



**COLORADO**  
Department of Public  
Health & Environment

Dedicated to protecting and improving the health and environment of the people of Colorado

To: Members of the State Board of Health

From: Mauricio Palacio, Office of Health Equity Director *MP*  
Health Equity Commission

Through: Karin McGowan, Deputy Executive Director and Director of Community  
Relations *KM*

Date: February 18, 2015

Subject: Request for approval of Health Equity Commission grant funding  
Recommendations for the Health Disparities Grant Program for Fiscal Years  
2016 - 2018

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The Office of Health Equity and the Health Equity Commission respectfully request approval of the enclosed fifteen grants for a total of \$10,576,015 for the next three-year funding cycle of the Health Disparities Grant Program, beginning July 1, 2015 and concluding June 30, 2018. Fifteen projects are recommended for a total of \$3,515,205 for the first year (fiscal year 2015-16), and continuing funding for years two (\$3,525,878) and three (3,534,932) will be contingent on satisfactory performance and funding availability.

The Health Disparities Grant Program Grant Program (HDGP), in alignment with the Cancer, Cardiovascular Disease and Pulmonary Disease (CCPD) Competitive Grants Program and the Tobacco Education, Prevention and Cessation Grant Program, released a Request for Applications (RFA) for funding on August 4, 2014. All three grant programs are funded by state tobacco tax revenues as prescribed by Amendment 35 and aligned the processes of this funding opportunity. Procedural steps of the RFA release, instruction, communication, submission, application reviews and dissemination of results were planned in conjunction with each other for broad reach to those eligible for funding and transparency of the processes.

The HDGP received 53 applications in response to the RFA. Thirty percent (30%) of the applicants recommended serve rural counties. The 15 grants recommended for funding follow the legislative requirements within House Bill 05-1262 that grants shall address at least one of the following:

- Translating evidence-based strategies into practical applications in healthcare, workplace and community settings;
- Providing appropriate arrangement for treatment of screen-detected illness;
- Implementing education programs for the public and healthcare providers; and
- Providing evidence-based strategies to overcome health disparities in the prevention and early detection of cancer, cardiovascular disease and chronic pulmonary disease.

The applications underwent a staff review process completed by the Office of Health Equity and the Prevention Services Division. The Health Equity Commission Review Committee completed an independent review process, resulting in recommendations to the Health Equity Commission, and represented in this letter. The Health Disparities Grant Program staff notified applicants that grant awards are contingent upon approval by the Board of Health and availability of funds.

The Amendment 35 application process was evaluated and feedback was solicited from applicants, reviewers, program staff and Health Equity Commission members. Specific feedback for the Health Disparities Grant Program falls into areas including Request for Applications, Application Review Process, Reviewer Coordination and Communication. The Office of Health Equity will work collaboratively with the Health Equity Commission and other Amendment 35 programs to implement improvements itemized below.

#### **Request for Applications (RFA)**

- Simplify the RFA to ensure large and small agencies can respond
- Provide resources including strategies, definitions and supporting documents on the website, instead of the RFA
- Reduce application content redundancies
- Use clear and concise language
- Post examples of acceptable proposals and attachments
- Consider an on-line process for RFA application submission and management

#### **Application Review Process**

- Establish a consistent Health Disparities Grant Program Subcommittee to guide application reviews
- Simplify the application review process
- Develop formulas for funding distribution
- Revise scoring methods and documents

#### **Reviewer Coordination**

- Establish an ongoing base of reviewers to assist Health Equity Commission members
- Develop a more robust and comprehensive reviewer education and preparation process
- Design a group communication process for those reviewing the same applications to work together
- Revise and improve the in-person, large group meeting process
- Consider an on-line scoring system for reviewers

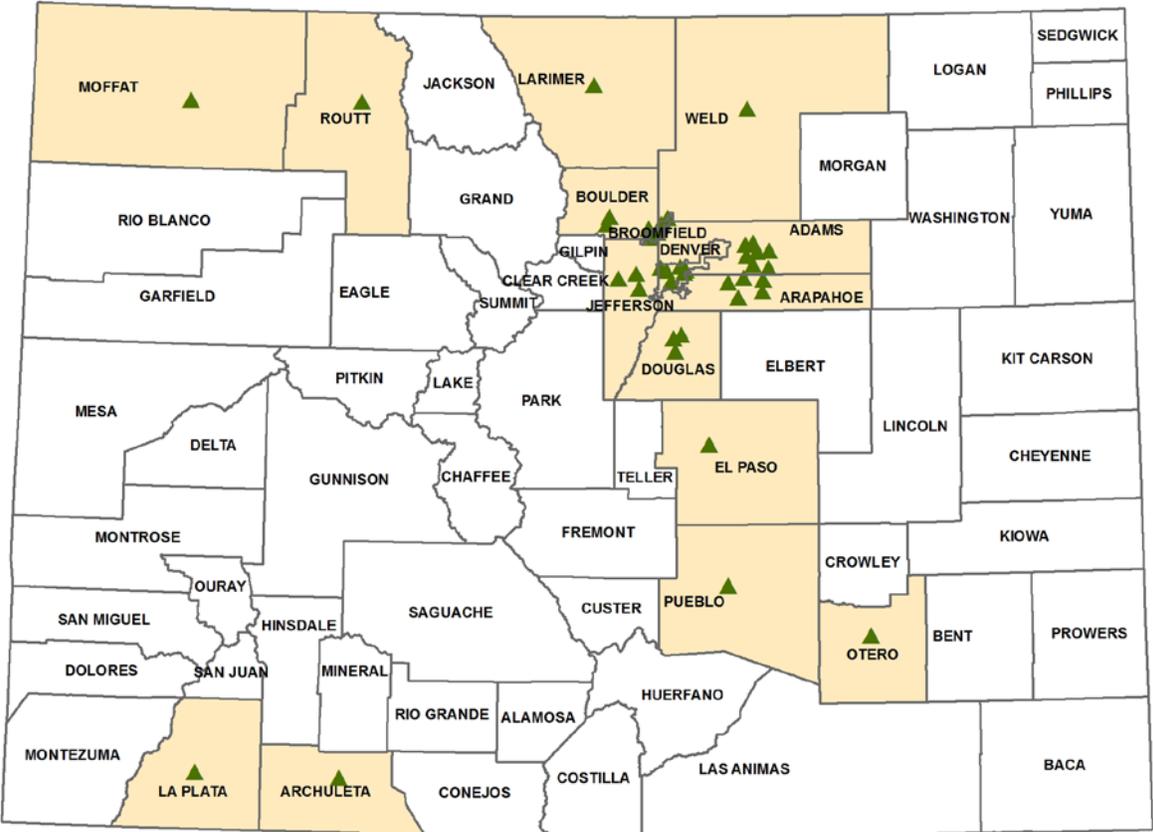
#### **Communication**

- Update the Office of Health Equity Website to accommodate the application process and inform customers
- Advertise the Request for Application (RFA) equitably to small, large and rural agencies
- Compile RFA questions and answers into one posted document
- Provide detailed application feedback

**Health Disparities Grant Program  
Funding Recommendations for Fiscal Years 2016-2018**

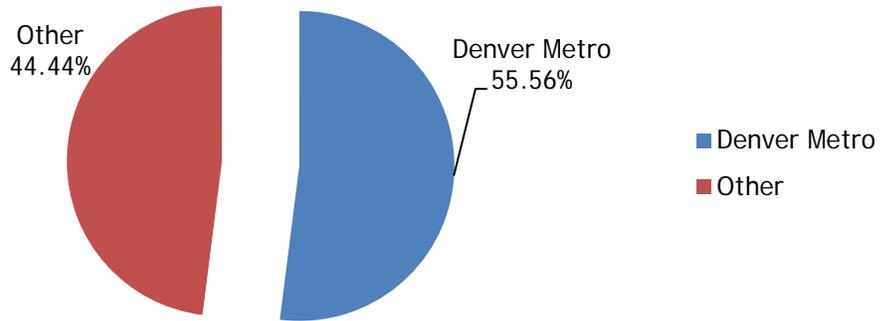
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# Counties Served

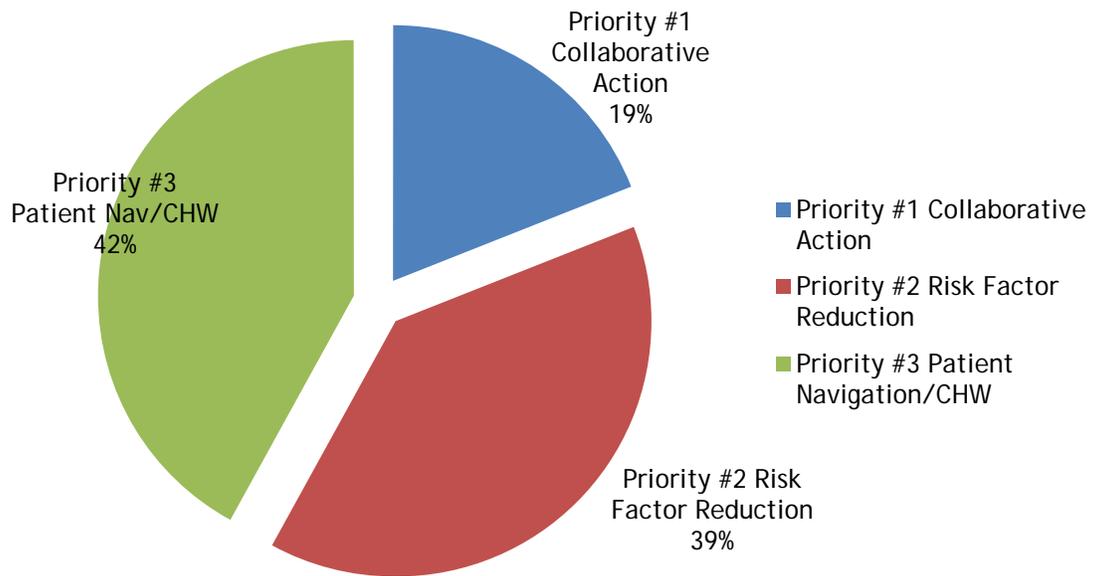


▲ Recommended Applicants

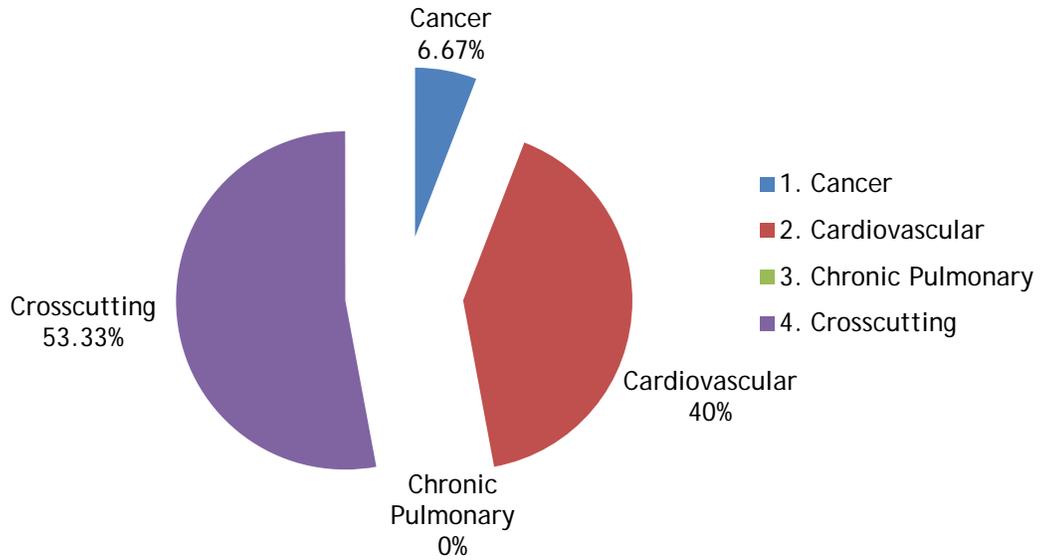
## Geographic Service Area



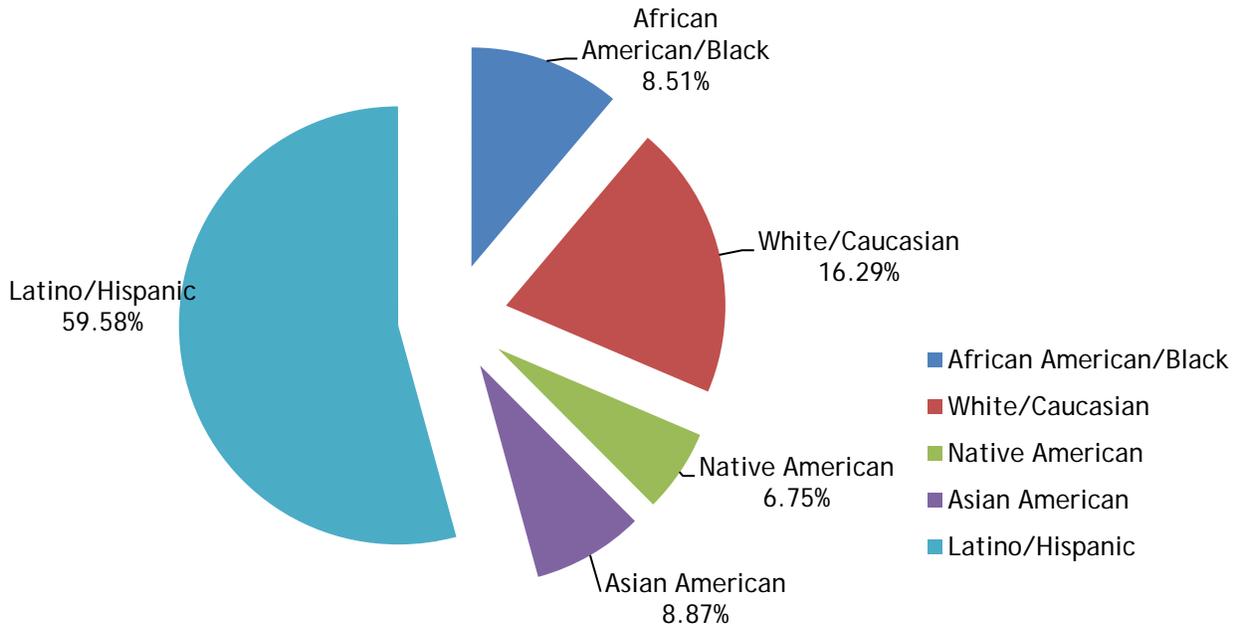
## Priorities



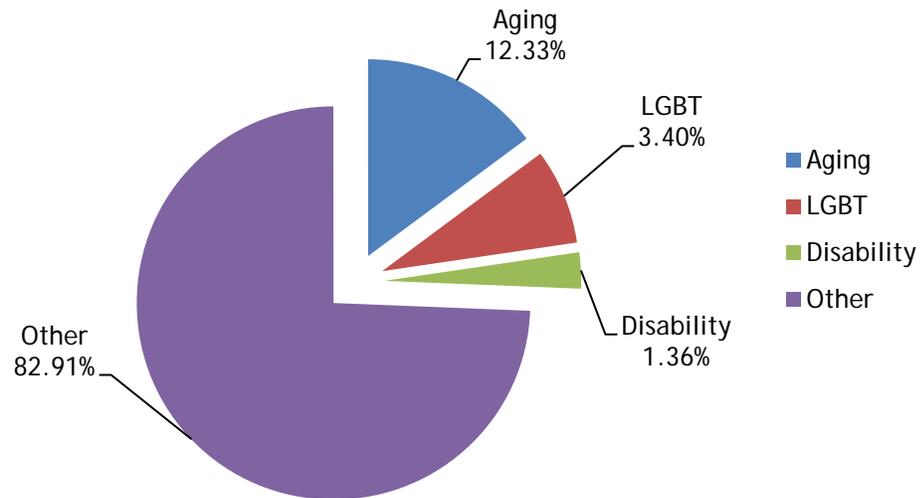
## Disease Categories



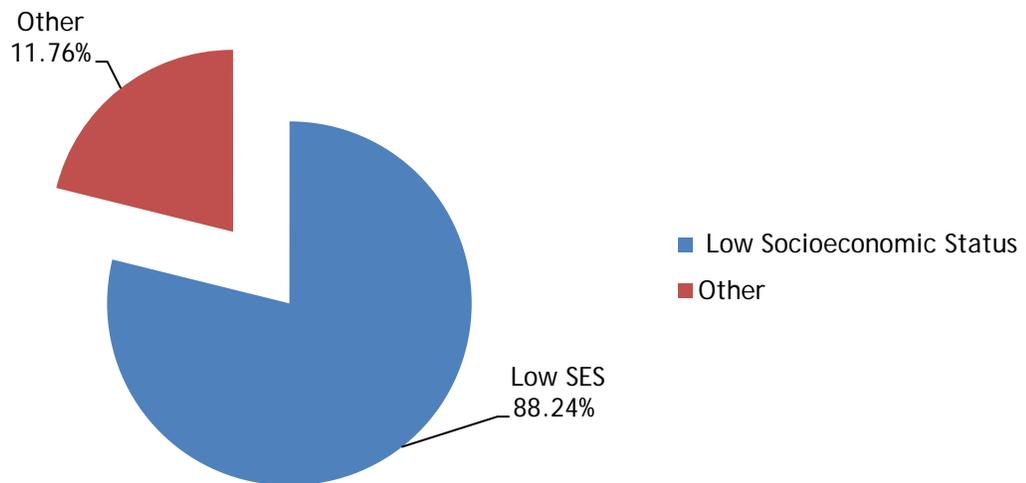
## Racial and Ethnic Populations



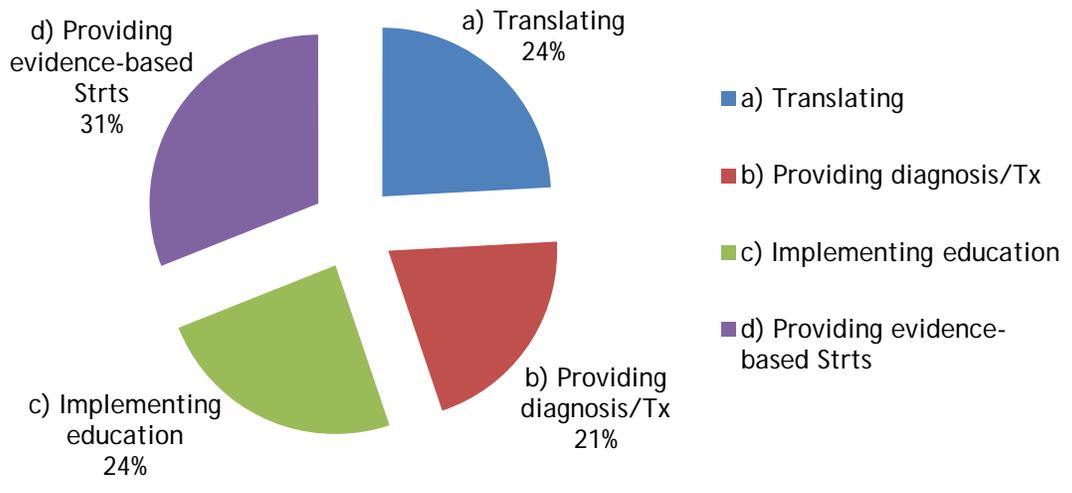
## Other Vulnerable Populations



## Low-socioeconomic Status



# Legislative Criteria



**1. Applicant H31:** Denver Health and Hospital Authority  
**Project Title:** Culturally Appropriate Patient Navigation for Refugees  
**Disease Category:** Crosscutting: Cancer, Cardiovascular Disease, & Chronic Pulmonary Disease  
**Funding Requested and Recommended:**  
     Year 1: \$250,000  
     Year 2: \$250,000  
     Year 3: \$250,000  
**3-Year Total:** \$750,000  
**Project Priorities:** Priority #3 Patient Navigation/Community Health Worker Case Coordination

**Intended Population:** Refugee, African American/Black, Low-SES, Asian American  
**Counties Served:** Denver

**Project Description:** The Culturally Appropriate Patient Navigation for Refugees program will address health disparities and barriers in the Denver’s refugee and immigrant populations. The program will add five (5) culturally appropriate part-time patient navigators, based at the Lowry Refugee Clinic at Denver Health (DH), to provide health system navigation to both newly arriving and current refugee patients at DH. These culturally appropriate patient navigators will be bilingual members of prominent local refugee populations (e.g. Burmese, Bhutanese, Ethiopian, Eritrean, Iraqi, Nepali, Somali, Somali Bantu). The program aims to improve access to health care for refugee and immigrant populations at DH through culturally appropriate patient navigation, increase systematic use of best practices to prevent and manage chronic diseases and reduce barriers to screening and treatment among refugee and immigrant patients. The program will serve 2,000 people per year.

**Program Evaluation:** The patient navigation program will ensure a rigorous evaluation process, utilize systematic data collection methods, and include customer feedback. Program data will be captured using a system that tracks participation, demographic information, health screening results, referrals, appointment attendance, and follow up calls.

Specific Metrics Collected
Basic demographic, racial/ethnic, and socio-demographic data including income level, educational level, marital status, employment status, primary language spoken in the home, type of health insurance, country of origin, race, ethnicity, refugee status, and family/caregiver support
Number of patients referred to and followed by the patient navigators
Type of health issues addressed including cancer, cardiovascular disease, chronic pulmonary disease, and other illnesses
Baseline disease specific data for refugee and immigrant populations prior to the culturally appropriate patient navigator project
Number of patients enrolled in health insurance
Number of referrals to health risk prevention or self-management programs
Number of referrals to community resources by type, reason for referral, and follow up
Primary care, prenatal, refugee screening, mental health, dental, subspecialty, and follow up appointments made and kept (and results)
Patient barriers addressed/methods used
Proportion of diabetic and hypertensive adults in adherence with medication regimens, hypertensive adults with controlled hypertension, adults with poorly controlled diabetes, adults and children with asthma in adherence to medication regimens, adults in adherence with national cancer screening guidelines
Proportion of children receiving recommended development assessments and screening for anemia and lead toxicity, adults and children with up-to-date immunizations, pregnant women receiving early prenatal care and recommended screening labs

**2. Applicant H30:** Northwest Colorado Visiting Nurse Association  
**Project Title:** Northwest Colorado Health Equity Project  
**Disease Category:** Crosscutting: Cancer, Cardiovascular Disease, & Chronic Pulmonary Disease  
**Funding Requested and Recommended:**  
Year 1: \$233,950  
Year 2: \$240,969  
Year 3: \$250,000  
**3-Year Total:** \$724,919  
**Project Priorities:** Priority #1 Collaborative Action for Coordinated Impact  
Priority #3 Patient Navigation/Community Health Worker Case Coordination

**Intended Population:** LGBT, Disabled, White, Native American/American Indian, Asian American, Latino/Hispanic, African American/Black, Aging, Low-Socioeconomic status  
**Counties Served:** Routt, Moffat

**Program Description:** The Northwest Colorado Health Equity Project is a community-wide action focused initiative to engage disparate populations and reduce the burden of cancer, cardiovascular and chronic pulmonary disease in frontier and rural, elderly, low-income, Hispanic and other populations experiencing health inequities. A Community Health Worker program will be implemented to serve rural and frontier vulnerable populations (Routt and Moffat Counties). The program aims to engage and listen to the community to find and offer appropriate solutions. Community Health Workers will provide a navigation system for underserved individuals, and address health inequities in access and availability of care. Culturally responsive navigation services will include health screenings, prevention education, referral and treatment for affected populations.

The project will also implement a Collaborative Action for Coordinated Impact process to strengthen and expand partnerships in Routt and Moffat counties. The Northwest Colorado Health Equity Advocacy Committee (NWCOHEAC) will be established to address health inequities for vulnerable, rural and frontier populations; support Community Health Workers; and ensure services for patients referred for cancer, cardiovascular and chronic pulmonary diseases.

The NWCOHEAC will finalize a Health Equity Action Plan that will be used to evaluate health behaviors, living conditions, education, job availability, and economic development activities impacting the intended population. The NWCOHEAC will use the plan to identify environmental and public health needs in the counties, and pursue policy solutions to overcome barriers. The project will serve 500 people per year.

**Program Evaluation:** Program progress will be measured by monitoring expected outcomes against the goals, objectives and activities planned. Program goals have been designed to align with the State Chronic Disease Plan. The program will address Health Disparities Grant Program efforts to reduce the burden of cancer, cardiovascular, and chronic pulmonary diseases for populations experiencing health inequities. The program will identify health risks and promote lifestyle changes, healthy foods and increased physical activity for underserved populations.

**3. Applicant H28:** Clinica Family Health Services  
**Project Title:** Advanced Medication Therapy Management - Clinical Pharmacist and Patient-Centered Primary Care Team Integration  
**Disease Category:** Crosscutting: Cancer, Cardiovascular Disease, & Chronic Pulmonary Disease  
**Funding Requested and Recommended:**  
Year 1:\$249,159  
Year 2:\$250,000  
Year 3:\$250,000  
**3-Year Total:** \$749,159  
**Project Priorities:** Priority #2 Risk Factor Reduction and Disease Prevention Programs for cancer, cardiovascular disease (including diabetes and other precursors) and chronic pulmonary diseases in vulnerable populations in Colorado

**Intended Population:** Aging, Disability, African American/Black, White, Native American/American Indian, Latino/Hispanic, Low- Socioeconomic status

**Counties Served:** Adams, Boulder, Broomfield

**Program Description:** The Advanced Medication Therapy Management program will increase clinical pharmacy service outputs within a patient-centered primary care environment. The program will translate evidence-based strategies to address cardiovascular disease risk factors, provide education and health referrals to underserved individuals, and document total cost and payment of care.

Clinica Family Health Services will implement the Advance Medication Therapy Management program to address diabetes, lipids, hypertension, anticoagulation, and polypharmacy rates. The project will also monitor cardiovascular disease outcomes for underserved individuals, especially those with diabetes, hypertension and highly medicated. The program establishes management plans for these individuals and utilizes evidenced-based practices to address the diseases. The program will serve 833 people per year.

Program activities include:

- Expanding clinical services
- Providing patient education related to medication administration and healthy living
- Improving diabetes control among targeted patients
- Improving lipid control among targeted patients
- Improving hypertension control among targeted patients
- Enhancing anticoagulation therapy
- Reducing Polypharmacy (the practice of administering or using multiple medications) rates
- Contributing to student advanced primary care training and work with underserved populations

**Program Evaluation:** The Medication Therapy Management program will implement an evaluation process to track a series of output and outcome objectives. The outcome objectives were chosen to measure program impact while remaining consistent with evidence-based care modalities proven effective by Clinica and the Medication Therapy Management. The program will collect demographic data for the populations served as supported by the electronic health record process. Clinical pharmacy data, outcomes, outputs and measures will be collected and analyzed to enable program improvement.

**4. Applicant H10:** YMCA of Metropolitan Denver  
**Project Title:** Diabetes Prevention Program  
**Disease Category:** Cardiovascular Disease (including Diabetes and other precursors)  
**Funding Requested and Recommended:**  
Year 1: \$249,979  
Year 2: \$249,979  
Year 3: \$249,979  
**3-Year Total:** \$749,937  
**Project Priorities:** Priority #2 Risk Factor Reduction and Disease Prevention Programs for cancer, cardiovascular disease (including diabetes and other precursors) and chronic pulmonary diseases in vulnerable populations in Colorado  
**Intended Population:** Aging, African American/Black, White, Latino/Hispanic, Low- Socioeconomic status  
**Counties Served:** Adams, Arapahoe, Denver, Jefferson

**Program Description:** The YMCA of Metropolitan Denver will implement and expand the Diabetes Prevention Program (DPP) as an innovative program model to help reduce the burden of diabetes for underserved individuals. The YMCA's DPP is a community-based lifestyle improvement program for adults with pre-diabetes. Its purpose is to empower adults with lasting lifestyle changes that will improve their overall health and reduce their chance of developing type 2 diabetes. The intended population is overweight adults at risk for type 2 diabetes.

The YMCA will engage 20 cohorts in year 1 and 25 cohorts in years two and three. Each cohort will serve approximately 14 individuals in each group. Each cohort will receive 16 sessions of weekly group education (1 hour each session), followed by eight months of aftercare where participants meet monthly to track their progress. Each group meeting focuses on an educational component related to nutrition and healthy lifestyles, as well as time for the group to discuss barriers and successes to achieving these goals. The goal of the program is to reduce and maintain individual weight loss of at least 5%, by learning about healthy eating and helping individuals increase their physical activity to 150 minutes per week. The YMCA will increase accessibility by providing the programs in trusted community locations, such as community schools, churches, nonprofits, and YMCA facilities. The program will serve 326 people per year.

**Program Evaluation:** The delivery of the YMCA's Diabetes Prevention Program is evaluated in multiple ways: 1) Participants evaluate the program (through self-reported questionnaires) at sessions 8, 16, and 24, via a paper pencil or online survey; 2) The Program Coordinator completes an observation assessment of each Lifestyle Coach delivering a class to ensure quality and adherence to the evidence-based curriculum; and 3) Participant data (attendance, weight, and physical activity) is stored securely in the MYnetico system, and monitored in real time by local Y Program Coordinators and Y-USA.

Every Y delivering the YMCA's Diabetes Prevention Program is required to use the Diabetes Prevention and Control Alliance's (DPCA) MYnetico, a web-based system where each Y can schedule classes, file claims for reimbursement, and monitor participant data in real time. Program Coordinators will utilize MYnetico to track participant outcomes, monitor Lifestyle Coach performance, schedule classes, enroll participants, and generate performance-based reimbursements. Lifestyle Coaches use the MYnetico system to capture participant attendance, weight loss, physical activity minutes, and food/physical activity tracker completion after every class.

**5. Applicant H33:** University of Colorado Denver  
**Project Title:** Collective Impact for High Public Service Utilizers  
**Disease Category:** Cardiovascular Disease (including Diabetes and other precursors)  
**Funding Requested and Recommended:**  
Year 1: \$250,000  
Year 2: \$250,000  
Year 3: \$250,000  
**3-Year Total:** \$750,000  
**Project Priorities:** Priority #1 Collaborative Action for Coordinated Impact  
Priority #2 Risk Factor Reduction and Disease Prevention Programs for cancer, cardiovascular disease (including diabetes and other precursors) and chronic pulmonary diseases in vulnerable populations in Colorado  
Priority #3 Patient Navigation/Community Health Worker Case Coordination

**Intended Population:** African American/Black, White, Native American/American Indian, Asian American, Latino/Hispanic, Low-Socioeconomic status

**Counties Served:** Adams, Arapahoe

**Program Description:** The University of Colorado Denver’s Collective Impact for High Public Service Utilizers program will implement a collaborative action approach and a continuity-of-care model to address cancer screening and healthy living needs for persons who face multiple levels of health disparities. Partnership with the Metro Denver Homelessness Initiative will improve access to health care coverage and coordination of referrals and services. The project will engage new partners beyond the current network.

Community health worker services will be available to homeless individuals to improve access to health care and providers. The project will address risk factor reduction and disease prevention for those who are homeless or at risk for homelessness. Community Health Workers will coordinate with service providers from the 7-county Denver metropolitan region to improve health service access, ensure screening opportunities and secure a referral system. The program will serve 2,266 people per year.

**Program Evaluation:** The Collective Impact for High Public Service Utilizers program will conduct a qualitative evaluation and develop thematic highlights. Data collected and analyzed will include coalition meeting documentation, identified barriers to accessing healthcare and community health worker system usage. Coalition input, key-informant interviews and survey results will be used to identify barriers in adherence to best practices, guide resource utilization and identify opportunities to implement solutions. Evaluative results will inform the development of educational materials (trainings, technical assistance), site-specific assessments and interventions for the demonstration projects planned. Statewide trainings, webinars and conferences will be evaluated by the Coalition, and report feedback from participants will be analyzed. The evaluation process will include the collection of baseline and post-intervention data to inform health screenings and improve chronic medical conditions for the intended population.

**6. Applicant H23:** University of Colorado Denver  
**Project Title:** Multilevel Intervention to Reduce Cervical Cancer Disparities among Latinas  
**Disease Category:** Crosscutting: Cancer, Cardiovascular Disease, & Chronic Pulmonary Disease  
**Funding Requested and Recommended:**  
Year 1: \$249,971  
Year 2: \$249,916  
Year 3: \$249,939  
**3-Year Total:** \$749,826  
**Project Priorities:** Priority #2 Risk Factor Reduction and Disease Prevention Programs for cancer, cardiovascular disease (including diabetes and other precursors) and chronic pulmonary diseases in vulnerable populations in Colorado  
Priority #3 Patient Navigation/Community Health Worker Case Coordination  
**Intended Population:** Latino/Hispanic, Low-Socioeconomic status  
**Counties Served:** Denver

**Program Description:** The University of Colorado Denver’s Multilevel Intervention to Reduce Cancer Disparities among Latinas is a collaborative project between the Latino Research and Policy Center (LRPC) and the Denver Health and Hospital Authority (DHHA), to address and reduce risk factors (e.g. HPV infection) for cervical cancer in underserved young Latinas. The program seeks to sustainably prevent cervical cancer by improving HPV vaccination rates in this population, who is at greater risk of cervical cancer incidence and mortality disparities compared to non-Latina whites. The multilevel intervention will address patient-level, provider-level, and system-level factors using cultural and linguistic evidence-based strategies, including Patient Navigation case coordination, to increase access and adherence to HPV vaccines.

The Multilevel Intervention to Reduce Cervical Cancer Disparities among Latinas program will address the four strains of the human Papillomavirus (HPV) that are responsible for about 99% of diagnosed cervical cancers. Hispanic women (Latinas) have the highest incidence and mortality rates. The program will aim to increase HPV vaccination completion rates among 19-26 year old women. The program will develop, implement, and evaluate a multilevel intervention that combines evidence-based methods to improve access and adherence to the 3-dose HPV vaccine among non-adherent Latinas. The program will serve 1,073, 19 - 26 years old Latina patients who have not completed all 3-doses of the HPV vaccine series.

**Program Evaluation:** The Intervention to Reduce Cervical Cancer Disparities among Latinas program includes an evaluation system to collect, analyze and utilize intervention data. Program design and implementation will be monitored for improvements. The evaluation system will review and analyze the program’s multilevel intervention process, including adherence with the HPV vaccination series among Latina patients, for necessary changes and modifications. Program videos, brochures, decision-aid tools and the website will be updated to ensure educational and training resources are available.

**7. Applicant H17:** American Diabetes Association  
**Project Title:** Diabetes Prevention Program  
**Disease Category:** Cancer  
**Funding Requested and Recommended:**

Year 1: \$166,481

Year 2: \$166,481

Year 3: \$166,481

**3-Year Total:** \$499,443

**Project Priorities:** Priority #2 Risk Factor Reduction and Disease Prevention Programs for cancer, cardiovascular disease (including diabetes and other precursors) and chronic pulmonary diseases in vulnerable populations in Colorado

**Intended Population:** Latino/Hispanic, Low-Socioeconomic status

**Counties Served:** Adams, Arapahoe, Denver, El Paso, Otero, Pueblo

**Program Description:** The American Diabetes Association (ADA) will implement the Diabetes Prevention Program (DPP). The program will use the DPP curriculum to encourage behavior change among high-risk, Spanish-speaking Latinos in Adams, Arapahoe, Denver, El Paso, Otero, and Pueblo counties. The Diabetes Prevention Program (DPP) will promote structured diet and physical activity interventions that achieve and maintain modest weight loss for overweight adults at risk for development of diabetes. The ADA will partner with existing community organizations to support and sustain the DPP program. Participants will be offered a year-long program that includes 16 core sessions, 6 post-core sessions, and a physical activity component.

Program methods will include lifestyle goals, case management, frequent contact with participants, a structured 16-session core-curriculum, behavioral self-management, strategies for weight loss and physical activity, supervised physical activity sessions, and a toolbox of adherence resources. The program will perform culturally competent outreach to high-risk Latinos through the Promotora system. The program will serve 66 people per year.

**Program Evaluation:** The Diabetes Prevention Program (DPP) evaluation system includes the use of pre-established and validated tools created by the Centers for Disease Control and Prevention (CDC) for all CDC recognized DPP programs. Program effectiveness will be evaluated through monthly data analysis, patient pre and post behavior tools. Program metrics will include client numbers enrolled, client demographics (age, ethnicity, race, sex), client height, session attendance, documentation of baseline and change in body weight, documentation of baseline and change in physical activity minutes, and client referral data. Process outcomes are tracked through qualitative data collection, including feedback from participants and program partners.

**8. Applicant H11: San Juan Basin Health Department**  
**Project Title:** Promotora & Cultural Competency Program  
**Disease Category:** Cardiovascular Disease (including Diabetes and other precursors)  
**Funding Requested and Recommended:**  
Year 1: \$216,431  
Year 2: \$219,176  
Year 3: \$219,176  
**3-Year Total:** \$654,783  
**Project Priorities:** Priority #3 Patient Navigation/Community Health Worker Case Coordination

**Intended Population:** Aging, LGBT, Disabled, Latino/Hispanic, Low-Socioeconomic status

**Counties Served:** La Plata, Archuleta

**Program Description:** The San Juan Basin Health Department (SJBHD) will implement the Promotora & Cultural Competency Program to reduce health disparities in Hispanic/Latino populations in La Plata and Archuleta counties through a Community Health Worker program as well as through cultural competence policy initiatives. The program will serve the Durango area with the goal of increasing access to interpretation and translation services, healthcare and reducing the burden of chronic health conditions among this population. The program aims to reduce health disparities in the Hispanic/Latino populations of La Plata and Archuleta counties through the combination of direct service (Promotora Program) and policy work (enhancing cultural competency). SJBHD will collaborate with key partners for both direct service and policy strategy implementation, and to enhance cultural competence among providers.

The Promotora & Cultural Competency Program will directly address the access to care barrier by focusing on connecting clients to a medical home or primary care provider, as well as connecting clients to numerous other services needed. Other services include screenings, dental services, sexual health services, housing resources, disability services, WIC, etc. While these referrals are for health-related services, they will also include connections to address social determinants of health, such as housing, income, and transportation. The Promotoras will empower participants by providing health education sessions (Platicas) and supporting self-management of health conditions through health coaching. The program will serve 433 people per year.

**Program Evaluation:** The Promotora & Cultural Competency Program will evaluate each activity and measure addressed in the statement of work. Program data will be collected, analyzed monthly, and reported quarterly as required. Evaluation data gathered will include patient demographics and statistics. The evaluation system will capture both quantitative and qualitative program measures and collect health screening results, self-reported information, and participant numbers. An Access database will be used to track program metrics related to all goals, objectives and activities. Participants will evaluate health education sessions (Platicas) using pen and paper self-report questionnaires. Individual behavior change data will be gathered through pen and paper or online evaluations, as well as health screening results gathered at the start and end of a client's participation period.

**9. Applicant H19:** Re:Vision (formerly Revision International)  
**Project Title:** Collaborative Action for Overcoming Health Disparities in Southwest Denver  
**Disease Category:** Cardiovascular Disease (including Diabetes and other precursors)  
**Funding Requested and Recommended:**  
Year 1: \$248,109  
Year 2: \$248,109  
Year 3: \$248,109  
**3-Year Total:** \$744,327  
**Project Priorities:** Priority #1 Collaborative Action for Coordinated Impact  
Priority #2 Risk Factor Reduction and Disease Prevention Programs for cancer, cardiovascular disease (including diabetes and other precursors) and chronic pulmonary diseases in vulnerable populations in Colorado  
Priority #3 Patient Navigation/Community Health Worker Case Coordination

**Intended Population:** African American/Black, White, Latino/Hispanic, Low-Socioeconomic status

**Counties Served:** Denver

**Program Description:** The Collaborative Action for Overcoming Health Disparities in Southwest Denver program is a comprehensive, evidence-based and resident-led approach for alleviating health inequities in underserved southwest Denver communities. The program focuses on two main strategies: (1) Improving access to and affordability of healthy food and food retail in food desert neighborhoods, and (2) Empowering local residents to act as community health workers. The program intends to increase access and affordability of healthy foods in underserved, food desert communities. The program seeks to improve the conditions and opportunities for good health and wellness where vulnerable communities live, work and play through the development of collaborative action plans and/or implementation of policies. The program will engage local residents and members of the very population affected by health disparities, to promote health and act as community health workers.

The program will implement a Community Health Worker program and provide health navigation services, outreach and case coordination. The program will ensure that service providers are engaged and available to support patient navigation efforts, and address cancer, cardiovascular disease, and chronic pulmonary disease in the intended population. Patient Navigators and Promotoras will schedule and perform health screenings of vulnerable populations in southwest Denver, as part of the Colorado Heart Healthy Solutions Program. Re:Vision Promotoras will facilitate health care coverage enrollment for residents eligible for health insurance plans and track those supported under the Affordable Care Act (ACA).

**Program Evaluation:** Re:Vision International maintains an evaluation team to provide technical and analytic support for the assessment of all program objectives. Re:Vision will work with Denver Public Health, the University of Colorado and Promotora staff to design an evaluation process and measure improvements in access to healthy food. The program will evaluate Promotora program infrastructure and patient connections to community health resources. Program data will include patient behaviors and clinical outcomes associated with preventing chronic disease (cancer, cardiovascular disease and diabetes). Program measures also include pounds of food grown, patient self-reported daily consumption of fruits and vegetables, and those screened for chronic disease.

**10. Applicant H21: Denver Indian Health and Family Services**

**Project Title:** The Good Path

**Disease Category:** Crosscutting: Cancer, Cardiovascular Disease, & Chronic Pulmonary Disease

**Funding Requested and Recommended:**

Year 1: \$227,700

Year 2: \$227,700

Year 3: \$227,700

**3-Year Total:** \$683,100

**Project Priorities:** Priority #1 Collaborative Action for Coordinated Impact

Priority #2 Risk Factor Reduction and Disease Prevention Programs for cancer, cardiovascular disease (including diabetes and other precursors) and chronic pulmonary diseases in vulnerable populations in Colorado

Priority #3 Patient Navigation/Community Health Worker Case Coordination

**Intended Population:** Aging, LGBT, Disability, African American/Black, White, Native American/American Indian, Asian, Latino/Hispanic, Low-Socioeconomic status

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

**Program Description:** The Denver Indian Health and Family Services will implement the Good Path project. The Good Path includes a patient navigation process for American Indian/Alaska Natives (AI/AN). Successful establishment of the Good Path (translated from Hozho O'oodaal in Navajo) is intended to improve healthcare and patient outcomes. The program seeks to reverse the conditions that lead to current disparities in the incidence of health problems in AI/AN communities, as well as promote continued collaboration with other healthcare providers. The project goal correlates with Health Disparities Grant Program efforts to address prevention, early detection and treatment of cardiovascular disease (CVD) and other precursors in underrepresented minority populations.

The Good Path project includes the following objectives: 1) implementation of a medical therapy management (MTM) program coupled with adherence, identification of issues related to newly prescribed medications and promotion of positive patient outcomes in areas of diabetes and CVD; and, 2) increased obesity and diabetes prevention through enhanced personal training and patient education with additional mammography services, cancer screenings and HPV vaccinations provided to patients through referrals from collaborating partners. The program will serve 408 people per year.

**Program Evaluation:** An independent contractor will lead the Good Path program evaluation process. Quantitative and qualitative measures will be used to assess program implementation and ensure that outcomes are accomplished. Project data will be collected in numerous ways, including participant logs collected for each grant activity and satisfaction in the experience. The evaluation process also includes participant interviews to assess knowledge and behavior. The program evaluation system will include outcome, process, and implementation assessment. Program staff will work with the evaluation contractor to identify tools/systems to be used to assess progress within the intended population.

**11. Applicant H5:** Colorado Prevention Center (CPC) Community Health  
**Project Title:** Community Heart Health Actions For Latinos At Risk (CHARLAR)  
**Disease Category:** Cardiovascular Disease (including Diabetes and other precursors)  
**Funding Requested and Recommended:**

Year 1: \$173,577

Year 2: \$173,577

Year 3: \$173,577

**3-Year Total:** \$520,731

**Project Priorities:** Priority #2 Risk Factor Reduction and Disease Prevention Programs for cancer, cardiovascular disease (including diabetes and other precursors) and chronic pulmonary diseases in vulnerable populations in Colorado  
Priority #3 Patient Navigation/Community Health Worker Case Coordination

**Intended Population:** Latino/Hispanic, Low-Socioeconomic status

**Counties Served:** Denver

**Program Description:** The CHARLAR program leverages evidence based strategies for the prevention and early detection of cardiovascular disease and implements culturally competent and linguistically appropriate interventions for specific racial and ethnic minority populations to reduce health disparities.

CHARLAR is a 12-week promotor(a)-led screening, health education, navigation, and skill building program for Latinos over 40 in Denver. They employ an evidence-based curriculum derived from the National Heart, Lung, and Blood Institute (NHLBI) "Su Corazon Su Vida" and the University of Arizona's "Pasos Adelante." The program curriculum has been rigorously field-tested and tailored to their clientele in the Denver metropolitan area through extensive participatory based research and input from a local Community Advisory Committee. The program will serve 400 people annually in West and North Denver neighborhoods. The program will serve 133 people per year. Program activities include:

- Employing local community members to be promotores de salud
- Offering culturally and linguistically appropriate health education programs at no charge
- Providing cardiovascular disease and diabetes screenings at no charge
- Counseling each participant in their preferred language on individual cardiac risk factors
- Assisting with Medicaid/Medicare/Exchange/Discount Program enrollment
- Providing child care and food at health education sessions
- Addressing social determinants of health by linking participants to food banks, housing, etc.

**Program Evaluation:** The Colorado Prevention Center (CPC) maintains an internal evaluation process for the CHARLAR program, and participates in quarterly state reporting processes. Program data results are continuously reviewed and shared with the CPC team and community partners. CPC will measure proposed outcomes using a data repository that tracks participation, demographic information, health screening results, referrals and follow up calls, etc. Program evaluation measures include health behaviors, screening and participation rates.

**12. Applicant H15:** Poudre Valley Hospital Foundation  
**Project Title:** Vida Sana: Uniting for Health Equity  
**Disease Category:** Crosscutting: Cancer, Cardiovascular Disease, & Chronic Pulmonary Disease  
**Funding Requested and Recommended:**

Year 1: \$249,877

Year 2: \$250,000

Year 3: \$250,000

**3-Year Total:** \$749,877

**Project Priorities:** Priority #1 Collaborative Action for Coordinated Impact  
Priority #2 Risk Factor Reduction and Disease Prevention Programs for cancer, cardiovascular disease (including diabetes and other precursors) and chronic pulmonary diseases in vulnerable populations in Colorado  
Priority #3 Patient Navigation/Community Health Worker Case Coordination

**Intended Population:** Aging, Disability, White, Latino/Hispanic, Low-Socioeconomic status  
**Counties Served:** Larimer

**Program Description:** The Vida Sana: Uniting for Health Equity program will combine direct and indirect interventions to improve the health of the community and to reduce health inequities in northern Larimer County, specifically within the populations of Hispanic/Latino residents and those with low socio-economic status. Strategies and outcomes are based on surveillance of community needs and rooted in best practices.

The Vida Sana program will ensure a coordinated patient navigation process that connects underserved residents to resources and referrals including Medicaid, other health plans, screening and risk assessments. The Vida Sana program seeks to increase physical activity within intended populations, increase quality and capacity of health care providers at reducing health disparities, and address further causes and factors of health disparities through partnerships and coalitions. Vida Sana will address root causes of health inequities. Residents and agencies within the Vida Sana communities have identified the need to address barriers to their health, which includes housing issues, access to health care, poor health outcomes and economic barriers.

The Vida Sana program will provide free, culturally congruent physical activity opportunities and interventions. The program will include social components, group classes, a health equity coalition, and culturally competent provider education. Policies that support health equity and reduce health disparities in health care systems will be identified and pursued to address health issues in Fort Collins and Loveland. The program will serve 9,100 people per year.

**Program Evaluation:** The Vida Sana program relies on process evaluation, with objectives grounded in public health literature. Results expected include increased policies to support health equity, changes in behavior, and capacity to address health equity in the community. Program outcomes are closely aligned with the Health Disparities Grant Program and are informed by research.

Specific program evaluation goals include:

- Increased policies that address social determinants of health
- Increased policies or procedures that address cultural competency in the University of Colorado north health system
- Increased community resources and referrals

**13. Applicant H39: Denver Health and Hospital Authority**

**Project Title:** Beyond Race and Ethnicity: Patient Navigation for Underrepresented and Marginalized Populations

**Disease Category:** Crosscutting: Cancer, Cardiovascular Disease, & Chronic Pulmonary Disease

**Funding Requested and Recommended:**

Year 1: \$250,000

Year 2: \$250,000

Year 3: \$250,000

**3-Year Total:** \$750,000

**Project Priorities:** Priority #3 Patient Navigation/Community Health Worker Case Coordination

**Intended Population:** LGBT, African American/Black, White, Native American/American Indian, Asian American, Latino/Hispanic, Low-Socioeconomic status

**Counties Served:** Denver

**Program Description:** The Denver Health and Hospital Authority (DHHA) will implement the Beyond Race and Ethnicity: Patient Navigation for Underrepresented and Marginalized Populations program in collaboration community-based agencies/organizations. The program is designed as the primary project intervention to reduce disparities by reducing barriers to care for underrepresented, individuals with disabilities, Lesbian, Bisexual, Gay, Transgender, and Questioning (LGBTQ) communities. Patient navigators will reach the LGBTQ and disability populations in two different ways. DHHA will connect with over 13 diverse organizations in Denver that work directly with the LGBTQ and disabilities communities. The program will connect patients to culturally and linguistically appropriate services to address cancer, diabetes, and cardiovascular disease, and to ensure access to medical home/primary care. Educational materials related to all types of screenings in this project will be examined and revised with input from the respective communities to ensure that our educational materials are culturally and linguistically appropriate. Patient navigation services available, eligibility requirements for the project and how to contact a patient navigator will be made known through various venues provided by community partners. Community health fairs, agency mailing lists, web pages, newsletters, etc. will be used to enhance participation in the patient navigation program. The program will serve 500 people per year.

**Program Evaluation:** The patient navigation program will utilize process and outcome evaluation data to determine effectiveness. Evaluative trends such as unique barriers, patient navigation issues, and health inequities within communities will be analyzed. DHHA will work collaboratively with the Colorado Patient Navigator Training Collaborative (CPNTC) to enhance assessment processes and ensure progress for LGBTQ and disabilities communities. Grant outcomes include:

- Reach persons in the LGBTQ and disabilities community ages 21-64 who are not current on their cancer, cardiovascular and diabetes screenings
- Identify and reduce socio-cultural, community, provider, policy and system level barriers that contribute to health disparities for the two intended populations
- Identify patient navigation training needed to provide culturally and linguistically appropriate services and referrals and content to all levels of training as needed
- Disseminate lessons learned, resources, and best practices through participation in state-level "Patient Navigator" activities, including networking and sharing with and among agencies and individuals and participate in the Patient Navigation/Community Health Worker stakeholder meetings and attend the training offered by the CPNTC
- Participate in state-level evaluation or surveillance studies regarding the impact of the overall grant program, including the use of state-level strategies, definitions, and resources.

**14. Applicant H20: University of Colorado Denver**

**Project Title:** CREAndo Bienstar Diabetes Prevention Program for Latinos

**Disease Category:** Crosscutting: Cancer, Cardiovascular Disease, & Chronic Pulmonary Disease

**Funding Requested and Recommended:**

Year 1: \$250,000

Year 2: \$250,000

Year 3: \$250,000

**3-Year Total:** \$750,000

**Project Priorities:** Priority #2 Risk Factor Reduction and Disease Prevention Programs for cancer, cardiovascular disease (including diabetes and other precursors) and chronic pulmonary diseases in vulnerable populations in Colorado

Priority #3 Patient Navigation/Community Health Worker Case Coordination

**Intended Population:** African American/Black, White, Native American/American Indian, Asian American, Latino/Hispanic, Low-Socioeconomic status

**Counties Served:** Denver, Adams

**Program Description:** The CREAndo Bienestar program will address the need for connecting the Latino community to health care systems by utilizing Promotoras (Latino CHWs), from the community-based organization CREA Results, to conduct outreach work. The program will provide health screening and education, community advocacy and empowerment, and will connect and refer individuals to health resources. Outreach work will include participation in a Spanish-language radio show, collaboration with 9Health Fair, and on-site presentations. CREAndo Bienestar participants will be screened for pre-diabetes, diabetes, high blood pressure (if these have not already been done at a health fair) and results will be addressed through the patient navigation process. Promotoras will serve as lifestyle coaches using the National Diabetes Prevention Program and Cooking Matters curricula.

The program will focus on Latinos in the Denver Metro area and link them to community health care systems. The education and lifestyle intervention program will include public education, outreach, and recruitment through partnerships. Partners include 9Health Fair and local churches and schools. The program will offer health screenings, referrals to medical homes, provider education, maintenance of referral systems, and a culturally-appropriate adaptation of the National Diabetes Prevention Program. The program will also ensure that practical nutrition and physical activity instruction is readily available to the intended population. The long-term goal is to decrease diabetes among Latinos in the Denver metro area. The program will serve 1,700 people per year.

**Program Evaluation:** The CREAndo Bienstar outreach work will be evaluated by the number and description of partners who work with the Promotoras. Measures of change include individual level (health outcomes), the extent and scope of contact with intended participants, the number and type of referrals made, and reach. Success of the Diabetes Prevention Program will be evaluated based on program registrations, attendance, measures of weight loss, and minutes of activity. The reporting process is consistent with evaluation responsibilities to the Centers for Disease Control and Prevention's Diabetes Prevention Recognition Program.

**15. Applicant H38: Colorado Refugee Wellness Center (Aurora)**

**Project Title:** Culturally Competent Continuum of Care for Aurora Refugees

**Disease Category:** Cardiovascular Disease (including Diabetes and other precursors)

**Funding Requested and Recommended:**

Year 1: \$249,971

Year 2: \$249,971

Year 3: \$249,971

**3-Year Total:** \$749,913

**Project Priorities:** Priority #1 Collaborative Action for Coordinated Impact

Priority #2 Risk Factor Reduction and Disease Prevention Programs for cancer, cardiovascular disease (including diabetes and other precursors) and chronic pulmonary diseases in vulnerable populations in Colorado

Priority #3 Patient Navigation/Community Health Worker Case Coordination

**Intended Population:** African American/Black, White, Asian American, Low-Socioeconomic status

**Counties Served:** Arapahoe, Adams

**Program Description:** The Culturally Competent Continuum of Care for Aurora Refugees program will establish a culturally responsive continuum of care system for refugees in Aurora. The program will expand patient navigation services through the addition of three patient navigators (PNs) and a project coordinator. The PNs will be members of the refugee communities they serve and will receive formal patient navigation training. The patient navigation team will be an integral component of the collaborative integrated model of care. Program staff will work closely with medical and behavioral health providers and ensure health resources to reduce barriers for refugees. Program components include health education, language services, case coordination, and provider education. The program will serve 260 people per year. Program goals include:

- Collaborate with organizations to create a continuum of providers to address health disparities among refugees
- Hire and train a Patient Navigator
- Implement standardized culturally competent care curriculum for all new providers and trainees
- Improve healthcare providers' practical knowledge of specific refugee cultures, medical practices, and health needs
- Improve refugees' knowledge and understanding of U.S. healthcare system.
- Increase refugees' understanding of chronic illnesses, including prevention strategies, signs and symptoms of illnesses
- Improve patient-provider communication
- Improve health literacy of refugees served
- Reduce cultural, linguistic, and systemic barriers to screening and treatment
- Improve screening, early detection, adherence to treatment and chronic disease management for cancer, cardiovascular and chronic pulmonary diseases.

**Evaluation Plan:** The Aurora Research Institute (ARI) will serve as the Culturally Competent Continuum of Care for Aurora Refugees program. Evaluation components include process measures, attendance at Patient Navigator team meetings, patient health outcomes, services rendered, and referrals made. Improvements in refugee health literacy and provider cultural competence will be assessed through focus groups. Additionally, patient and provider satisfaction surveys will be administered to ensure participant needs are being met. ARI will provide program tools and quarterly reports on an ongoing basis, and ensure that medical health record information

is available. ARI will work closely with Patient Navigators and members of the community to conduct culturally appropriate focus groups and administer survey tools to address program needs.

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