, the Promotoras provided 667 referrals with a referral follow through rate of 305. Project participants were assessed through the Vida Sana

Health Survey and the feedback was shared with project staff and Promotoras, and used to make programming improvements.

b People Served and Services Received

The Vida Sana project reached 5,230 underserved individuals. Clients were provided with obesity risk factor reduction, physical activity and healthy eating education. Promotoras provided interventions for residents in the Fort Collins communities, ensuring that health screenings were available for the clients. Other navigation services included food access assistance and access to health care providers.

c State-Level Evaluation

The Poudre Valley Health System Foundation participated in the state-level evaluation studies regarding the impact of the overall Health Disparities Grant Program spearheaded by the Community Epidemiology and Program Evaluation Group (CEPEG). Project information was provided to CEPEG regarding Promotora(s) job descriptions and navigator roles. CEPEG completed initial and follow-up interviews for the preliminary report.

d Evaluation Results

The project achieved improved access to community resources through the Promotora process, ranging from food access assistance, to health care providers and physical activity participation. Promotoras referred a total of 2,247 people to 47 agencies or organizations for follow-up services. Free access

to physical activity programming encouraged participation at Northside Aztlan Community Center (NACC) to 4,647 individuals. Project lessons learned included the importance of meeting underserved individuals “where they are.” Creating a strong network of resources and partners to help serve the intended population was critical. Partners should invest in the overall well-being of the underserved people and provide educational, preventative and interventional programming. The project and resources provided positively impacted individuals throughout the north Fort Collins communities.

e Measures and Methods to Determine Effectiveness

Program measures included improved access to community resources, increased participation in physical activity, and improved healthy eating habits. Access to community resources included the number of referrals made by Promotoras and the rate at which community members followed through with the referral. Increased participation in physical activity at the Northside Aztlan Community Center (NACC) was an important indicator. Self-reported physical activity successes were reported to show a 97 percent overall increase. A total of 4,647 underserved individuals used Vida Sana daily passes for the NACC. A total of 92 percent of the individuals working with Promotoras reported that participation in Vida Sana helped them improve healthy eating habits. These measures were collected through an audit of Promotora records, attendance documentation for Vida Sana programming, and surveys conducted at various times of the year.

The Vida Sana project employed evidence-based practices and strategies known to help reduce health disparities. The Promotora model was used

to engage the community and address individual health care needs. Promotoras were residents of the community and served as liaisons to work between individuals and health professionals. They were selected based on their reputation as being the trusted voice of their respective communities. The Promotoras served as advocates, educators, mentors, outreach workers, role models and interpreters when needed. In the three-year period, Promotoras conducted 4,359 home visits and made 1,957 outreach phone calls and 2,247 referrals to appropriate follow-up organizations. The Vida Sana Promotoras advocated for community members to be present at decision-making meetings and to help make changes to programming. After it was discovered that cooking classes were desired by the community, this method of health education was added to the services.

Project results will be used to plan future services and build sustainability for the Vida Sana project. Results related to individual behavior changes and positive impacts will be used to assess which parts of programming should be replicated in north Fort Collins. Project findings will be used to inform key stakeholders and policymakers, and to improve health equity. Project data gathered from the Vida Sana project and lessons learned through the evaluation process will be used to inform key stakeholders and policymakers on health inequities and the role of community policy in addressing improvements.

f Sustainability

The Poudre Valley Health System Foundation will continue the Vida Sana project under the Health Disparities Grant Program for another three years. In addition to funding provided through this program, the agency will pursue other sources to

achieve improved financial sustainability. Next steps for the Vida Sana project include increasing services to six north Fort Collins communities and one Loveland community facing similar disparities. The project will emphasize physical activity programming and health education.

g Impact on Intended Population

The project was customized for the intended population and designed with specific accommodations for those with poor or no access to physical education or activity. The Promotora model used in the project encouraged self-empowerment and trust. The project encouraged clients to grow in confidence and to be involved in community exercise opportunities. Underserved individuals were also encouraged to participate in community advocacy and to ensure equitable opportunities.

h Approach to Cultural Competence

Vida Sana staff members are bilingual in English and Spanish and materials and communication were provided in both languages. Cultural factors were considered during the design of marketing materials and the Promotora process. Vida Sana programming was based on the preference of community members and offered at no cost so that underserved individuals with low socioeconomic status could fully participate.



Project Title: PCCHD Health Disparities Program

Disease Category: Crosscutting disease

Year 1 (FY 12-13): \$143,123

Year 2 (FY 13-14): \$164,578

Year 3 (FY 14-15): \$164,575

3-Year Total: \$472,276

Project Priority: Risk Factor Reduction / Cardiovascular Disease

Intended Population: African American/Black, Asian American/Pacific Islander, Latino/Hispanic, Native American/American Indian, White/Caucasian

Counties Served: Pueblo

3-Year Population Reach: 27,250

Project Summary: The PCCHD Health Disparities Program is implemented as a strategy to reduce the incidence of cardiovascular disease (CVD) and precursors such as obesity in disparate populations of Pueblo County. The three-year project established the Community Health Improvement Plan (CHIP) Advisory Team, built relationships with and educated community partners on CVD risks, and worked with clinics to secure local policies in place to increase access to healthy foods in food desert areas and for underserved residents.

The project included work with schools and educators to promote wellness and healthy living. Project staff performed outreach to communities, including low-socioeconomic status individuals and key leaders.

The information below is a response to the HDGP Program Rules 6CCR1014-5 Final Evaluation Report questions as required.

a Key Accomplishments

PCCHD’s ultimate goal was to address obesity and other associated CVD risk factors through wellness initiatives and access to healthy foods. The project built partnerships with service providers and enhanced knowledge about underserved populations and health needs. The project educated community partners on obesity and other associated CVD risk factors. Project employees worked with schools on a wellness team initiative, provided outreach to the intended population to increase awareness of obesity, and enlisted organizations to address obesity and food access.

PCCHD involved the Mid-Level Obesity Team (MLOS), the Food Advisory Council (FAC) and other organizations to provide local education through programs and/or classes. Other partners included

city and county planners, school districts, hospitals, growers, businesses and community organizations. Public education was accomplished through Weight of the Nation (WON) presentations addressing the growing obesity epidemic in the United States, and social media outlets and activities. Community input was a critical aspect and supported project goals. Tools used to collect feedback were the Food System Assessment, the Healthy Change Perception survey, and customer questionnaires administered through the Healthy Corner Store Pilot project.

PCCHD worked with both the Pueblo City Schools and District 70 to develop and implement district-wide wellness policies. The political focus included increasing student health education, physical activity during the school day and access to healthy foods. The wellness effort also promoted healthy opportunities for students, faculty and family members, and to engage in Health Eating and Active Living activities. PCCHD has contributed to reducing cardiovascular disease rates in Pueblo County by reaching disparate populations in two large school districts. The effort included instituting a policy in each school district, as well as the inclusion of evaluation and accountability planning to maintain consistency. The intent was to build a foundation for school based wellness practices in Pueblo that will continue to reduce cardiovascular and other chronic disease risks related to inactivity, unhealthy dietary choices and other lifestyle behaviors.

b People Served and Services Received

The PCCHD Health Disparities Program impacted 27,250 people through policy changes, and educational and healthy food events. Seventy-one percent or 12,972 of those students participated in free and reduced lunch, and 40 percent or 3,288

of students in District 70 are on free and reduced lunch. The students were educated on healthy eating and active living strategies and reached through media campaigns, and solicited for feedback through retail food surveys. The Pueblo County community benefited from the project, and it was critical to have council partners and health care providers engaged.

c State-Level Evaluation

N/A

e Measures and Methods to Determine Effectiveness

The project convened various councils and increased reach to the Pueblo community. The collaborations were discovered to be critical to addressing cardiovascular disease in the community. For example, St. Mary Corwin Hospital implemented a Farm Stand in a local neighborhood with reduced access to healthy food options. A partnership was formed with a local producer, the Colorado State University Extension and Integrated Community Health Partners, to provide fresh produce, healthy recipes and information for underserved consumers. The Food System Assessment and the customer service data were critical to the Food Advisory Council. The findings demonstrated a lack of access to healthy foods in the neighborhoods. It was discovered that placement and marketing of healthy food options and educational opportunities should be increased. Lessons learned included the need to modify the customer survey, and make it consistent with the produce available in the Pueblo community.

A prioritization process was used to determine the evidence based strategies needed in the project to address obesity, food choices and diet quality as related to CVD risk factors. The U.S. Department of Agriculture Economic Research Service (USDA ERS), particularly its Food Environment Atlas was an evidence-based resource used for planning. The USDA ERS was a resource used to assess food environment factors such as store and restaurant proximity, food prices, food and provided guidance for structuring food assistance programs. The Healthy Corner Store Pilot used the Pueblo County Geographic Information System to map identified census tracts where residents are lacking access to healthy food options. The Healthy Corner Store Pilot collected 250 customer surveys, five store visual assessments and five manager surveys. Based on the mapping and location results, the FAC identified 27 convenience stores to be a part of the Healthy Corner Store Pilot of stores providing healthier and affordable food options.

The Health Perceptions survey was used to assess client perceptions of prior health, current health, health outlook, resistance/susceptibility to illness, health worry and concern, sickness orientation, rejection of sick role, and attitudes about going to the doctor. A total of 459 in-depth surveys were completed. A survey was administered to physician interns inquiring about their top concerns when addressing obesity issues with clients.

PCCHD gathered data through the Community Health Assessment, Food System Assessment, Health Perceptions survey, Healthy Corner Store customer surveys, and Weight of the Nation screenings. The process included reviewing the data and then prioritizing approaches to meet community needs and to address obesity and CVD

risk factors. Coordination with other organizations maximized resources and reduced duplication. Clear Point Strategy Software was used as scorecard software to help the organization manage and improve the project. Assessment results from public feedback, studies, and surveys were disseminated to local partners within the district, and through social media outlets and public presentations.

f Sustainability

The Mid-Level Obesity Team (MLOS) and Food Advisory Council (FAC) will maintain regular meetings. The committees will continue to provide project guidance and participate in decision making processes and future efforts to reduce obesity rates and CVD risk factors. PCCHD received funding for the next three years to continue work on the Healthy Corner Store Pilot Project. In addition to surveying customers, participating stores will work on changes in healthy food options, placement or marketing of healthy food options and to increase educational opportunities for customers, and the development of a Healthy Corner Store certification/ recognition program. District 70 required each school to form a wellness team and at least one representative from that team to sit on the District 70 Wellness Committee. Policy and wellness initiatives in collaboration with the community also will ensure sustainability.

g Impact on Intended Population

The Health Disparities Program impacted 27,250 people. Impact to the intended populations and

systems changes were measured and self-reported by students and teachers. Improved access to healthy food in corner stores are the greatest impact to the identified neighborhoods. The FAC and MLOS and FAC committees will continue to work together to combine resources and collaborate on projects. The collaborations are intended to gain further reach with the Pueblo community, increase access to healthy eating and active living, and maximize education, policy and systems changes for this jurisdiction.

Approach to Cultural Competence

Health Disparities project employees were trained in cultural competence through a four-hour, in-person training. This education was effective for work with the population and increased the ability to address cardiovascular risk with diverse clients. For example, during the pilot project for the Healthy Corner Store initiative, customer surveys were modified based on cultural competence considerations. Changes to the assessment process included the researcher reading the survey questions to all customers instead of the clients completing the surveys on their own. Some questions were modified to increase comprehension and improve accuracy of customer responses.



Project Title: Strengthening Diabetes Care in a Rural, Underserved Area**Disease Category:** Cardiovascular disease

Year 1 (FY 12-13): \$178,115

Year 2 (FY 13-14): \$205,780

Year 3 (FY 14-15): \$204,638

3-Year Total: \$588,533

Project Priority: Patient Navigation/Case Management Services
Risk Factor Reduction/Obesity**Intended Population:** African American/Black, Asian American/Pacific Islander, Latino/Hispanic,
Native American/American Indian, White/Caucasian**Counties Served:** Alamosa, Conejos, Costilla, Mineral, Rio Grande, Saguache**3-Year Population Reach:** 1,460

Project Summary: Strengthening Diabetes Care in a Rural, Underserved Area project addressed cardiovascular disease and diabetes self-management in high-risk communities. The project was based in frontier and rural counties of the San Luis Valley. The Valley has some of the highest rates of morbidity and mortality from diabetes and this proposal is design to address this unmet need. The project involved evidence-based strategies to overcome health disparities in the prevention and treatment of diabetes. Key provisions include navigation services for 300 persons in Year 3, evidence-based weight loss/Lifestyle classes, the Stanford Chronic Disease Self-Management Program, and the culturally appropriate online health resources to people across the Valley.

The information below is a response to the HDGP Program Rules 6CCR1014-5 Final Evaluation Report questions as required.

a Key Accomplishments

The Strengthening Diabetes Care in a Rural, Underserved Area project addressed the goal of improving diabetes self-management by providing evidence-based resources to our community. The project had three major components:

- 1 deliver Diabetes Navigation Services,
- 2 offer PRO-Fit Lifestyle Change classes, and
- 3 provide the Stanford Chronic Disease Self-Management Program (CDSMP).

Prior to having a diabetes navigator, clients had a consistent no-show rate. The diabetes navigator served as a part of the medical team and provided one-on-one care visits. Navigation processes reduced barriers in transportation, medication assistance,

education, and resources such as PRO-Fit, eye doctor, dentist, foot doctor, and mental health. Clients were contacted and provided reminders about appointments and health goals, and were given guidance to access the complex medical system. Waist circumference and loss was monitored and clients were provided techniques to self-manage symptoms.

b People Served and Services Received

The project served 1,460 individuals in the San Luis Valley. An emphasis was placed on those clients at risk cardiovascular disease and those who needed to improve diabetes self-management. Clients received diabetes navigation services and participated in the PRO-Fit cardiorespiratory exercise program. Stanford Chronic Disease Self-Management Program (CDSMP) classes were provided in 2013 through a partnership with South-Central Colorado Seniors, and information was available for aging adults. By April 2015, 15 classes (each six 2-1/2 hour sessions) were completed. A total of 145 community members completed CDSMP and three participants who strongly believed in the program, went on to become trainers. By June 2015, 258 community members had subscribed to the e-newsletter and there were 2,698 visits to the diabetes webpage from subscribers and non-subscribers. This webpage is available to the entire community.

c State-Level Evaluation

N/A

d Evaluation Results

During the start of navigation services, primary care providers were resistant to having a navigator on the team without knowing the navigator's role. Once they understood what a navigator can do for underserved individuals, they were more open to the idea of case management. Evaluation survey results showed 100 percent of providers agreed a diabetes navigator is an important member of their medical team, 100 percent agreed navigation is an important part of the services they offer, and 100 percent agreed that clients better understand diabetes and improved in self-care.

Certain times of the year presented challenges for the PRO-Fit class enrollment. Client attendance was especially challenged during flu season and Spring Break. When children were on break, parents did not attend class. Survey results showed 43 percent of participants had a busy work/home/family schedule. To help increase attendance, the holiday session schedule was adjusted to give participants more family time in December. Fifty-two percent of the participants asked for more exercise time overall and the class was restructured to accommodate that request. Key exercise activities included yoga, step aerobics and home workout strategies. Seventy-three percent of PRO-Fit participants lost or maintained weight, 71 percent decreased in Body Mass Index, and 73 percent lost or maintained their. Collectively, participants lost a total of 1,273 pounds and 765 centimeters in waist circumference.

e Measures and Methods to Determine Effectiveness

Several program evaluation tools and systems were used to track outcomes and effectiveness.

Navigation services were documented in a database. An electronic medical record system was to manage client information and referrals. The diabetes registry was used to track and monitor hemoglobin (HbA1c) levels and annual screenings including eye, foot exam, dentist and annual flu shot. PRO-Fit class activities and client records were managed through an Excel database for pre and post waist, weight, and height measurements to be monitored. Body Mass Index, change in waist circumference, and weight lost were calculated during the analysis phase. Navigation Services, PRO-Fit, and Chronic Disease Self Management Program activities were tracked through a Google Drive and client feedback obtained through satisfaction surveys.

Participant surveys were used to determine effectiveness. Success in the navigation program was based on survey data from both participants and providers. Ninety-two percent of the clients agreed the navigator provided good information for managing diabetes in an easy-to-understand way. Eighty-nine percent agreed the navigator was encouraging and helped them maintain motivation, and 94 percent felt they had greater energy and are better able to self-manage diabetes. PRO-Fit participant surveys were conducted to get feedback on lifestyle change. Ninety-one percent of participants, after completing the program felt healthier and had increased energy, and 86 percent were less depressed and irritable, and were able to handle everyday stress more effectively. Ninety-five percent of the participants thought the lessons gave them helpful hints to help be more active and make healthier food choices, and 100 percent found PRO-FIT to be a worthwhile and positive experience. Eighty-five percent of participants stated they were certain they learned from the health education and 75 percent stated after completing the diabetes self-management education they were confident in managing symptoms or health problems.

Lab results from navigation services were delivered to the provider who then relayed the data to the client. The diabetes navigator worked with providers to correspond with clients and deliver screening results. PRO-Fit results were entered and shared with the participant's primary care provider and entered into the client medical records.

f Sustainability

Due to budget constraints and lack of grant funding, diabetes prevention, the Strengthening Diabetes Care in a Rural, Underserved Area project and the PRO-Fit Lifestyle program will not continue. However, it is planned that South-Central Colorado Seniors will continue Stanford Chronic Disease Self-Management Program classes.

g Impact on Intended Population

Clients showed improvements on PRO-Fit class exams. They attended classes and those who previously had not a place to address health issues or access care were no longer lost in the system. Clients obtained support and education from the diabetes navigator and benefitted from the increased services. For example, a client came to see the diabetes navigator in June 2014, with a 9.4 percent A1C reading from an April 2014 draw (a high reading). His physician wanted to initiate Insulin, but thanks to diabetes education he already had taken steps to improve his numbers by exercising and losing eight pounds in the previous three months. He continued diabetes education classes, exercising, decreased sweets, and subsequently lost 14.2 pounds. With this lifestyle change, the client

managed to decrease his A1C from 9.4 percent to 6.4 percent in five months. This client demonstrated great glycemic control through personal determination and hard work. He ultimately never went on insulin.

The Stanford Chronic Disease Self-Management Program enhanced the diabetes education provided and the curriculum structure and was helpful to people needing self-management skills. Clients commented they were initially skeptical when they came to find out about the program and afterward were glad they participated. Others commented they gained a world of knowledge and appreciated the expertise and personal experience with diabetes. Clients' lives were changed and they claimed the program made a difference in the community. One of the female clients professed to "have her husband back, interested and excited about life."

Approach to Cultural Competence

Cultural competence is addressed through the patient navigation and case management services. The San Luis Valley Health has a high Spanish speaking population and the project was designed to accommodate cultural and language services needs. The diabetes navigator developed strong relationships with clients and worked to increase the number of those comfortable gaining advice. A Diabetes webpage was developed for project use and to share culturally appropriate information with the community. Educational handouts as well as diabetes instructions were available in both English and Spanish. PRO-Fit class materials also were available in both English and Spanish.



Project Title: Community Care Team Promotora Program

Disease Category: Cardiovascular disease

Year 1 (FY 12-13): \$90,833

Year 2 (FY 13-14): \$96,271

Year 3 (FY 14-15): \$204,638

3-Year Total: \$96,271

Project Priority: Patient Navigation/ Case Management

Intended Population: Latino/Hispanic, Native American/American Indian, White/Caucasian

Counties Served: Archuleta, La Plata

3-Year Population Reach: 398

Project Summary: The Promotora Program was implemented as a three-year project to reduce health disparities rates and address cardiovascular disease for low-socio-economic status, Latino and/or Spanish speaking adults and children. The project provided health risk screenings, language interpretation, navigation through the health care system, and lifestyle education and support. Key objectives included offering patient navigator services, improving basic health risk indicators and providing health interventions for Archuleta and La Plata county residents.

The information below is a response to the HDGP Program Rules 6CCR1014-5 Final Evaluation Report questions as required.

a Key Accomplishments

The results achieved by San Juan Basin Health’s Promotora Program demonstrate its success in reducing health disparities and improving access to care by providing over 350 low-income Spanish speaking individuals with health screening and coaching, navigation and referral, health education and interpretation services. Key to the success of the program has been the focus on addressing the social determinants of health, by ensuring that the wide range of referrals and services offered included connection to resources such as housing assistance, food support, mental health, transportation and others.

b People Served and Services Received

San Juan Basin Health Promotora Program served 398 low-socioeconomic status individuals; the majority were Spanish speakers. The services provided included health screenings, health coaching sessions, navigation services including referrals and follow-up, Platicas (health education sessions) and translation/interpretation services.

c State-Level Evaluation

San Juan Basin Health participated in state-level evaluation conducted by Community Epidemiology & Program Evaluation Group (CEPEG). Evaluative focus areas included:

- 1 lessons learned in developing and running a PN or CHW program,
- 2 how the PN and CHW roles are similar and different, and
- 3 the impact of the PN or CHW role in the programs studied.

SJBH participated in two qualitative site visits and shared de-identified quantitative data for collective measurement purposes of the study. CEPEG completed a preliminary report available through the Office of Health Equity.

Positive feedback was provided by CEPEG evaluators regarding program design, process and reach, as well as tips on future scope of work (SOW) development and measurement.

d Evaluation Results

The Promotora Program achieved the larger goal of reducing health disparities by addressing cardiovascular disease and increasing health services for the Latino/Hispanic population. Feedback from clients indicated language had been a major barrier to accessing care. Feedback said this was overcome through the program. For many clients, the Promotora program connected them to primary care and resources difficult to pursue with limited English proficiency. Clients who participated in health coaching were empowered to take steps to improve health outcomes. Clients who attended Platicas (also in Spanish) further increased knowledge on healthy lifestyle strategies and received culturally relevant information to apply the concepts to their lives. The relationship of trust between the SJBH Promotora and clients enabled Latino/Hispanic individuals to develop a better understanding of the local health care system and accessing services. It was determined that the intangible qualitative data reported by clients is almost more important than some of the metric goals achieved.

e Measures and Methods to Determine Effectiveness

The SJBHD's Health Planner ensured adherence to the SOW and program goals. Two database systems were used to track client information and program activities. Initially, data was managed through the Apricot database. In program year 3, SJBHD created a customized Access database more suited to the evaluation needs of the Health Disparities Grant Program project. Data metrics included the number of:

- clients,
- clients screened,
- Platicas,
- clients attending Platicas,
- breast and cervical cancer assessments,
- clients reached through health coaching,
- referrals,
- follow-ups,
- clients supported through patient navigation services, and
- organizations and health care providers reached through outreach.

Methods used to determine effectiveness of the Promotora Program included evaluation and analysis of the metrics and qualitative feedback through anonymous client surveys and presentation evaluations. Results from the last three years of the Promotora Program were used to revise and improve delivery of the program and pursue changes to achieve the highest level of impact on the intended population possible. Feedback from clients helped to ensure that gaps can be addressed and enhanced services can be provided.

Results of the Promotora Program were shared through a variety of channels, with project leadership and community partners. SJBH's Communication Director will continue the project feedback process by disseminating results through the SJBH Facebook page, website, annual reporting and outreach presentations. Additionally, future communication to participants will highlight program successes, and encourage sharing with others. The agency will pursue community outreach and sharing between clients and with friends and family.

f Sustainability

The Promotora Program will be maintained through the Health Disparities Grant Program. SJBH will increase Promotora staff from one position to three. The organization will maintain and add health equity policies to achieve systems-level change and pursue new goals to impact underserved communities and reduce cardiovascular disease risk for individuals.

g Impact on Intended Population

One hundred percent of the clients served by the Promotora Program were low-socio-economic status individuals. One-fourth of the clients were children under the age of 17 and 28 percent were aging and/or over 55 years of age. An estimated 85 percent of clients spoke Spanish as their first language. Many of the clients reported that numerous barriers had previously prevented them from accessing health care and other crucial resources. The Promotora Program provided individuals and families with navigation services, health screenings, health coaching, referrals and follow-up, Platicas and interpretation services.

h Approach to Cultural Competence

Efforts were taken to ensure that Promotora clients were treated in a culturally competent and respectful ways. All written materials associated with the program including Platicas were presented in English and Spanish, and the Promotora provided interpretation services, as needed. The Promotora completed the webinar titled 2013 CLAS Standards

for Patient Navigators, as well as a two day Bridges to Poverty Training also completed by the program manager. Additionally, the program manager attended a Health Equity Webinar Series presented by The Colorado Trust. This education was critical to working with bilingual and diverse clients and important to maintaining cultural considerations necessary for working with the intended population.



Project Title: Decreasing Health Disparities through Personalized Health Planning**Disease Category:** Cardiovascular disease

Year 1 (FY 12-13): \$199,455

Year 2 (FY 13-14): \$226,865

Year 3 (FY 14-15): \$226,865

3-Year Total: \$653,185

Project Priority: Patient Navigation/ Case Management**Intended Population:** African American/Black, Asian American/Pacific Islander, Latino/Hispanic, Native American/American Indian, White/Caucasian**Counties Served:** Clear Creek, Grand, Lake, Park, Summit**3-Year Population Reach:** 9,268

Project Summary: The Decreasing Health Disparities through Personalized Health Planning project was implemented to reduce cardiovascular disease (CVD) and related risk factors through comprehensive screening, individualized health planning, health education and personalized strategies to mitigate adverse health outcomes. Project staff organized as a Care Team utilized culturally relevant health and evidence-based strategies and curriculum. Clients were screened for cardiovascular disease and risk factors, and each client was offered an individualized health action plan.

The information below is a response to the HDGP Program Rules 6CCR1014-5 Final Evaluation Report questions as required.

a Key Accomplishments

SCCC met overall goals to enroll participants in the personalized health planning project through an intense screening process. Approximately 67 percent of the participants enrolled in the project. Fifty percent of the clients pursued enrolled, and 72 percent demonstrated positive change. During year 1, SCCC focused on making adjustments to the electronic health system so that recorded data could be analyzed successfully. Once the workflow and data collection issues were resolved, Years 2 and 3 were focused on increasing client engagement and ensuring that those who entered the project were retained and achieved personal health goals. Patient navigators and the Care Team learned valuable skills to increase participation in the project, and engage clients in meaningful ways to achieve their own health goals.

b People Served and Services Received

The personalized health planning project reached 9,268 clients over the 3-year period. Clients faced barriers to health screening and access to services, and were at risk of poorer health outcomes. Seventy percent of the clients were uninsured, 22 percent were Medicaid and most with limited incomes. Additionally, many clients were limited English proficient, and 40 percent maintained a primary language other than English. Multicultural and multilingual health coaches worked with clients to increase access to health care and to change health outcomes. Ultimately, SCCC promoted individual health change and empowerment, and encouraged clients to know they had control over how they feel and how healthy they are.

c State-Level Evaluation

SCCC participated in state level evaluation regarding overall project impact. Data collection and methodology were evaluated and feedback was provided by the Community Epidemiology & Program Evaluation Group (CEPEG). It was recommended that SCCC begin to collect data on why clients refused to participate in the health coaching program. Analyzing client participation allowed the Care Team to adjust the ways they advertised the program to clients. Adjustments made to outreach processes increased project enrollment. Improvements also were made to project administration. For instance when a client refused participation in the program based on lack of time or inability due to work schedule, health coaches offered after hours appointments and phone coaching sessions when clients were available.

d Evaluation Results

The SCCC is now more knowledgeable about how to engage clients more effectively and assist them to manage their own chronic conditions. While client engagement continues to be the primary challenge, recent changes made to the project made a difference. Encouragement strategies were discovered to be critical and clients that report smoking cessation, weight loss or other measureable change are sent a “Congratulations!” card from the Care Team with a gift card. Clients are asked for permission to add their story to our “wall of success” which celebrated clients who have made positive health changes. This technique proved remarkably successful, and was discovered to be more effective than posting information about the detrimental impacts of poor health choices. The Wall of Success was located where clients check out so they can see successes are achievable. Another important lesson was that each client was motivated differently. Motivational interviewing was an important precursor to overall success. Project staff discovered what was meaningful and motivating differed for each client.

e Measures and Methods to Determine Effectiveness

Several measures were used to determine progress. Measurements included numbers of clients screened for cardiovascular disease risk and results of those assessments. Screening tools related to mood and substance use were used including the Patient Health Questionnaire (PHQ-9), Alcohol and Substance Abuse (AUDIT) and Drug Abuse Screening Tool (DAST). These systems are multipurpose instruments for screening, diagnosis and monitoring severity of client symptoms and duration.

Health coaching surveys were administered to assess clients' perception of how well they understand their own health issues. All results were entered into an electronic health record system called Aprima, and were aggregated with other client demographic data including age, income, gender, race, ethnicity, insurance status, zip code, etc. Metrics used to determine health program effectiveness included weight, Body Mass Index, blood pressure measurements, hemoglobin A1c, etc. Results of screening tools and electronic health records helped project staff measure change over time.

Project evaluation results were shared with project staff, the Care Team, funders, the SCCC Board and clients. Data findings enabled staff to make changes to project delivery, enhance workflow and adjust client service strategies. SCCC also employed the Model for Improvement and the "Plan, Do, Study, Act" as strategies for pursuing further project improvements. The three-year time span allowed the Care Team to try a variety of workflows, interventions and data collection techniques. The length of time was critical to project effectiveness and ability to sustain services beyond the grant funding period.

f Sustainability

The personalized health coaching and patient navigation processes will continue despite the end of the funding period. Patient Navigators now are a permanent part of the care team. The Care Team will include a medical provider, medical assistant, patient navigator/health coach, and behavioral health counselor. The team will meet daily to manage client cases and discuss specific health visit needs. Health Coaches were assessed to be a critical component of the Care Team. They will

be maintained to reduce workflow for providers and provide individualized, culturally competent, high touch support for clients.

g Impact on Intended Population

Providers and staff at SCCC wanted clients to feel welcome and empowered to make changes and improve health outcomes over time. Clients were informed that screening, health education and coaching was available to them, and encouraged to participate in personalized planning. One-hundred percent of the SCCC clients enrolled in the project were screened for risk factors and offered support. Seventy-two percent of the clients self-reported noticeable and positive health changes after participating in the coaching program.

h Approach to Cultural Competence

SCCC maintained multicultural and multilingual project staff to work with diverse clients. Clients were asked what is culturally important to them, what their health beliefs were and what language they prefer. The Care team was careful to manage each client as an individual and not to make assumptions about health needs, desires and cultural traditions. SCCC maintained the goal that all clients were comfortable and that trust was built with project staff. SCCC included organizational hiring practices that promoted diversity in staff and client processes. The project staff were offered continuing education to increase skills with underserved and minority populations. Dialogue with and feedback from community leaders and residents was educational to project staff and important to addressing cultural needs.



Project Title: Well Body Interventions for Persons with Behavioral Health Disorders

Disease Category: Crosscutting (Cancer, Cardiovascular, and Chronic Pulmonary disease)

Year 1 (FY 12-13): \$199,587

Year 2 (FY 13-14): \$223,386

Year 3 (FY 14-15): \$223,386

3-Year Total: \$646,359

Project Priority: Collective Action for Collective Impact
Patient Navigation/Case Management Services
Risk /Factor Reduction/Obesity

Intended Population: African American/Black, Asian American/Pacific Islander, Latino/Hispanic, Native American/American Indian, White/Caucasian

Counties Served: All

3-Year Population Reach: 151,000

Project Summary: The Well Body Interventions for Persons with Behavioral Health Disorders (Well Body) project offered systems change strategies for community health organization and service providers, and technical assistance to address weight management. The project included provider self-assessments and customized feedback on ways to design weight management programming for people with behavioral health disorders. Providers were educated on effective policy and systems change activities. Well Body trainings and regional peer-to-peer opportunities also were available. The project provided educational addendums and curriculum to health peers, navigators and community health workers to maximize weight control and wellness skills for those professionals.

The information below is a response to the HDGP Program Rules 6CCR1014-5 Final Evaluation Report questions as required.

a Key Accomplishments

The Well Body project offered both provider- and peer-driven weight management and nutrition services to people served in behavioral health care and primary care settings. Provider education included sustainable weight management, nutrition programming and policy initiatives. Training and technical assistance were provided to organizations across Colorado including 73 organizations, 57 providers and 96 peers. Training included health disparities concepts, evidence-based weight management techniques and clinical skill development, and included on-line video modules. The education promoted peer counseling and facilitated the sharing of successes and challenges. Several resource tools were created for health care providers including a toolkit in English and Spanish.

The toolkit included five supplements for priority populations and a report detailing continuity of care model for justice-involved populations.

b People Served and Services Received

The project reached 151,000 including providers and organizations. These clients were reached through technical assistance, consultation, and training. The number of unduplicated clients served by the public behavioral health system is collected annually by the Colorado Department of Human Services, Division of Behavioral Health. Clients participated in the assessment process, training and resource processes and involved in regional peer and provider trainings. Providers then developed goals to improve work with underserved people and those with behavioral health challenges. Clients developed goals and established improvement strategies, and learned to design project outcomes, use lessons learned, and institute recommendations for future activities. The DIMENSIONS: Well Body for Healthcare Providers Toolkit and addendums were provided to professionals and included techniques for working with young adults and pregnant mothers. The tools also addressed techniques with low socioeconomic status individuals and those in the criminal justice system. The educational resources were available to health care providers, navigators, and community health workers to build skills and to improve wellness services.

c State-Level Evaluation

N/A

d Evaluation Results

Project training evaluations were conducted and feedback was solicited from provider and organization participants. Evaluation results indicated the Well Body program successfully met grant objectives and provided high quality training and practical tools helpful to providers. Ninety-seven trainees agreed or strongly agreed they were satisfied with the training program. Ninety-two percent of those trained agreed or strongly agreed the training provided them with the knowledge and confidence needed to successfully implement wellness interventions. Of those trained in Advanced Techniques, 61.5 percent reported currently or previously running the DIMENSIONS toolkit. An additional 44 percent reported using the Well Body group materials individually with clients or to supplement other groups or programs. Seventy-eight percent of the participants reported accessing, using or sharing the English language versions of toolkits and resources.

e Measures and Methods to Determine Effectiveness

The Well Body evaluation process involved mixed methodologies (i.e., qualitative and quantitative) to measure progress toward identified objectives. Training evaluation data and feedback from participants were used to make project improvements and informed future planning. Project staff worked with the Colorado Department of Public Health and Environment (CDPHE) staff and an evaluation team to determine program reach and determine numbers of providers and sites trained. A conservative estimate of reach was established and based on an unduplicated count of state funded behavioral health clients. This estimate was averaged across

behavioral health centers, and the ultimate reach was 151,000.

A total of 73 behavioral health, integrated care and primary care organizations received organizational assessments with customized tools and resources to help them expand wellness services at their organizations. Where relevant, organizations also received reports of how wellness services had changed over time. These assessments informed UCD of target organizations most in need of trainings and technical assistance. Evaluation data from trainings and presentations, satisfaction surveys from community partners, and outcomes data from trainings and peer-to-peer programming also were used to determine the project's impact on health disparities. A DIMENSIONS: Action Plan (rapid improvement tool) was used at each training to help organizations set goals for implementing change and improving service to clients. Ninety-two of the trainees reported achieving planned goals after the training.

Comprehensive reports from the self-assessments were sent to all participating agencies, and a summary report of organizational stages of change was shared with project staff and CDPHE. Results from training evaluations and satisfaction surveys were compiled and used to improve the project overall.

f Sustainability

UCD is committed to building sustainability and developing lasting relationships and partnerships. The peer-led group training (Well Body Advanced Techniques) was delivered as a train-the-trainer model. This training focuses on program reach and provides organizational sustainability in case

of employee turnover.

The Well Body project also conducted ongoing networking calls for Advanced Techniques training attendees. The training provided opportunities to work with other service providers and pursue wellness skills from a community standpoint. The project addressed a variety of health care and behavioral health settings including home care, hospitals, community clinics, public health agencies and criminal justice facilities. The extensive reach to providers was intended to sustain wellness programming and policy work to address weight management and work with underserved and behaviorally challenged individuals.

g Impact on Intended Population

The Well Body project was intended to address all demographics, including racial and ethnic minorities, Lesbian, Gay, Bisexual and Transgender individuals, youth and adults, non-native English speakers and geographically isolated populations. The project focused on behavioral health populations, those with low socio-economic status and in the criminal justice system. The project reached behavioral health and integrated care organizations, but also addressed primary care and criminal justice facilities. Trainings were hosted in both rural and urban locations, in the Denver metro area, eastern plains, central mountains, western slope and the Four Corners region.

h Approach to Cultural Competence

The Well Body project provided culturally competent services, trainings, and resources. The project utilized professional expertise from those

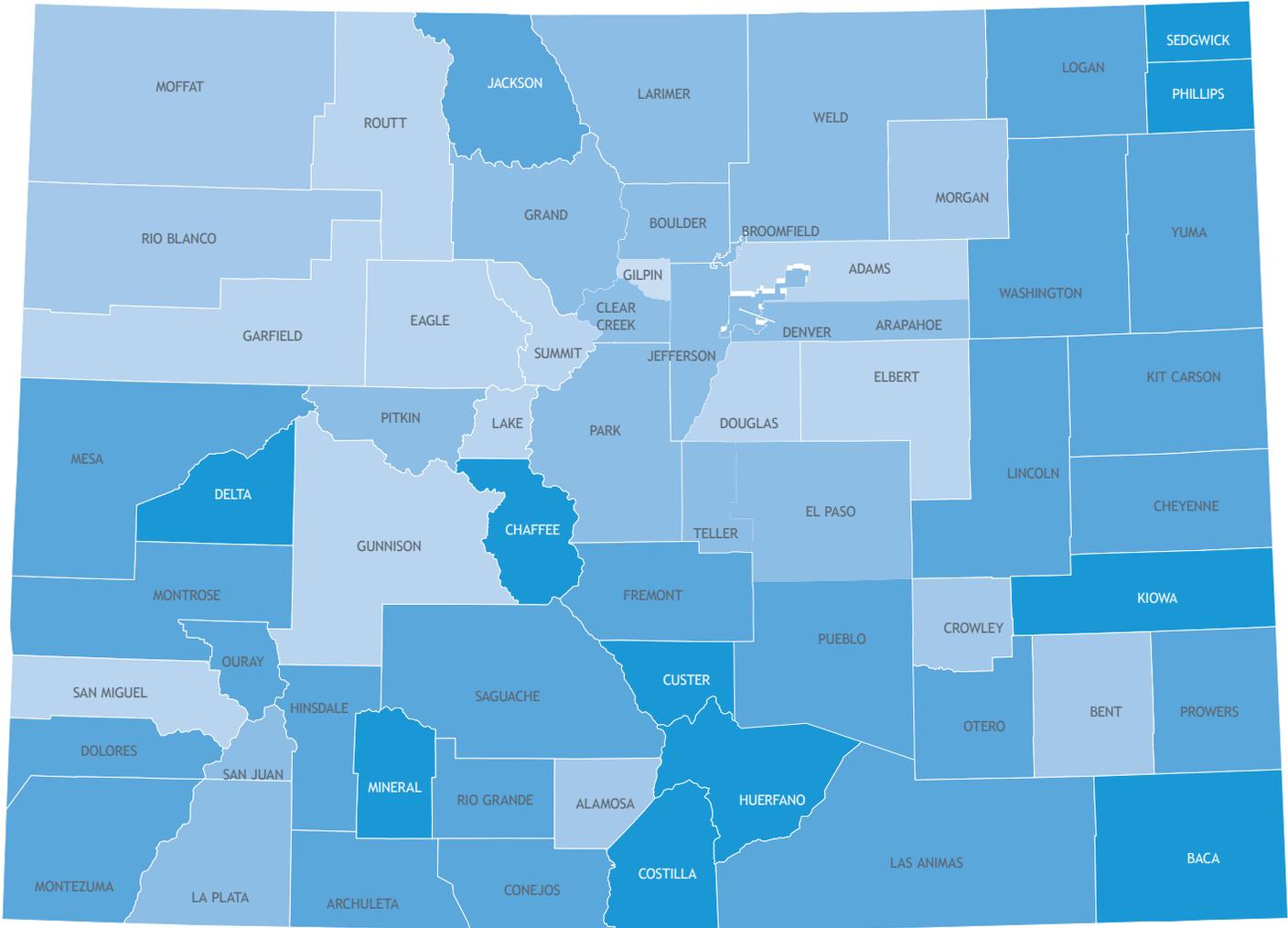
working within behavioral health and criminal justice settings. Peer learning was valued among those with experience working with the intended populations. Peer support was critical to the process and important to reducing client hospitalizations, diminishing exacerbations of symptoms and ensuring treatment for persons with behavioral health conditions. Behavioral health providers possessed

and shared weight management interventions. Cultural competence considerations were important to addressing therapy with clients, managing care and choosing recovery-focused models of care. The Well Body training provided tools and resources for considering the unique needs of diverse and behaviorally challenged individuals.









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