



COLORADO

Department of Public
Health & Environment

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To: Members of the State Board of Health

From: Rick Brown, Chair, Cancer, Cardiovascular Disease and Pulmonary Disease Grants Program Review Committee

Andrea Wagner, MA, Manager, Cancer, Cardiovascular Disease and Pulmonary Disease Grants Program

Through: Elizabeth M. Whitley, PhD, RN, Director, Prevention Services Division, CDPHE *EW*

Larry Wolk, MD, MSPH, Executive Director, CDPHE *LW*

Date: July 20, 2016

Subject: **Request for approval of Cancer, Cardiovascular Disease and Pulmonary Disease Grants Program Review Committee funding recommendation for new grant projects and Healthy Colorado Kids Survey funding for fiscal years 2017-2018**

The Review Committee for the Cancer, Cardiovascular Disease and Pulmonary Disease (CCPD) Grants Program (Grants Program) respectfully requests approval of:

- The enclosed recommended grants for a total amount of up to **\$7,999,897** in fiscal years 2017 and 2018 to begin October 1, 2016 and concluding June 30, 2018.
- An increase in funding to support the analysis, local utilization, and administration of data from the Healthy Colorado Kids Survey in the amount of **\$80,000** in fiscal years 2017 and 2018 (to begin July 1, 2016 and end June 30, 2018). This is an additional \$40,000 each year for two years.

Total amount of this request for approval: **\$8,079,897**

Enclosed with this memo is the CCPD Grants Program Funding Recommendations for New Grant Projects for Fiscal Years 2017 and 2018, the application review processes and the resulting decisions and recommendations.

Per statute, the review committee shall submit to the executive director of the department recommended grant recipients, grant amount and the duration of each grant. Dr. Larry Wolk has reviewed and concurs with the recommendations of the review committee for grant awards. Per statute, the Review Committee's funding recommendations for projects impacting rural areas were presented to the Executive Director of the Department of Local Affairs. On June 24, 2016, Irv Halter, Executive Director of the Department of Local Affairs, was notified of the CCPD Review Committee's funding recommendations.

Please contact Andrea Wagner, CCPD Grants Program Manager, at 303-692-2516 with any questions or requests for additional information prior to the Board of Health meeting.

Background:

The Nov. 13, 2015 meeting of the Cancer, Cardiovascular and Pulmonary Disease (CCPD) Review Committee included an overview of the 2015-16 Prevention, Early Detection, and Treatment Fund that supports the CCPD grants program and an examination of the current balances of that fund. The balance was comprised of the following elements:

- Fund reversions from grantees who did not spend down all of their awards
- Reduced spending by grantees conducting Cancer Screening Programs
- Additional, unforeseen revenues from tobacco taxes
- The recurring minimal balance reserved for future years

These contract reversions and reduced spending can mainly be attributed to recent improvements in the health care landscape of Colorado, primarily through the state's implementation of the Affordable Care Act (ACA), which expanded coverage for prevention services for many thousands of additional Coloradans.

At the December 2015 Review Committee meeting, the committee decided to award approximately \$4 million in projected additional revenue per year for the next 2 years (FY17 and FY18), to implement an approach which includes:

1. Funding current grantees up to a 15% increase to expand their existing work,
2. Setting aside the additional program resources for expanded evaluation and other needs to support grantees, and
3. Distributing the remaining funds available through a new funding opportunity (Request For Applications).

This funding recommendation and approval request is associated with items two (2) and three (3).

Recent Application & Funding Recommendation Process:

Following approval by the CCPD Review Committee, the CCPD grants program began implementing an open competitive funding opportunity through a Request for Applications (RFA) process for FY 2017 (year 2) and FY 2018 (year 3) of the current funding cycle.

With guidance from the CCPD Review Committee, the grants program released RFA #2584 on February 23, 2016 to supplement its existing portfolio of grant work. The intent of the RFA was to fund a subset of the 17 evidence-based strategies of the current portfolio and also to provide an opportunity for applicants to propose evidence-informed innovative strategies that advance the goals of the committee and program. Applications prioritized under this funding opportunity included those that focused on reducing health disparities and: 1) were not currently receiving CCPD grant funding or 2) proposed evidence-informed innovations.

On April 8, 2016, the CCPD Grants Program received 35 applications in response to the RFA opportunity, for a total request of \$16,669,766 for FY17 & FY18.

The grant program conducted a multi-stage review process to determine which applications met the RFA requirements and would be recommended for funding. This included:

1. A programmatic review during the application intake process to ensure applications met minimum qualifications
2. Grouping applications by focus area and assigning groups of applications to teams of reviewers. Each team was comprised of at least three (3) subject matter experts (e.g. CCPD Review Committee members, CDPHE Chronic Disease program staff, Kaiser Permanente evaluation project staff, and external partners with expertise in Chronic Disease prevention)

3. A detailed independent review of each application by team members. Each member of the review teams were provided with the same applications and same scoring methodology/tool to provide an objective score for each application
4. A team review and discussion of the applications to determine scoring and ranking of applications prioritized for funding, and
5. A public meeting (the Funding Conference), held on May 13, 2016, during which review teams presented and discussed all applications prioritized for funding recommendations for the CCPD Review Committee.

Funding Decisions:

On May 13, 2016, during the Funding Conference and CCPD Review Committee meetings, new projections for the CCPD Grants Program budget were provided. The new projected balance for the next two fiscal years (FY17 & FY18), increased from \$2 million each year (at the time the RFA was released) to \$4 million each year, or \$8 million total, to fund new CCPD grants.

With this new budget information, the Funding Conference resulted in recommending seventeen (17) new grant projects in total of \$7,999,897 for 2 years, to the CCPD Review Committee. On May 13, 2016, the CCPD Review Committee discussed the funding recommendations and voted to approve the recommendations to present to the Board of Health for funding awards. *(Funding is contingent upon satisfactory performance and funding availability.)*

Recommended Amounts by Funding Categories:

**Table numbers have been rounded and may vary slightly*

Statutory Program Categories - Entire Community Grantee Portfolio FY 16-18 (3 year) grants + FY 17-18 (2 year) grants	Total Amounts	Percent of Total
Cancer (including Healthy Eating and Active Living)	\$16,479,923	36%
CVD (including Healthy Eating and Active Living)	\$22,646,104	50%
Pulmonary	\$6,261,796	14%
Treatment	\$912,095	2%
Rural	\$12,397,800	27%

Healthy Eating Active Living work is divided 50%/50% between cancer and cardiovascular disease.

Statutory Program Categories - RFA #2584 (FY 17-18, 2 year grants)	2 Year Total Amounts	Percent
Cancer (including Healthy Eating and Active Living)	\$2,281,346	28%
CVD (including Healthy Eating and Active Living)	\$4,728,837	58%
Pulmonary	\$989,714	14%
Treatment	\$888,995	11%
Rural	\$1,808,603	23%

Healthy Eating Active Living work is divided 50%/50% between cancer and cardiovascular disease.

Strategy Categories - RFA #2584 (FY 17-18, 2 year grants)	2 Year Total Amounts	Percent of Total
Healthy Eating and Active Living	\$1,767,678	22%
Cancer	\$1,397,507	18%
Cardiovascular Disease	\$3,844,998	48%
Pulmonary	\$989,714	12%
Total	\$7,999,897	100%

FY 2016-18 CCPD Grants Program Funding Portfolio Summary

BOH approval date	Grantees & projects	Up to FY16 \$ Amount	Up to FY17 \$ Amount	Up to FY18 \$ Amount	Up to 3yr/project \$ Amount
February 18, 2015	Community grantees - CCPD strategy projects	\$11,528,263	\$11,521,955	\$11,520,125	\$34,570,343
May 15, 2015	CEPEG - TABS on Health Surveillance administration	\$300,000	N/A	N/A	\$300,000 (one year request)
July 15, 2015	Kaiser Permanente - CCPD and Health Disparities grants program evaluation	\$800,000	\$800,000	\$800,000	\$2,400,000
February 17, 2016	CEPEG - Healthy Kids CO Survey (HKCS) administration	\$10,000	\$10,000	\$10,000	\$30,000
April 20, 2016	Community grantees - CCPD strategy projects (EXPANSION for existing community grantees)	N/A	\$1,523,238	\$1,522,078	\$3,045,316
April 20, 2016	Kaiser Permanente - CCPD and Health Disparities grants program evaluation (EXPANSION to support an anticipated 7-8 new grantees via RFA #2584)	N/A	\$120,000	\$120,000	\$240,000
July 20, 2016	Community grantees - CCPD strategy projects (RFA #2584, FY 17-18) (17 agencies - 17 projects)	N/A	\$4,052,124*	\$3,947,773*	\$7,999,897*
July 20, 2016	CEPEG - Healthy Kids CO Survey (HKCS) administration for FY17 & FY18 - Increase in funding to current vendor	N/A	\$40,000*	\$40,000*	\$80,000*
TBD	Additional program resources for expanded evaluation, Training and TA, and other needs to support grantees	N/A	TBD	TBD	TBD
TOTALS		\$12,638,263	\$18,067,317*	\$17,959,976*	\$48,665,556*

**Pending BOH approval in this request; numbers have been rounded and may vary slightly*

The following sections of this document list the recommended applications for funding by strategy categories. Please note that all funds recommended are listed as "not to exceed." The information contained in the project summaries has been abstracted from the applications with minor edits by program staff. The final award amounts, as well as the scopes of work/project details, will be determined as scope of work and budget negotiations are completed. The grantee may receive less than the total listed as recommended by the CCPD Review Committee and presented to the Colorado Board of Health, and the details of the project may differ from the project summaries that were submitted during the application process and used in this document.

**Requests for Programs in Healthy Eating and Active Living
(Cancer and Cardiovascular Disease Prevention)**

[Recommendations are listed in alphabetical order by the lead agency.]

Applicant	Recommended 2 Year Amount	Strategy	Rural
Larimer County Department of Health and Environment	\$599,576.00	Regional, county, or municipal policies that lead to the development of enhanced access to walking, biking and other physical activity; and combination of approaches in non-clinical settings including education, promotion, awareness, and policy/systems interventions.	0
Livewell Longmont	\$596,987.50	Regional, county, or municipal policies that lead to the development of enhanced access to walking, biking and other physical activity, and technical assistance (at the county or municipal level) that supports access to healthier food retail in underserved areas.	0
North Colorado Health Alliance	\$157,224.00	Regional, county, and municipal policies that support the consumption of healthy foods and beverages in government settings, public venues and worksites.	0
Total	\$1,353,787.50		

Applicant Agency: Larimer County Department of Health and Environment
Project Name: Larimer Built Environment
Disease Category: Cancer and Cardiovascular Disease via Health Eating/Active Living (HEAL)
Strategy(ies): Strategy 1 - Regional, county, or municipal policies that lead to the development of enhanced access to walking, biking and other physical activity.
 Strategy 8 - Combination of approaches in non-clinical settings including education, promotion, awareness, and policy/systems interventions.
Funding: FY17: \$314,532 FY18: \$285,044 **Total: \$599,576**
Counties to serve: Larimer
Project Description (from application):

Larimer County Department of Health and Environment’s (LCDHE) proposal serves to develop and influence built environment policies and infrastructure in Loveland, Fort Collins and within unincorporated Larimer County to impact access to physical activity opportunities among communities including those who experience health disparities. Additionally, funds will be used to build organizational infrastructure capacity to address obesity prevention strategies. This project will take a unique look at built environment infrastructure, policy gaps and opportunities for improved policy implementation as they relate to affordable housing in our area, particularly mobile home parks that fall within growth management areas of the two cities. With funding from CCPD LCDHE will create an active living coalition, inventory infrastructure gaps, policies, and conduct key informant interviews to identify opportunities to provide technical assistance to

municipalities, county and affordable housing organizations. This will be coalesced into an active living plan that will include prioritized evidence-based policy recommendations.

Since 2004, this coalition driven work has increased community capacity, built momentum and created the community and political will for future system and environmental changes to address obesity prevention in Larimer County. Funding from CCPD will facilitate the transition of HEAL leadership from UHealth to LCDHE and will allow for the expansion of coalition efforts into Larimer County, rather than just focusing on the geographical scope of Cities of Loveland and Fort Collins. This transition strategy aligns with the state's obesity plan to build capacity among local public health agencies to lead these efforts in Colorado and create a statewide movement to reduce obesity

Applicant Agency: Livewell Longmont
Project Name: Working together for one healthy Longmont
Disease Category: Cancer and Cardiovascular Disease via Healthy Eating/Active Living (HEAL)
Strategy(ies): Strategy 1 - Regional, county, or municipal policies that lead to the development of enhanced access to walking, biking and other physical activity.
Strategy 3 - Technical assistance (at the county or municipal level) that supports access to healthier food retail in underserved areas.
Funding: FY17: \$276,987.50 FY18: \$320,000 Total: \$596,987.50
Counties to serve: Boulder
Project Description (from application):

Working Together for One Healthy Longmont (One Healthy Longmont) supports Longmont residents most impacted by health disparities and chronic disease by building community member capacity to successfully advocate for improvements in their built environment and access to healthy food. LiveWell Longmont will serve as the backbone agency for the One Healthy Longmont initiative. Using a nationally-recognized engagement, training, and skills-building program, LWL will elevate the leadership of established and emerging Latino leaders living in and advocating on behalf of Longmont neighborhoods. The prioritized neighborhoods face high poverty rates (over 27%) and are home to high proportions of Latino residents, two social determinants correlated with health disparities, especially in chronic disease rates. With LWL collaboration, these leaders will more effectively identify and address barriers in the built environment while improving retail access to healthy food options in their neighborhoods.

The One Healthy Longmont approach is to address policies, systems and environmental changes within a defined geographic neighborhood within the City of Longmont. We will achieve and advance the goals of Strategy 1: Built environment with municipal policies that lead to the development of enhanced access to walking, biking, and other physical activity.

The One Healthy Longmont Application will also work to address policies, systems and environmental changes within a defined Longmont geographic neighborhood through Strategy 3: Healthy Food Retail - technical assistance at the municipal level that supports access to healthier food retail in underserved areas.

By identifying strategies with the City and recommending improvements within the prioritized neighborhoods while at the same time piloting a Healthy Food Retail Initiative within Longmont's food desert the health disparities in Longmont's Latino communities will be reduced by mid-2018.

By executing a community-led, neighborhood focused approach, those residents facing the most health disparities will build collective advocacy in Longmont changing future policymaking.

Applicant Agency: North Colorado Health Alliance
Project Name: Healthy Food and Beverage Policies in Weld County
Disease Category: Cancer and Cardiovascular Disease via Healthy Eating/Active Living (HEAL)
Strategy(ies): Strategy 4 - Regional, county, and municipal policies that support the consumption of healthy foods and beverages in government settings, public venues and worksites.
Funding: FY17: \$78,612 FY18: \$78,612 **Total: \$157,224**
Counties to serve: Weld
Project Description (from application):

This project serves to advance healthy food and beverage policies within public venues and institutions so that healthier choices are easier, more practical, and more available to Weld County residents. Weld County faces significant challenges in preventing and controlling chronic disease, and poor nutrition and obesity are major risk factors for many chronic diseases. Implementing healthy food and beverage policies can work to change individual factors, social factors, and environmental factors, making healthier food and beverages more readily available, affordable, and appealing.

Since public venues and institutions serve people of all ages and backgrounds, implementing healthy food and beverage policies at the regional, county, and municipal levels can have an especially broad impact for Weld County residents. The intended audience for the proposed project is children and adults in Weld County, with a priority focus on minority populations and those living in Greeley/Evans.

Key objectives include: 1) establishing a Healthy Foods and Beverages Steering Committee, 2) conducting a comprehensive assessment of food environments, 3) adopting a model healthy food and beverages policy, and 4) implementing policy guidelines in key settings. Expected outcomes include: 1) established Healthy Food and Beverages Steering Committee, 2) comprehensive assessment report of existing food and beverage policies and practices, 3) model healthy food and beverage policy, and 4) increased number of settings that adopt and implement policy guidelines for healthy food and beverages.

Requests for Programs for the Prevention, Early Detection and Treatment of Cancer
[Recommendations are listed in alphabetical order by the lead agency.]

Applicant	Recommended 2 Year Amount	Strategy(ies)	Rural
Summit Community Care Clinic	\$181,262.00	Cancer: Provider/Clinic Interventions and Clinical Systems Quality Improvement	100%
University of Colorado Denver Cancer Center	\$434,590.00	Cancer: Provider/Clinic Interventions (survivorship)	30%
University of Colorado Denver School of Public Health	\$781,655.00	Combination of approaches in non-clinical settings including (skin cancer prevention) education, promotion, awareness, and policy/systems interventions	22%
Total	\$1,397,507.00		

Applicant Agency: Summit Community Care Clinic
Project Name: CCPD Grant Program for Summit Community Care Clinic
Disease Category: Cancer
Strategy(ies): Strategy 6 - Cancer: Provider/Clinic Interventions, and Strategy 11 - Clinical Systems Quality Improvement
Funding: FY17: \$90,631.00 FY18: \$90,631.00 **Total: \$181,262.00**
Counties to serve: Chaffee, Grand, Lake, Park and Summit
Project Description (from application):

This project’s goal is to increase colorectal cancer screening, lung cancer, and other screening rates and HPV immunization rates among eligible patients of the Summit Community Care Clinic (SCCC). Patients at SCCC experience a variety of barriers to accessing, high quality, affordable health care. Some of the barriers faced by patients include income, housing, transportation, language and health literacy. Patients also experience a higher rate of chronic disease than the general population and have a lower compliance rate for general cancer screening and immunization recommendations.

To achieve the above goal, the SCCC intends to complete four key steps. The first step will be to collect an accurate baseline of patients needing screening or immunization services. A data clerk will review current records and secure an accurate screening and immunization history for current patients. Once an accurate history is established, an assessment of the current reminder system will be undertaken. Improvements to the system that flags patients to receive a reminder will be made. A registered nurse, working in collaboration with the health teams, will then outreach to patients out of compliance or needing a first time screening or immunization.

In addition to improvements in the reminder system, changes and enhancements will be made to the SCCC’s policies and procedures related to screening and immunizations. All staff will be trained in the new protocols. Additional trainings will occur throughout the SCCC on the value of screening and the various community resources that are available which support patients with follow up and navigation related to cancer treatment. Finally, a renewed focus and commitment will be made by the medical provider to ensure 100% of SCCC patients are provided with the proper cancer screening recommendations at 100% of primary care visits.

Applicant Agency: **University of Colorado Denver Cancer Center**
Project Name: **Building Capacity for Quality Cancer Survivorship Care**
Disease Category: **Cancer**
Strategy(ies): **Strategy 6: Cancer: Provider/Clinic Interventions**
Funding: **FY17: \$216,762* FY18: \$217,828* Total: \$434,590.00**
Counties to serve: **Statewide**
Project Description (from application):

The proposed project will increase the delivery of patient specific treatment summaries and self-care plans (TS/SCPs) in Colorado. We will build vital capacity in the delivery of survivorship TS/SCPs in Colorado through the development of a novel virtual e-learning community using the Project ECHO (Extension for Community Health Outcomes) platform. Project ECHO uses case-based, team-based learning combined with input from experts to create virtual e-learning communities, which has been a successful strategy in improving care delivery in other chronic conditions especially in rural and underserved areas.

Additional activities include formative and summative evaluations with the following components: 1) Bi-annual statewide assessment via online survey of existence of cancer treatment summary and care plans for pre/post program comparison (i.e. assess baseline levels of delivery and again at project end); 2) key informant interviews of survivorship care providers to determine needs and themes for proposed ECHO sessions, 3) reporting of workflow capacity and best practices for survivorship care/care plan delivery through in-depth post-program site evaluation. Additionally, we will provide technical assistance and a web-based repository for survivorship resources in Colorado to promote translation and implementation of materials from the ECHO sessions.

****adjusted amounts approved by the Board of Health on July 20, 2016.***

Applicant Agency: **University of Colorado Denver School of Public Health**
Project Name: **Multi-component, campus-wide programs to reduce environmental, policy, and behavioral risks for skin cancer at colleges and universities in Colorado**
Disease Category: **Cancer**
Strategy(ies): **Strategy 8 - Combination of approaches in non-clinical settings including education, promotion, awareness, and policy/systems interventions.**
Funding: **FY17: \$399,451 FY18: \$382,204 Total: \$781,655**
Counties to serve: **Boulder, Denver, El Paso, Gunnison, La Plata, Larimer, Mesa, Pueblo and Weld**
Project Description (from application):

The project serves to reduce the incidence of melanoma and non-melanoma skin cancer in Colorado by increasing the use of sun protection and decreasing indoor tanning and other ultraviolet (UV) exposure behaviors among young adults attending colleges and universities in nine Colorado counties. The project will engage Colorado colleges and universities in a multicomponent, campus-wide skin cancer prevention initiative addressing key environmental, policy, educational, and attitudinal factors to reduce indoor tanning and increase effective sun protection practices among young adults. It is based on the Skin Smart Campus Initiative, a program sponsored by the National Council on Skin Cancer Prevention and supported by the MD Anderson Cancer Center. It also incorporates evidence-based intervention strategies shown to be effective in reducing skin cancer risk behaviors among young adults. We will partner with 10

college and university campuses across Colorado to identify, implement, and enforce environmental and policy changes known to reduce skin cancer risks on college campuses and to incorporate evidence-based skin cancer prevention education into the health and wellness programs provided to the college community. At the end of the project period, all participating sites will have developed and implemented a comprehensive plan for reducing risks from UV tanning and for improving sun protection practices in their campus community, including provisions for enforcement. They will have also implemented a multi-pronged educational program for students and other members of the campus community, including the delivery of a UV photography intervention to highlight sun-induced skin damage and the dissemination of an interactive web-based, multi-media tool that provides tailored skin cancer prevention education about the risks of indoor tanning and benefits of sun protection.

Requests for Programs for the Prevention, Early Detection and Treatment of Cardiovascular Disease

[Recommendations are listed in alphabetical order by the lead agency.]

Applicant	Recommended 2 Year Amount	Strategy(ies)	Rural
American Diabetes Association	\$296,786.00	National Diabetes Prevention Program (DPP)	0
Center for African American Health	\$434,400.00	National Diabetes Prevention Program (DPP)	0
Clinical Tepeyac	\$377,342.00	Evidenced-Informed Innovation focused on Community Clinical Linkages	0
Colorado Coalition for the Homeless	\$400,000.00	Clinical Systems Quality Improvement	46%
Denver Health and Hospital Authority	\$1,099,553.00	Clinical Systems Quality Improvement	0
Southeast Mental Health Services	\$296,852.00	National Diabetes Prevention Program (DPP)	100%
University of Colorado Denver Department of Family Medicine	\$526,174.00	Self-measured blood pressure monitoring	100%
Total	\$3,431,107.00		

Applicant Agency: American Diabetes Association
Project Name: ADA Diabetes Prevention Program - El Paso County
Disease Category: Cardiovascular Disease
Strategy(ies): Strategy 12: National Diabetes Prevention Program (DPP)
Funding: FY17: \$148,393 FY18: \$148,393 **Total: \$296,786.00**
Counties to serve: El Paso
Project Description (from application):

American Diabetes Association (ADA)- Colorado Area plans to implement the evidence-based Diabetes Prevention Program (DPP) among 200 (80 in year one and 120 in year two) high-risk, monolingual Spanish-speaking Latinos in El Paso County. We chose this vulnerable population because of their documented health outcome disparities related to prediabetes and related modifiable risk factors. Our project will also use promotoras to provide health education to increase awareness and knowledge of prediabetes and modifiable risk factors. Our project will also focus on improving community and clinical linkages and addressing risk factor reduction and disease prevention.

Applicant Agency: Center for African American Health
Project Name: Fit, Body and Soul (Diabetes Prevention Program)
Disease Category: Cardiovascular Disease (including Diabetes)
Strategy(ies): Strategy 12: National Diabetes Prevention Program (DPP)
Funding: FY17: \$217,200 FY18: \$217,200 **Total: \$434,400**
Counties to serve: Adams, Arapahoe, Boulder, Denver and Jefferson
Project Description (from application):

The Center for African American Health (the Center) is requesting \$217,200 per year for two years to implement the *Fit Body and Soul* DPP curriculum. The *Fit Body and Soul* is a CDC approved Diabetes Prevention Program (DPP) that has been tailored to the needs of African Americans. The DPP program is an evidence-based year-long program that addresses the risk factors for diabetes and cardiovascular diseases through physical activity and healthy living strategies. Through improving dietary behaviors and increasing physical activity, *Fit Body and Soul* leads to modest weight loss, lowered blood sugar and reduce future risk of type 2 diabetes. The primary outcomes for the project are weight loss (at least 7% of baseline body weight) and increased physical activity (at least 150 minutes of moderate intensity exercise/ week). Secondary outcomes include improved dietary choices, and reduction in blood sugar.

The Center has been a leader in implementing evidence-based programs for African Americans in the Denver metro area. With funding through CCPD, the Center will expand this powerful program to reach 400 (175 in year one and 225 in year 2) African-Americans with prediabetes or at high risk.

Applicant Agency: Clinica Tepeyac
Project Name: Linking Communities and Care to Reduce Chronic Disease Among At-Risk Residents in GES
Disease Category: Cardiovascular Health (including Diabetes)
Strategy(ies): Evidenced-Informed Innovation focused on Community Clinical Linkages
Funding: FY17: \$193,234 FY18: \$184,108 **Total: \$377,342**
Counties to serve: Denver
Project Description (from application):

Clínica Tepeyac (Clínica) requests funding for an innovative, community-level approach to reduce chronic disease disparities (specifically cardiovascular disease) in the low-income, predominantly Latino Globeville, Elyria and Swansea neighborhoods (referred to as GES) in Denver, Colorado. There is existing evidence that residents of GES are disproportionately at risk for chronic disease, and specifically cardiovascular disease. The project will address this evidence through three major deliverables. The first is a community health assessment (CHA) that is led by nonprofits in GES, informed by GES residents, and administered by culturally responsive community health workers. The CHA will examine the health profile of GES and seek feedback from GES on the resources and linkages they need to achieve health. The second deliverable is the development of an innovative, data sharing infrastructure and agreement between four leading GES nonprofits. This structure will enable these providers to more effectively meet the needs of residents and link them with care and health services. Furthermore, this infrastructure will build upon the Clínica's work in providing DPP through increased collaboration. Third, the CHA will explore the common barriers that keep otherwise likely candidates for DPP from participating in completing DPP. This will enable project partners to assess DPP barriers and formulate an alternative, DPP-based curriculum that builds on DPP concepts and increases the readiness of participants to be able to participate in DPP. The expected outcomes are that GES community organizations will strengthen collaboration through data-sharing, leading to improved services and better linkage to health services and care; that the CHA will provide insight on how organizations can better serve residents in overcoming chronic disparities; and at least 150 at-risk GES community members will access DPP or a community responsive diabetes prevention curriculum and reduce Latinos' rate of diabetes (a precursor to cardiovascular disease).

Applicant Agency: Colorado Coalition for the Homeless
Project Name: CCH Chronic Disease Registry: Bridge to Integrated Care Coordination
Disease Category: Cardiovascular Disease (including Diabetes)
Strategy(ies): Strategy 11: Clinical Systems Quality Improvement
Funding: FY17: \$200,000 FY18: \$200,000 Total: \$400,000
Counties to serve: Adams, Arapahoe, Baca, Bent, Boulder, Broomfield, Denver, Douglas, Las Animas, Jefferson, Otero, Prowers, Pueblo
Project Description (from application):

The Colorado Coalition for the Homeless' (CCH) proposed project will implement clinical system level changes to improve access, early interventions and evidenced-based treatment strategies for homeless patients experiencing chronic diseases in metro Denver and southeastern Colorado. Our project—*Population Management Tool: Bridge to Improving Point of Care and Integrated Care Coordination*—focuses on Health Systems. Specifically, the project addresses Strategy 11, Clinical Systems Quality Improvement.

CCH will enhance our current electronic health record (EHR) with a population management data tool to provide point-of-care guides for primary care visits, create patient registries and direct the work of care teams. Care coordination teams will be trained on the population management tool, allowing them to identify interventions at patient appointments to improve health outcomes for patients with cardiovascular disease, diabetes, hypertension, and tobacco use disorder. People experiencing and at-risk for homelessness have specific health care access and treatment adherence challenges, and can benefit from tailored patient treatment plans, navigation and care coordination services.

The deliverables for the project are quarterly reports to CDPHE summarizing the progress on measurements of expected results and annual reports summarizing progress on activities and expected results during the period. CCH expects the following outcomes:

1. Increase in the number of tobacco cessation interventions.
2. Increase in the number of behavior health and disease-specific interventions.
3. Increase in early interventions to prevent progression of diabetes, hypertension, and cardiovascular disease.
4. Increase in point of care interventions to prevent poor cardiovascular disease outcomes.
5. Completed implementation of a system of care coordination to improve management of sub-populations of patients with cardiovascular disease

By the end of the two-year grant period, CCH will implement this population management workflow into all of our integrated care teams at the Stout Street Health Center and our satellite clinics.

Applicant Agency: Denver Health and Hospital Authority
Project Name: Community Resource Inventory Service for Patient e-Referral (CRISPeR)
Disease Category: Cardiovascular Disease
Strategy(ies): Strategy 11 - Clinical Systems Quality Improvement
Funding: FY17: \$500,476 FY18: \$599,077 Total: \$1,099,553
Counties to serve: Adams, Arapahoe and Jefferson
Project Description (from application):

This project serves to optimize electronic health records (EHR) systems to enable e-Referral to evidence-based, patient-tailored, diabetes prevention, treatment, and management plans.

The project will: 1) create a process to maintain a comprehensive, accurate, and timely inventory of community resources, 2) facilitate access to resource inventories by increasing automated search capacity when providers seek patient-specific community resources, 3) establish a HIPAA compliant e-Referral hub, and 4) deploy the e-Referral hub to share referral information (i.e., requests and service summaries) between providers' EHRs and community-based resources/organizations. An e-Referral to community based resources will enable providers to more thoroughly assist patients as they engage with community assets to support chronic disease management.

By the end of year 1, we will have completed a comprehensive business analysis to generate comprehensive and precise documentation for business, technical, and governance requirements for each component and respective participants. Through careful requirements detailing, the correct technical solution will be designed and built to meticulous business specifications. A governance process will be developed to assure regulatory compliance, respect participants' contributions, and maximize collective success by leveraging competencies and skills. The technical solution will align with clinical workflow and increase information flow. The resultant inventory system will have capacity to ultimately address community resource needs for all CCPD focus areas. By the end of year 2, pilot community resource e-Referral implementation will be deployed to at least six different community-based organizations and two federally qualified health centers in the Denver Metro region. These pilots will serve as a model for extension across Colorado; a community of practice and roadmap will be established to support expansion to additional regions, community resources and providers in subsequent years.

Applicant Agency: **Southeast Mental Health Services**
Project Name: **National Diabetes Prevention Program**
Disease Category: Cardiovascular Disease
Strategy(ies): Strategy 12 - National Diabetes Prevention Program
Funding: FY17: \$148,426 FY18: \$148,426 Total: \$296,852
Counties to serve: Baca, Bent, Crowley, Kiowa, Otero, Prowers
Project Description (from application):

Southeast Health Group (SHG), a fully-integrated physical and behavioral health provider serving Baca, Bent, Crowley, Kiowa, Otero and Prowers counties in southeastern Colorado, respectfully requests a CCPD grant in the amount of \$148,426 per year for two years. SHG intends to hire and train 2.0 FTE bachelor-level Lifestyle Coaches to implement Focus Area 3: Community-clinical Linkages/Approach A/Strategy 12: National Diabetes Prevention Program (DPP) throughout southeastern Colorado. SHG will apply to become a CDC-recognized DPP program, with the goal of reducing the number of pre-diabetic patients in southeastern Colorado who are diagnosed with type 2 diabetes through lifestyle change.

The DPP program is a CDC-recognized, group-based program which is proven to prevent type 2 diabetes, and can be taught by trained non-professionals in community-based settings. Research has shown that people with prediabetes who take part in a structured lifestyle change program can cut their risk of developing type 2 diabetes by 58% (71% for people over 60 years old). Follow-up studies 10 years after completing the program have shown that people who completed a diabetes prevention lifestyle change program were one third less likely to develop type 2 diabetes.

SHG will accept referrals of eligible patients at risk for developing diabetes from area primary care physicians (PCP's), federally qualified health centers (FQHC's), departments of public health, and the in-house primary care team to participate in the DPP classes, and provide screening with the paper/pencil CDC Prediabetes Screening Test at outreach events. SHG will recruit 30-45 patients to participate in the DPP classes over a two-year period in La Junta, Lamar and Springfield. Patients enrolled in the DPP program will have access to a facility that offers fitness equipment and classes. Staff will participate in bi-monthly meetings of the Colorado DPP work group, and upload referral and program data to the CDC & CDPHE databases.

Applicant Agency: **University of Colorado Denver Department of Family Medicine**
Project Name: **The Just Check It Program: A Public Health - primary care partnership to reduce cardiovascular risk**
Disease Category: Cardiovascular Disease
Strategy(ies): Strategy 9 - Self-measured blood pressure monitoring
Funding: FY17: \$334,020 FY18: \$192,154 Total: \$526,174
Counties to serve: Bent, Cheyenne, Kiowa, Logan, Morgan, Otero, Phillips, Prowers, Sedgwick, Washington, Yuma
Project Description (from application):

Just Check It (JCI) is a multi-component home blood pressure (BP) management program for Colorado that actively engages primary care providers and clinics and local public health agencies. JCI translates evidence-based strategies for the prevention and early detection of cardiovascular disease into practical application in clinical and community settings, offering tangible toolkits (including validated home blood pressure monitors for patients) education, an information-sharing system (using the HIPAA secure JCI Registry for patients to store, review, and share their home BP measurements) and technical assistance. JCI has been developed over eight years and evaluated in rural and urban safety net clinics and community-based organizations. JCI is ready to for scaling to a statewide program. We propose to begin dissemination and implementation in public health and primary care practices in rural and frontier eastern Colorado. This proposed program grows a partnership with public health agencies to implement JCI promotional and enrollment activities through their existing prevention programs and newly identified community venues and expands program utilization at primary care settings. Our deliverables focus on an extensive engagement of 2,000 patients, five local public health departments, and 25 primary care practices in rural eastern Colorado. Outcomes include: 1) enrollment of 2000 residents over 2 years, 2) an average decrease of at least 6/4 mmHg in average home BP program participants, 3) an increase of 40% in the proportion of participants at target home BP levels over baseline, 4) a paper and online version of the *Just Check It* community awareness and implementation materials for continued use in eastern Colorado and for dissemination to other underserved communities, and 5) an increased number of primary care practices trained in coding and billing for telehealth hypertension care.

Requests for Programs for the Prevention, Early Detection and Treatment of Pulmonary Disease

[Recommendations are listed in alphabetical order by the lead agency.]

Applicant	Recommended 2 Year Amount	Strategy	Rural
National Jewish Health	\$317,974.00	School-centered multi-component asthma management	100%
University of Colorado Denver Department of Pediatrics	\$671,740.00	Evidenced-Informed Innovation of Community Clinical Linkages	0
Total	\$989,714.00		

Applicant Agency: **National Jewish Health**

Project Name: **San Luis Valley School-Centered Comprehensive Asthma Management Program**

Disease Category: **Pulmonary Disease**

Strategy(ies): **Strategy 14 - School-centered multi-component asthma management**

Funding: **FY17: \$159,134 FY18: \$158,840 Total: \$317,974**

Counties to serve: **Alamosa, Mineral, Rio Grande and Saguache**

Project Description (from application):

The goal of the proposed project is to build-capacity within schools to partner effectively with health providers and families through implementation of an evidence-based school-centered asthma program to improve asthma management and decrease health and educational disparities associated with poorly controlled asthma. The project will occur in the rural-frontier San Luis Valley (SLV), a region characterized by risk factors for health disparities, and will target students with asthma and their families, health care providers and schools in Creede, Center, Del Norte, Sargent, and Sangre de Cristo school districts. SLV risk factors for disparities include a large percentage of the population living in poverty, being of Hispanic descent, and living in a chronically underserved health care region. Children and youth of the SLV have higher asthma prevalence rates, 12-14% compared to the state average of 10%. Our school-centered asthma program aligns perfectly with the CCPD program goal to address disparities in Colorado by implementing evidence-based programs to narrow disparities and advance health equity. Our project consists of six steps: 1) Identify students with asthma; 2) Assess asthma risk level; 3) Secure essential supports for successful management at school; 4) Provide self-management education to students; 5) Provide case management for at-risk students with asthma; and 6) Prepare for the next school year. A cross cutting program activity is communication and coordination among students and their families, health providers and schools for successful asthma management. Expected project outcomes will be improvements in student preparedness to successfully manage asthma at school (completed Colorado School Asthma Management Plans with accompanying inhaler), student asthma management knowledge and skill levels, asthma control, quality of life, school absenteeism and unscheduled health services use due to asthma. In addition, through our project, we will build capacity and a model for sustainability and replication throughout the region.

Applicant Agency: **University of Colorado Denver Department of Pediatrics**
Project Name: **Breathing Counts**
Disease Category: **Pulmonary Disease**
Strategy(ies): **Evidenced-Informed Innovation of Community Clinical Linkages**
Funding: **FY17: \$333,496 FY18: \$338,244 Total: \$671,740**
Counties to serve: **Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Jefferson**
Project Description (from application):

The Breathing Counts Program is designed to increase adherence to asthma medications, decrease asthma readmissions and revisits, and to improve health behaviors on the part of children with asthma, at high risk for a repeat asthma exacerbation, and their respective caregivers. This project will consist of enrolling 100 patients, ages 7 to 18 years, admitted to the Children's Hospital Colorado for a severe asthma exacerbation. During the admission for asthma we will contact the caregivers and offer enrollment in the Breathing Counts Program. Patients will be assigned into 2 separate groups. Adherence monitoring will be offered to both groups of patients, however one group of patients, approximately 50% of the enrolled patients, will also have an asthma navigator assigned to them who will focus on delivering adherence reports to the key stakeholders in the patient's "medical neighborhood", including their specialty care provider, primary care provider, and school nurse. The asthma navigator will facilitate communication between these providers, and seek to address barriers to adherence indicated by the patients and their caregivers. We hope that this project will decrease the burden of asthma on the individuals enrolled in Breathing Counts by reducing admissions and emergency department visits, very important indicators of high burden for asthma-related morbidity in the State of Colorado. We anticipate that the impact of adherence monitoring will be greater in the group that is assigned an asthma navigator due to the close communication that will be facilitated. We feel that such a program will provide a circle of support for children at high risk for a repeat asthma exacerbation and improve overall asthma control for these children.

**Requests for Programs in
Healthy Eating and Active Living *and*
for the Prevention, Early Detection and Treatment of
Cardiovascular Disease**

[Recommendations are listed in alphabetical order by the lead agency.]

Applicant	Recommended 2 Year Amount	Strategy(ies)	Rural
Aurora Mental Health Center	\$372,703.00	Self-measured blood pressure monitoring	0
University of Colorado Denver Children’s Hospital of Colorado	\$455,078.00	Evidenced-Informed Innovation focused on Community Clinical Linkages	0
Total	\$827,781.00		

**The amounts for these applicants are split between healthy eating active living and cardiovascular disease strategy categories*

Applicant Agency: **Aurora Mental Health Center**
 Project Name: **Mobile Heart Health Project**
 Disease Category: **Cardiovascular Disease and Cancer via Healthy Eating/Active Living (HEAL)**
 Strategy(ies): **Strategy 9 - Self-measured blood pressure monitoring**
 Funding: **FY17: \$203,874 FY18: \$168,829 Total: \$372,703**
 Counties to serve: **Adams and Arapahoe**
 Project Description (from application):

Aurora Mental Health Center (AuMHC) in partnership with the Metro Community Provider Network (MCPN) hopes to implement a self-measured Blood Pressure monitoring program in its existing highly-integrated, bi-directional clinic. Our clinic’s primary focus is improving the health and wellness of adults with serious mental illness (SMI), and we have identified patients in our programming who have unmet health needs related to hypertension. This opportunity would allow the integrated team to focus on targeting individuals at risk for hypertension, or who are already struggling with it.

Through existing partnerships with MCPN, the University of Colorado School of Nursing and Clinical Health Psychology program, Boomers Leading Change in health, and Share Our Strength’s Cooking Matters, we plan to offer programming in line with the Million Hearts Initiative. This program’s design will focus on: 1: Improving access to effective care, 2: Focusing clinical attention on the prevention of heart attack and stroke, 3: Activating the public to lead a heart-healthy lifestyle, 4: Improving the prescription and adherence to appropriate medications for the ABCS, 5: Improving quality of care for the ABCS of health heart; Aspirin when appropriate, Blood pressure control; Cholesterol management; Smoking cessation.

The Aurora Research Institute (ARI) plans to partner with us in providing comprehensive evaluation of the project. As the evaluator, ARI will analyze the process and outcome measures related to the following goals: Goal 1: Establish network of care for individuals with SMI and (pre-) hypertension; Goal 2: Increase provider competence on best-practices; Goal 3: Implement in-home blood pressure monitoring program; Goal 4: Provide support services, such as group programs, to clients receiving in-home blood pressure monitoring; Goal 5: Improved health

outcomes. We expect to find a significant improvement in health outcomes with the individuals who have access to intensive programming and support around their hypertension that we hope to offer through this opportunity.

Applicant Agency: **University of Colorado Denver Children’s Hospital Colorado**
Project Name: **Community-Clinical Linkages for Diabetes Prevention in Low-income Families: The Healthy Living Program**
Disease Category: **Cardiovascular Disease and Cancer via Healthy Eating/Active Living (HEAL)**
Strategy(ies): **Evidence-Informed Innovation of Community Clinical Linkages**
Funding: **FY17: \$238,539 FY18: \$216,539 Total: \$455,078**
Counties to serve: **Adams**
Project Description (from application):

This work will deliver to low-income and predominantly Latino families the screening and treatment for childhood obesity that is recommended by the US Preventive Services Task Force. As demonstrated in previous studies in which the “Healthy Living Program” was delivered by low-cost community personnel integrated with the primary care home, a significant decrease in child BMI will occur. The effect on BMI is predicted to significantly reduce type 2 diabetes incidence and generate a positive return on investment for the payer from type 2 diabetes prevention and reduced costs for diabetes management. Child emotional quality of life, fitness, and healthy eating patterns will also improve. Parents attending the Healthy Living Program lost weight and decreased waist circumference, demonstrating the benefit of this family weight management approach. This grant will transition the program from a successfully grant-funded research collaboration between the University, safety-net clinics, and community recreation centers to a sustainably funded clinic and community partnership. The work of this proposal will enable the program to be disseminated broadly across Colorado, increasing access to USPSTF recommended care.

**Requests for Additional Funding
to Support the Healthy Kids CO Survey (HKCS)**

Applicant	Recommended 2 Year Amount	Strategy(ies)	Rural
University of Colorado Regents, Community Epidemiology, Planning and Evaluation Group (CEPEG)	\$80,000.00	N/A - Evaluation and surveillance	N/A - Statewide
Total	\$80,000.00		

Applicant Agency: University of Colorado Regents, Community Epidemiology, Planning and Evaluation Group (CEPEG)

Project Name: Healthy Kids CO Survey (HKCS)

Funding: FY17: \$40,000 FY18: \$40,000 **Total: \$80,000**

Project Description:

HKCS is a survey that collects anonymous information from students in 6th to 12th grades about health-related attitudes and behaviors. This survey provides health-related information about youth that assists in and advances the efforts of the CCPD grant program by:

- Providing state and regional estimates of a wide range of youth health behaviors that are comparable to national estimates.
- Tracking trends in behaviors at state, regional, and local levels over time.
- Increasing public awareness about health and behavior issues that impact youth.
- Informing program planning and evaluation, as well as grant applications.

This survey, also called the Unified Youth Health Survey, is a coordinated effort supported by combined funding from multiple state agencies, the CDPHE, the CO Department of Human Services (CDHS), and the CO Department of Education (CDE).

At the February 2016 Board of Health meeting, \$10,000 was approved for the HKCS for FY17 and FY18 (\$20,000 total for both years). The program is now requesting that amount be increased by \$40,000 each year for the next two years. The combined amounts, totaling \$50,000 for FY 17 and FY18 (\$100,000 total for both years), would be leveraged with A35 Tobacco funding, Marijuana Cash Tax funding and funding from the CDHS and CDE, and used to:

- Weight and analyze the data for state, regional, district and school level comparisons.
- Building the capacity of local communities and schools to use and understand the data - making the data useful and relevant to communities (including CCPD applicants and grantees).
- Preparing and planning for the administration of future HKCS.
- Administering and analyzing future HKCS survey data.

In 2013, CDPHE conducted a competitive solicitation process that resulted in the selection of the CEPEG as the contractor for this work. Since that time, CEPEG has remained the contractor due to the unique expertise, experience and existing infrastructure of the group.

CCPD legislation requires that evaluation be adequately funded and the data resulting from the HKCS is used by agencies around the state to describe and monitor health events in their jurisdictions, set priorities, and assist in the planning, implementation and evaluation of interventions and programs.