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Colorado Department of Public Health and Environment

Funding Recommendations from the Minority Health Advisory Commission for the Health Disparities

Grant Program for Fiscal Year 2012-2013
(October 1, 2012 and concluding June 30, 2013)

These projects were recommended for funding by the Minority Health Advisory Commission and approved by the State Board of Health for Fiscal Year 2012-2013.

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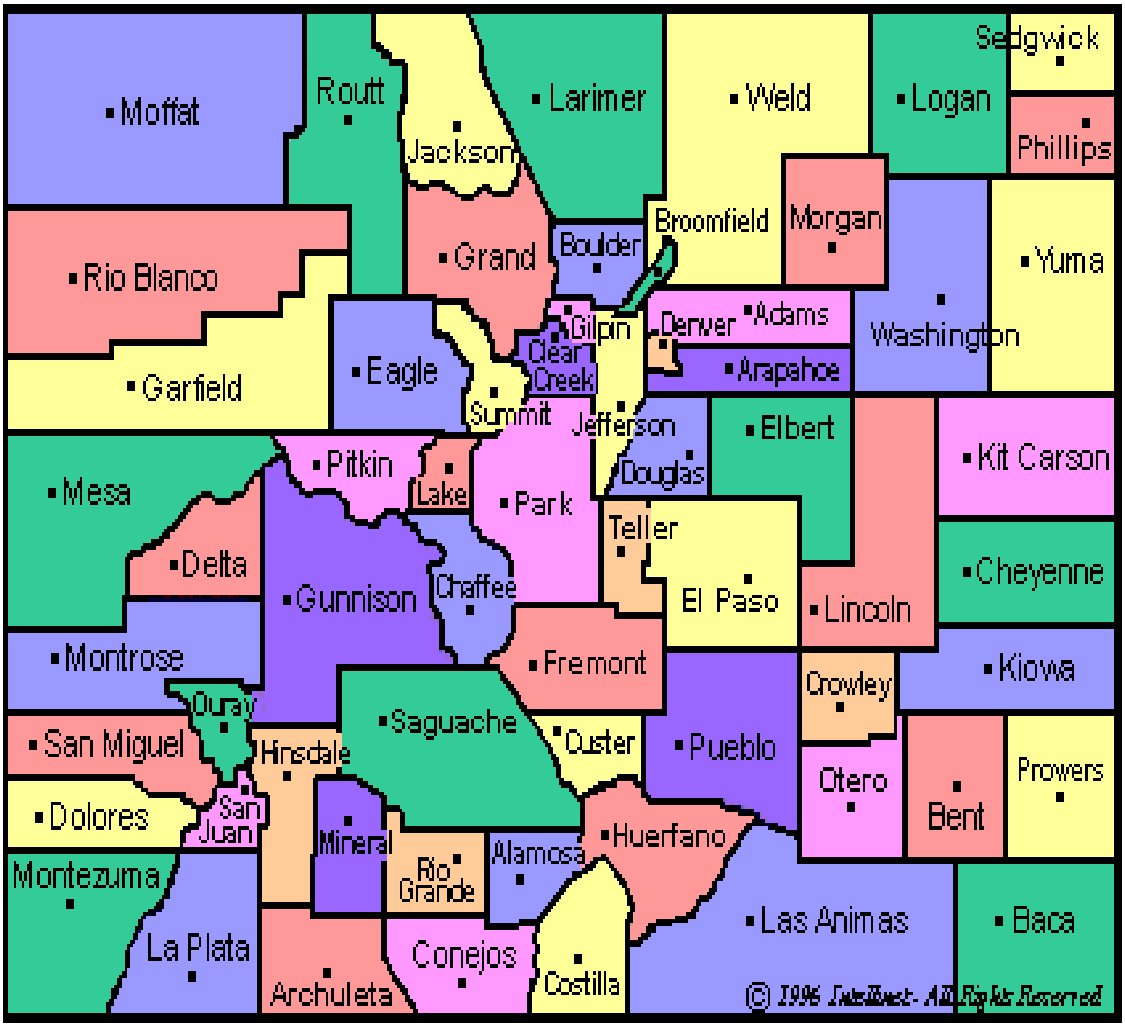

Key to Abbreviations

AA/B -- African American/Black
AA/PI -- Asian American/Pacific Islander
CACI -- Collective Action for Collective Impact
CD -- Cardiovascular Disease
L/H – Latino/Hispanic
NA/AI -- Native American/American Indian
OHD -- Office of Health Disparities
PatNav/CM -- Patient Navigation/Case Management
PD -- Pulmonary Disease
RFR -- Risk Factor Reduction
W/C White/Caucasian

Grantee 1: **CPC Community Health**

Project Title: **Patient Navigator and Community Health Worker Collaborative**

Project Category: Cancer **Funding Recommended: $43,576**
Project Priorities: 1.Patient Navigation/ Case Management Services (Requested) Year 1 (FY13): $43,576
2.Risk Factor Reduction/Obesity
Target Population: Latino/Hispanic
Geographic Area: Metro **Counties Served:** Denver

Project Summary:
Latinos carry a disproportionate burden of cardiovascular (CVD) risk factors compared to non-Latino whites yet are less likely to receive blood pressure and cholesterol screening and know their risk factor values. Through local community partnerships, Community Heart Healthy Actions for Senior Latinos at Risk (CHARLAR) has been successful decreasing CVD health disparities in older adult Latinos in Northwest Denver. In addition to a 12 week educational program, we provide participants with free health screenings (cholesterol, blood pressure, glucose, and body mass index) and onsite medical counseling regarding their CVD risk factors with referral and follow up calls to facilitate entry into local community clinics. The 12-week culturally tailored education and skill building program includes walking and dancing groups led by promotoras. Although we have secured funding for the 12-week education program, there is no funding for the health screenings.
This application seeks funding for the health screenings that take place prior to and after the 12-week program. We also seek funding to support our follow up and navigation services. Funding from The Office of Health Disparities will provide CVD and diabetes screening, counseling on risk factors, comprehensive surveys to collect diet and physical activity information and provide participants direct referral, follow up and navigation services. Feedback from our Community Advisory Committee and participants suggests that the health screenings are essential to motivating participants to enact and maintain healthy lifestyle changes.

Through these screenings linked with the educational program, CHARLAR will initiate and sustain behavior change to support chronic disease prevention among vulnerable older adult Latinos in Northwest Denver. To date, CHARLAR has enrolled over 700 participants with measurable improvements in both CVD risk factors and healthy lifestyle behaviors.

Grantee 2: **Colorado Access**

Project Title: **Community Heart Health Actions for Senior Latinos at Risk**

Project Category: Cardiovascular Disease **Funding Recommended: $199,956**
Project Priority: 1. Patient Navigation/ Case Management Services (Requested) Year 1 (FY13): $199,956
Target Population: African American/Black, Asian American/Pacific Islander, Latino/Hispanic, Native American/American Indian, White/Caucasian
Geographic Area: Metro **Counties Served:** Adams, Arapahoe

Project Summary:
This project brings a novel approach to the evidence-based practices of patient navigators (PN) and community health workers (CHW) to patients at-risk for cardiovascular disease (CVD) and their families in Original Aurora by pairing the community-based CHW with the clinic-based PN. This model will enhance the transitions across health care settings and community settings. PNs and CHWs have demonstrated improved outcomes for the medically underserved populations by bridging health care systems with communities, providing culturally appropriate and accessible health education, and providing informal counseling (Viswanathan, 2009; Rosenthal, 2011). This project brings together ideal partners to implement this collaboration. Aurora Health Access, a community coalition committed to creating a health care system in Aurora that meets the needs of all residents in

the community, will serve as the steering committee, and Colorado Access, the Regional Care Collaborative, will serve as the fiscal agent.
PNs and CHWs will be trained using evidence-based curricula. PNs will be placed at community clinics serving Original Aurora residents, Metro Community Provider Network (MCPN) and Clinica Tepeyac. These PNs will provide case management and evidence-based strategies to reduce weight, blood pressure, cholesterol and smoking for patients from Original Aurora with high-risk for CVD. Additionally, CHWs in Original Aurora will work with these patients and their families to navigate community resources and to increase knowledge and skills with evidence-based strategies to meet cardiovascular health goals. Family approaches to health interventions have demonstrated effectiveness in lifestyle changes, improved health outcomes and self-management (Rosland, 2008; Nader, 1989).

The model to be implemented is complex by design as means to solidify long-term and sustainable partnerships among organizations that serve a large proportion of medically underserved Original Aurora residents.

Grantee 3: **Summit Community Care Clinic, Inc.**

Project Title: **Decreasing Health Disparities through Personalized Health Planning**

Project Category: Cardiovascular Disease
Funding Recommended: **$199,446**
Project Priority: Patient Navigation/ Case Management Services
(Requested) Year 1 (FY13): $199,446
Target Population: African American/Black, Asian American/Pacific Islander, Latino/Hispanic, Native American/American Indian, White/Caucasian
Geographic Area: Rural
Counties Served: Clear Creek, Grand, Lake, Park, Summit

Project Summary:
With funding from HDGP, Summit Community Care Clinic will implement "Decreasing Health Disparities through personalized health planning". This project aims to reduce Cardiovascular Disease and related risk factors through: comprehensive screening; targeting of risk factors that have been demonstrated to cause disease; and individualized health planning to reduce or mitigate adverse health outcomes. Treatment teams consisting of a medical provider, medical assistant, behavioral health provider, nutritionist and health educators will screen patients, create culturally relevant health curriculum based on evidence based strategies, and help patients identify individualized action plans to improve health. 100% of primary care patients seen at Summit Community Care Clinic who are over the age of 13 will be comprehensively screened (approximately 2800 people screened); of those patients identified with the presence of disease or multiple risk factors, a minimum of 50% (approximately 480) will receive targeted individualized interventions resulting in reduction of risk factors and improvement on numerous clinical measures in a minimum of those patients (240).
Culturally competent Health Educators (HEs) will have a significant role in the individualized treatment plan. Health Educators are increasingly being recognized as a critical part of quality, comprehensive medical care. The growing need for health care provision in rural areas, coupled with the shortage of primary care providers results in physicians and mid-levels seeing more patients in less time, which limits the opportunity for necessary health maintenance education. By providing personalized education, goal setting, motivational interviewing and support to patients, reduction of cardiovascular disease and related risk factors will occur. The patient's experience will be enhanced, while higher trained, higher paid staff can move more quickly from room to room. This more personalized approach to care will reduce negative health events which will lower the cost of health care to the patient and the community.

Grantee 4: **Denver Public Schools**

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

Project Category: Cardiovascular Disease
Project Priority: Risk Factor Reduction / Obesity
Funding Recommended: **$199,150**
(Requested) Year 1 (FY13): $199,150
Target Population: African American/Black, Asian American/Pacific Islander, Latino/Hispanic, Native American/American Indian, White/Caucasian

Geographic Area: Metro
Counties Served: Denver

Project Summary:

Denver Public Schools (DPS) will increase physical activity levels among students by improving quality physical education (PE). This will be accomplished through implementation of the evidence-based SPARK curriculum, providing professional development, and evaluating PE teachers. This project will put into practice and enforce a 2010 DPS policy requiring that students are engaged in moderate to vigorous physical activity (MVPA) a minimum of 50% of PE class time.

This approach follows best practices in the field of PE, and is aligned with state and national recommendations, including the Community Preventive Services Task Force, Colorado Physical Activity and Nutrition, and the National Physical Activity Plan.

Additionally, parents will be engaged in educational trainings designed to promote lifelong fitness and local resources for physical activity.

Grantee 5: **San Luis Valley Regional Medical Center**

Project Title: **Strengthening Diabetes Care in a Rural, Underserved Area**

Project Category: Cardiovascular Disease
Project Priorities: 1. Patient Navigation/ Case Management Services
2. Risk Factor Reduction/Obesity
Funding Recommended: **$178,115**
(Requested) Year 1 (FY13): $178,115
Target Population: Latino/Hispanic, White/Caucasian
Geographic Area: Rural
Counties Served: Alamosa, Conejos, Costilla, Rio Grande, Saguache

Project Summary:

This proposal addresses the goal of the Health Disparity Grant Program to reduce cardiovascular disease and in particular to improve diabetes self-management by providing evidence-based clinical and community resources to a high-risk community in the 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. Evidence-based strategies to overcome health disparities in the prevention and treatment of diabetes are the foundation of the proposal. Key objectives are to 1) initiate navigation services; 2) initiate evidence-based weight loss/Lifestyle classes; 3) expand a fledging Community Health Worker program; and 4) expand culturally appropriate online health resources for people across the Valley to access.

Expected outcomes include improved health outcomes as indicated by lower hemoglobin A1c (HbA1c), and increased number of people with diabetes who obtain a majority of the recommended annual screenings. 75% those who participate in the Lifestyle classes are expected to lose weight and/or waist circumference along with increasing their physical activity levels. Participants in the Self-Management classes will increase their confidence in managing their diabetes and have improved health outcomes such as decreased HbA1clevels.

All programs are designed to allow participation from community members from development to evaluation. All providers in the Valley can refer their patients to these community resources. Classes will be offered in various counties.

Grantee 6: **Denver Public Schools**

Project Title: **DPS Students & Families Healthy Choices**

Project Category: Cardiovascular Disease **Funding Recommended: $173,093**
Project Priority: Risk Factor Reduction/ Obesity (Requested) Year 1 (FY13): $199,093
Target Population: African American/Black, Asian American/Pacific Islander, Latino/Hispanic, Native American/American Indian, White/Caucasian
Geographic Area: Metro **Counties Served:** Denver

Project Summary:
The Department of Extended Learning within Denver Public Schools will design and offer a comprehensive community-based program that includes in depth and culturally appropriate after-school activities and classes for children and families in Northwest Denver to address obesity, encourage fitness, and learn healthy lifestyle choices. The purpose of this program is to intervene in the trek toward obesity in the population that this CDPHE grant specifically addresses.

The objective is to address cardiovascular disease, specifically obesity and diabetes, impacting students and families in low-income, primarily Hispanic school communities in Northwest Denver, through risk-factor reduction education and physical activity programs. The strategy is to target 1,000 DPS individuals (students and their family members) per year where the students attend Skinner Middle School, TreVista, Centennial, Valdez and Colfax Elementary and K-8 schools. These schools have the highest poverty rates as measured by the federal Department of Agriculture's Free and Reduced Lunch program ranging from 77 to 97 percent.

These programs will focus on fitness, weight loss and nutrition serving more than 200 family units at the Skinner Neighborhood Center and through the DPS Fit Fun programs held in Northwest feeder schools.

Participation in this program will result in improved and healthier lifestyles for students and their families. Participants who successfully complete a 6-12 week health program will demonstrate a decreased BMI, increased fitness level and a 60% gain in knowledge of nutrition and healthy behaviors.

Ultimately, reaching these goals reduces health-related issues that affect each family's economic status, as well as reducing the costs borne by the State of Colorado that would otherwise be spent on health-related illnesses.

Grantee 7: **Pueblo City-County Health Department (PCCHD)**

Project Title: **PCCHD Health Disparities Program**

Project Category: Cardiovascular Disease
Project Priority: Risk Factor Reduction/ Obesity

Funding Recommended: **$143,123**
(Requested) Year 1 (FY13): $143,123

Target Population: African American/Black, Asian American/Pacific Islander, Latino/Hispanic, Native American/American Indian, White/Caucasian
Geographic Area: Metro 90%
Rural 10%

Counties Served: Pueblo

Project Summary:

PCCHD Health Disparities Program brings together three strategies to reduce the incidence of cardiovascular disease (CVD) precursors such as obesity in disparate populations of Pueblo County. The prevalence of obesity is higher in Pueblo (26.5%) than in Colorado (20.1%)(BRFSS, 2009-2010). Over 27% of children in Pueblo County age 2-14 are overweight or obese which is above the state average of 31%. Key objectives of the project are (1) to establish and maintain a Community Health Improvement Plan (CHIP) Advisory Team aimed at reducing obesity and other associated cardiovascular disease (CVD) risk factors in Pueblo County by building relationships and educating community partners on CVD risk factors and working to promote organizations to implement activities to address obesity and CVD within the community, (2) to develop an advisory team to educate the community and explore the feasibility of increasing access to healthy food options in identified food desert areas of Pueblo County, (3) to develop active school wellness teams in local public schools with disparate populations to enhance the health of children in the community using an evidence-based strategy. These three objectives center on increasing awareness and educating the target population on obesity and other CVD risk factors by integrating community efforts, fostering empowerment in neighborhoods, and developing policy for change in an attempt to improve overall health.

The PCCHD Health Disparities Program will strive to reduce the risk of developing the chronic cardiovascular disease precursors such as obesity by providing education and opportunities for the disparate populations identified through County Health Rankings, the BRFSS, and USDA food desert maps. Project activities will foster lifestyle changes that increase the probability of permanent improvement in overall health status.

Grantee 8: **Eagle County Public Health Agency**

Project Title: **Eagle County Healthy Communities**

Project Category: Cardiovascular Disease
Project Priority: Risk Factor Reduction/ Obesity

Funding Recommended: **$141,828**
(Requested) Year 1 (FY13): $141,828

Target Population: Latino/Hispanic, White/Caucasian
Geographic Area: Rural

Counties Served: Eagle

Project Summary:

The Office of Health Disparities Grant, through the Colorado Department of Public Health and Environment, would be used to develop the ¡Soy Sano! Project as a program between Eagle County Public Health(ECPH)and community partners. The ¡Soy Sano! Project is designed to promote nutrition and healthy food access to reduce

obesity risk factors and thus decrease cardiovascular disease in the Eagle County Latino population. The key objectives of ¡Soy Sano! are nutrition education, nutrition awareness, healthy food access, and healthy food access policy. Expected outcomes for year 1 of the funding cycle include the following: 1) 26 Spanish language cooking shows will have been created and aired on ECO TV 18 2) Nine Spanish language nutritional radio shows will have been created and aired on the local Spanish radio station, La Nueva Mix 3) Two, eight week sessions of the Expanded Food and Nutrition Education Program (EFNEP) will be taught to clients of the Vail Valley Salvation Army (VVSA) 4) The Go, Slow, and Whoa Program (GSW) will have been implemented at VVSA and other local food banks/pantries 5) A marketing plan for The Plant a Row for the Hungry Campaign (PAR) will have been implemented 6) 10 members of the Latino Health Leadership Group (LHLG) will be meeting monthly 7) A marketing company will begin meeting with the LHLG and planning a Healthy Food Access Policy social marketing campaign.

Grantee 9: **Clinica Tepeyac**

Project Title: **Clinica Tepeyac Health Disparities**

Project Category: Cardiovascular Disease **Funding Recommended: $120,337**
Project Priority: Risk Factor Reduction/ Obesity (Requested) Year 1 (FY13): $134,337
Target Population: African-American/Black, Latino/Hispanic, White/Caucasian
Geographic Area: Metro **Counties Served:** Adams, Arapahoe, Jefferson

Project Summary:
Clínica Tepeyac (Clínica) requests funding from the Colorado Department of Public Health, Office of Health Disparities for a community-level, comprehensive program to address cardiovascular health disparities in Denver's low-income Latino community. Mi Corazon Saludable will leverage Clínica's longstanding history as a trusted medical provider to low-income Latinos by providing chronic disease education, chronic disease screening for diabetes (a precursor to cardiovascular disease), education on healthy cooking using low-cost ingredients, and access to exercise programming. Participants who are patients will be enrolled in an electronic patient registry that will track their health outcomes and give them access to their own health outcomes through an online portal—allowing them to better manage their own health and play an empowered role in reducing disparities in cardiovascular disease among Denver's working poor Latino population. Those are who are not patients will be given the opportunity to become a patient at Clínica and enroll in the patient registry.
The purpose of Mi Corazon Saludable is to empower Denver's traditionally, medically-underserved low-income Latino population with the knowledge and resources to make lifestyle changes that will reduce the incidence of cardiovascular disease among this high-risk population. Participants will exhibit healthier behaviors and improved health indicators related to diabetes and cardiovascular disease.

Grantee 10: **San Juan Basin Health Department**

Project Title: **Community Care Team Promotora Program**

Project Category: Cardiovascular Disease
Project Priority: Patient Navigation/ Case Management Services

Funding Recommended: $92,398
(Requested) Year 1 (FY13): $102,648

Target Population: Latino/Hispanic, Native American/American Indian,White/Caucasian
Geographic Area: Rural **Counties Served:** Archuleta, La Plata

Project Summary:
The latest health data available for the nation, Colorado, and La Plata and Archuleta counties establishes the need for addressing access to health care for disparate populations, namely, the Hispanic/Latino population. The purpose of this proposed project will be to reduce health disparities rates by improving access to health care and prevention services for low-income Latino adults and children. The goal is to improve health status by hiring a bi-lingual, bi-cultural promotora to provide: health risk screenings, language interpretation, navigation of the health care system, and health and lifestyle education/support to improve the health status of Latinos in our community. Key objectives include offering patient navigator services to low income Latino adults and children and to improve basic health risk indicators on re-screening after clients receive health care interventions via patient navigation in Archuleta and La Plata counties.

Grantee 11: **Colorado African Organization**

Project Title: **Patient Navigation and Community Education for Refugees and African Immigrants**

Project Category: Crosscutting
Project Priority: Patient Navigation/ Case Management Services

Funding Recommended: $199,834
(Requested) Year 1 (FY13): $199,834

Target Population: African-American/Black, Asian-American/Pacific Islander, White/Caucasian
Geographic Area: Metro **Counties Served:** Adams, Arapahoe, Denver

Project Summary:
The proposed project by the Colorado African Organization (CAO) targets community members in refugee and immigrant communities from Burma, Bhutan and Africa. Since many of these communities are underserved, lack a medical home and face healthcare barriers such as language, understanding of systems and culture, CAO's community-based program combines education and awareness with patient navigation. Refugees and immigrants face adverse health outcomes as relates to cancer, cardiovascular and pulmonary disease as a result of poor health conditions in their home countries, acculturation, lack of awareness around risk and preventive measures and difficulty in accessing screening, diagnosis and treatment. The purpose of the program is to improve health literacy and health access in the targeted communities through community-based education and patient navigation. Key objectives are to train program staff in patient navigation in accordance with state level efforts to ensure high quality program implementation and delivery; increase education and awareness of cancers, cardiovascular and pulmonary disease and screening, diagnosis and treatment options; reduce the incidence and risk factors associated with targeted disease; and reduce health disparities in the targeted disease in these populations.

This project will address Program Criteria (a) in order to translate evidence-based strategies regarding the prevention and early detection of cancer, cardiovascular disease and chronic pulmonary disease into practical application in a community setting. The priority area addressed is (1): Patient Navigation, in order to increase access to healthcare and treatment services for refugees and African immigrants.

Desired outcomes include: trained community-based community health workers (CHWs) and patient navigators targeting refugee and immigrant communities; greater awareness in target populations as to risk and preventive factors for cancers, cardiovascular and pulmonary disease; improved health literacy of refugee and immigrant communities in cancers, cardiovascular and pulmonary disease; enhanced access by the target populations to screening and treatment opportunities in mainstream resources such as clinics and health departments; increased referral to screening efforts offered by mainstream providers by the immigrant and refugee communities; enhanced access by communities to local community based healthcare clinics, FQHCs and healthcare providers; improved understanding and utilization of the American healthcare system by immigrant and refugee communities; and decreased health disparities in and risk factors for cancer, cardiovascular and pulmonary disease.

Grantee 12: **University of Colorado Denver**

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

Project Category: Crosscutting **Funding Recommended: $199,588**
Project Priorities: 1. Collective Action for Collective Impact (Requested) Year 1 (FY13): $199,588
2. Patient Navigation/Case Management Services,
3. Risk /Factor Reduction/Obesity
Target Population: African American/Black, Asian American/Pacific Islander, Latino/Hispanic, Native American/American Indian, White/Caucasian
Geographic Area: Statewide **Counties Served:** All

Project Summary:
Excess weight is an "epidemic within an epidemic" for the 1 in 5 Americans that have a diagnosable mental illnesses and addictions (i.e., behavioral health disorders) during the course of any given year (U.S. DHHS, 1999; NASMHPD, 2008). While the knowledge base for effectively serving the weight management and nutrition needs of this population continues to grow, a substantial science-to-service gap exists. Health weight for persons with behavioral health disorders is a multifaceted problem, and necessitates a comprehensive recovery plan. Through a comprehensive weight control approach, we can bring about systems change for behavioral health, and ultimately increase the life expectancy, decrease disability, and increase quality-of-life for persons with behavioral health disorders.

Year 1 Outcomes
1. Disseminate the Well Body Organizational Self-Assessment to statewide community health organizations. Provide customized feedback weight management programming, policy, services, and motivation to change. Compiled data will drive regional training objective.
2. Conduct two regional Provider Well Body trainings. Organizations will develop SMART goals and individualized rapid improvement projects.
3. Provide tailored TA for behavioral health centers for SMART goals and rapid improvement projects.
4. Conduct two regional Peer-to-Peer Well Body Program trainings for peer specialists providing services at community healthcare facilities.
5. Create a Well Body toolkit for providers providing evidence-based information in community health centers and integrated care settings on policy, design and implementation, and special populations.

6. Create the Peer-to-Peer Well Body Program online video modules, which will serve as a freely available resource on the BHWP website as continuing education for peer trainees.
7. Leverage ongoing state-level relationships to create a Sustainability Recommendations report for well body treatment workflow and payment strategies.

Grantee 13: **Colorado Coalition for the Homeless**

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

Project Category: Crosscutting
Project Priority: Patient Navigation/ Case Management Services
Target Population: Native American/American Indian
Geographic Area: Metro

Funding Recommended: $149,138
(Requested) Year 1 (FY13): $149,138

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

Project Summary:
Colorado Coalition for the Homeless (CCH) proposes a three-year project addressing health disparities of homeless Native American adults in Metropolitan Denver. The project conjoins Native and western medicine by: 1) continuing CCH hosted Talking Circles and 2)introducing Patient Navigation/Case Management to increase access to health care and treatment services. Three Talking Circles will be hosted weekly at two sites frequented by homeless and at-risk Native Americans. Patient Navigation/Case Management will be utilized with the overall objective of increasing access to health care and treatment services and improving health outcomes in the areas of cancer, cardiovascular and pulmonary disease. Services will be provided by culturally competent staff members who have the unique ability to identify with and engage this highly vulnerable population. Patient Navigation/Case Management services will facilitate access to integrated health services, provided at no patient cost to people experiencing homelessness and at affordable rates to people at-risk of homelessness. Integrated health services – including permanent supportive housing - will be delivered by providers participating in project delivered cultural awareness enhancing activities that are implemented by proposed staff members. During the course of the three-year grant period, four hundred (400) homeless Native American adults will be served through the proposed program. All 400 participants will have access to Patient Navigation/Case Management services, including a total of 24 over the three year period who, as a result of project assistance, will move into permanent, supportive housing utilizing the evidence-based practice of Housing First. Additionally, during each year of the proposed project, all CCH newly hired medical, mental health, dental, substance treatment, housing and other supportive service providers serving homeless Native Americans will receive training regarding delivery of culturally competent services to homeless Native Americans.

Grantee 14: **Inner City Health Center**

Project Title: **Promoting Access, Prevention & Coordinated Care**

Project Category:	Crosscutting	**Funding Recommended:**	**$142,636**
Project Priority:	Patient Navigation/ Case Management Services	(Requested) Year 1 (FY13):	$142,636
Target Population:	African American/Black, Asian American/Pacific Islander, Latino/Hispanic, Native American/American Indian, White/Caucasian		
Geographic Area:	Metro	**Counties Served:**	Adams, Arapahoe, Boulder, Denver, Jefferson

Project Summary:
Inner City Health Center provides quality care to vulnerable populations that is accessible, affordable, and focused on prevention.
The objective of this project is to establish an effective and efficient conduit between community efforts that facilitates prevention and early detection of cardiovascular disease and chronic pulmonary disease and direct connection to actual comprehensive primary care for diagnosis, treatment, and continuity of care.

Our Methodology:

1.Inner City Health Center will engage in a three-month planning process to create the system for employing evidenced-based strategies for prevention and early detection of cardiovascular disease and chronic pulmonary disease in community and translating those at risk or with abnormal test results to actual clinical care and treatment.

2. Congregational Health Ministry (the outreach program for Inner City Health Center) will conduct evidence-based strategies in the community to educate, promote awareness, and offer screenings for cardiovascular disease risk factors, and chronic pulmonary disease. We anticipate 250 participants at community health events with 150 of the referred to the clinic for follow-up care.

3. Inner City Health Center will receive those referred from community identified as being at risk or with abnormal test results. The Health Center will be available to serve as a healthcare home and provide primary comprehensive care and treatment. We anticipate communicating will 100% of the 150 individuals referred for follow-up care; with at least 30% of those established as patients maintaining a treatment plan.

Grantee 15: **Poudre Valley Hospital Foundation**

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

Project Category: Crosscutting **Funding Recommended: $133,603**
Project Priorities: 1. Collective Action for Collective Impact (Requested) Year 1 (FY13): $133,603
2. Patient Navigation/Case Management
3. Risk Factor Reduction/Obesity
Target Population: Latino/Hispanic, White/Caucasian
Geographic Area: Metro **Counties Served:** Larimer

Project Summary:
Vida Sana: Uniting for the health equity of Latinos/Coalición Mejorar La Salud De Nuestra Comunidad Latina is a comprehensive, three pronged approach addressing all three priority areas of the Health Disparities Grant Program, including utilizing the strengths of a diverse coalition and three partner organizations to mobilize the Fort Collins Hispanic/Latino community around:
1) increasing access to culturally relevant, evidence based preventative health services and wellness programs for children and adults. This includes neighborhood, worksite and school based policy changes recommended by the Centers for Disease Control to impact obesity and chronic disease rates at the community level (Risk Factor Reduction Programs)

2) establishing a neighborhood based Promotora/Community Health Worker and case management system that replicates an existing, nationally recognized system for women's breast and cervical cancer prevention and treatment but applies to cancer, diabetes and cardiovascular disease prevention (Patient Navigation/Case Management). This proposal also seeks to develop an enhanced network of providers who offer culturally responsive prevention and intervention for chronic disease and associated risk factors among Hispanic/Latinos

3) influencing changes to the built environment to impact the social determinants of health in Fort Collins through comprehensive and inclusive community planning processes involving key community stakeholders and residents. (Collective Action for Collective Impact).

In addition to addressing all three OHD's priority areas, this project addresses all ten essential public health services and is congruent with OHD's vision of "All Coloradans will have an equal opportunity to be healthy regardless of race and ethnicity."

The Community Health Department staff, through Poudre Valley Health System and the CanDo Coalition (Coalition for Activity and Nutrition to Defeat Obesity), have led Vida Sana for the past 18 months, working to integrate the original goals of Vida Sana with CanDo's healthy eating and active living strategies and maximize the effectiveness of the group's work. This proposal seeks to build upon many years of capacity building with Hispanic/Latinos and agencies who work closely with them to make lasting impacts on systemic changes that eliminate health disparities.

As a result of participation and collaboration with Vida Sana: Uniting for the Health Equity of Latinos/Coalición Para Mejorar La Salud de Nuestra Comunidad Latina Project, Hispanic/Latinos in Fort Collins will have increased levels of physical activity, healthy eating, and perceptions of safety in the community. This proposal will further the creation of a network of culturally competent health providers to address lifestyle factors such as healthy eating, physical activity and diabetes management with community members. This proposal seeks to amplify the efforts on which Vida Sana coalition members have been working for more than three years, including the successful implementation of increased opportunities for physical activity in one area recreation center, advocating for policy change to community planning efforts in their neighborhoods and schools, and creating a comprehensive network of resources for lifestyle interventions. In doing this work, coalition members

and the Hispanic/Latino community have identified the need for a Promotora/Community Health Worker (CHW) program (similar to one that exists for women's breast and cervical cancer prevention/treatment), culturally responsive and low or no cost referral sources for healthy eating, physical activity, children's programming (in neighborhood) and the absence of such resources as a major factor in diabetes, cancer, and cardiovascular disease prevention. This project will also foster increased linkages between schools, faith communities, and social service agencies to address health disparities among Hispanic/Latinos in Fort Collins. Lastly, a comprehensive and culturally relevant campaign will be designed and implemented by coalition members to address the benefits of investing in wellness and health as well as increasing community members' (both Latinos and non-Latinos) understanding of health disparities in Fort Collins and how one's zip code or country of origin can be a matter of life or death.