AGENDA ITEM or FINAL CONTRACT REVIEW SUBMITTAL FORM

AgendaTitle:
Grant Application; Colorado Department of Health and Environment Amendment 35 Grants Program; Office of Gunnison County Health Equity Project; Gunnison County Multicultural Resources Office; 7/1/15 thru 6/30/18; $274,866

Action Requested: County Manager Signature

Parties to the Agreement: BOCC & Colorado Dept Public Health & Environ. -Office of Health Equity

Term Begins: July 1, 2015 **Term Ends:** 6/30/2018 **Grant Contract #:**

Summary:
This is application to the Office of Health Equity for Amendment 35 funds. This is the first of a 3 year funding opportunity. Work will help strengthen Community Health Worker role through guidance from CDPHE as well as improved data collection and CLAS standards implementation. Work will also increase positive health behaviors of under-represented populations with the greatest health disparities.

Fiscal Impact: $91,622 for Year I

Submitted by: C Worrall **Submitter's Email Address:** cworrall@gunnisoncounty.org

Finance Review: (●) Required ( ) Not Required

Comments:

This is a new grant program. DHHS increased the request since the initial letter of intent from $60,000 to $91,622. If the grant is awarded we will need to amend the County budget. This grant includes 10% indirect cost.

Reviewed by: GUNCOUNTY1\lNienhueser Discharge Date: 9/23/2014

County Attorney Review: (●) Required ( ) Not Required

Comments:

Reviewed by: GUNCOUNTY1\atrezise Discharge Date: 9/25/2014 Certificate of Insurance Required Yes ( ) No (●)

County Manager Review:

Comments:

Reviewed by: GUNCOUNTY1\mbirnie Discharge Date: 9/25/2014

(●) Consent Agenda ( ) Regular Agenda ( ) Worksession Time Allotted:

Agenda Date: 10/7/2014 Follow Up Agenda Date:

Revised April 2013

GUNNISON COUNTY HEALTH EQUITY PROJECT

COVER LETTER

Gunnison County
COLORADO

HEALTH AND HUMAN SERVICES DEPARTMENTS
Human Services Phone: (970) 641-3244 Fax: (970) 641-3738
Public Health Phone: (970) 641-0209 Fax: (970) 641-8346
225 N Pine, Gunnison, CO 81230
Website: www.GunnisonCounty.org

September 20, 2014

Amendment 35 Grants Program
Attn: Sherryl Garcia
[PSD-A5], Colorado Department of Health & Environment
4300 Cherry Creek Drive South
Denver, CO 80246-1530

RE: RFA #1237

Dear Ms. Garcia,

We are pleased to submit Gunnison County Department of Health and Human Services' application for the Office of Health Equity Grant Program FY16. Enclosed please find the required documents for this application.

The request of $91,622 is for the "Gunnison County Health Equity Project" for Year 1 of a three year funding opportunity. The proposed work will systematically address factors to reduce health disparities in our county.

The Multicultural Resource Services, within the Public Health Division of Gunnison County Department of Health & Human Services, has worked to address health disparities for over ten years, informally partnering with many local agencies. We are excited to formalize this work into the Community Health Worker model, informed by participation in work at the state level. Culturally and linguistically appropriate services (CLAS) standards implementation will be informed by state training opportunity through this grant. Through technical assistance from CDPHE we will develop a robust system of data collection to guide future work to address health disparities as well as assist in sustainability efforts.

Thank you for reviewing our application and we look forward to hearing from you.

Sincerely,

Matthew Birnie
Gunnison County Manager

GUNNISON COUNTY HEALTH EQUITY PROJECT

ATTACHMENT A:

APPLICANT INFORMATION FORM

2015/2016 | REQUEST FOR APPLICATIONS

Office of Health Equity (HD) Grant Program
Cancer, Cardiovascular Disease, and Pulmonary Disease Grant Program
Tobacco Education, Prevention and Cessation Grant Program
(Complete one per application)

Applicant Information Form

Agency Name: Gunnison County Department of Health & Human Services, Public Health Division

Agency Legal Name: Gunnison County Department of Health & Human Services, Public Health Division

Agency Contact: Carol Worrall, RN, BSN

Agency Address: 225 N Pine Street, Ste E,

City, State, Zip: Gunnison, Colorado 81230

Counties served: Gunnison

Agency Telephone: 970-641-0209 **Fax:** 970-641-8346 **Email:** cworrall@gunnisoncounty.org

Administrative Contact: Ellen Pedersen

Administrative Telephone: 970-641-7999 **Fax:** 970-641-8346 **Email:** epedersen@gunnisoncounty.org

Financial/Contract Contact: Jane Wyman, Senior Accountant

Financial/Contract Telephone: 970-641-7671 **Fax:** 970-641-7643 **Email:** jwyman@gunnisoncounty.org

Authorized Signature Contact: Matthew Birnie, County Manager

Authorized Telephone: 970-641-0248 **Fax:** 970-641-3061 **Email:** mbirnie@gunnisoncounty.org

Requested Funding:

Please enter the dollar amount requested for ***July 1, 2015 through June 30, 2016*** $ 91,622
Please enter the dollar amount requested for ***July 1, 2016 through June 30, 2017*** $ 91,622
Please enter the dollar amount requested for ***July 1, 2017 through June 30, 2018*** $ 91,622

Project Title: Gunnison County Health Equity Project

2015/2016 | REQUEST FOR APPLICATIONS

Project Description:

Gunnison County Health Equity (GCHE) Project will reduce health disparities for vulnerable populations within Gunnison County. This includes individuals living in poverty, Limited English Proficiency, sexual minorities (LGBTQ), the aging populations and those with disabilities. The GCHE project is multifaceted working with healthcare providers and those receiving their services as well as working at the local level with state level participation.

GCHE Project will support culturally and linguistically appropriate services (CLAS) standards within the healthcare system by strengthening relationships with collaborators (a key deliverable of this project). This will be accomplished through staff trainings and regularly scheduled collaborator meetings. An enhanced referral system will be developed with input from members of the collaborator group. CLAS training by the Community Health Worker (CHW) of the project will guide how to implement CLAS standards within two primary care practices.

Key deliverables include: Increase positive health behaviors by those populations with the highest level of health disparities. This includes early screenings to prevent chronic disease, and self-management for those with chronic disease. With implementation of CLAS standards within the healthcare system, combined with prevention education of individuals, the participation in positive health behaviors will increase.

Another key deliverable is development of a robust data collection system with technical assistance from CDPHE. This will allow tracking of preventative screenings and related behaviors. Improved data collection will raise awareness of health disparities within those unrepresented populations. Such data will enable evaluation of the CHW model as well as support sustainability efforts.

2015/2016 | REQUEST FOR APPLICATIONS

DEMOGRAPHIC INFORMATION

*Please provide total estimated program reach here (how many people will you serve?):__4,300__

Include **percentages** for each applicable category below and **percentage totals must add to 100%**

Intended Population- Race / Ethnicity	**Percent**
Asian / Pacific Islander	3%
Black / African American	2%
Hispanic / Latino	35%
Native American / American Indian	10%
Caucasian / Anglo / White	51%
TOTAL PERCENTAGES MUST ADD TO 100%	
Intended Population- Other Vulnerable Populations	**Percent**
Individuals who identify as gay, lesbian, bisexual, transgender, or questioning (LGBTQ)	9%
Individuals with low socioeconomic status	38%
Individuals with physical disabilities	31%
Aging Individuals	23%
TOTAL PERCENTAGES MUST ADD TO 100%	
Intended Population- Socio-economic	**Percent**
Free/Reduced Lunch (school-age children who are eligible for free or reduced-lunch programs based on financial need)	8%
Medicaid (individuals who are eligible for Medicaid benefits)	48%
Medicare (individuals who are eligible for Medicare benefits)	23%
Uninsured (Individuals who do not have any health insurance who are not eligible for Medicaid or Medicare benefits)	21%
TOTAL PERCENTAGES MUST ADD TO 100%	
Intended Population-Age Group	**Percent**
Infants / Preschool (birth to less than 6 years old)	6%
School-Age (6 years old to less than 18 years old)	14%
Young Adult (18 years old to less than 25 years old)	14%
Adult (25 years old to less than 55 years old)	42%
Older Adult (55 years old to less than 65 years old)	13%
Senior (equal to or greater than 65 years old)	10%
TOTAL PERCENTAGES MUST ADD TO 100%	
Intended Population- Gender/Gender Identity	**Percent**
Male	53.89%
Female	45.89%
Transgender	0.22%
TOTAL PERCENTAGES MUST ADD TO 100%	

GUNNISON COUNTY HEALTH EQUITY PROJECT

COPY OF LETTER OF INTENT

Gunnison County

HEALTH AND HUMAN SERVICES DEPARTMENTS
Human Services Phone: (970) 641-3244 Fax: (970) 641-3738
Public Health Phone: (970) 641-0209 Fax: (970) 641-8346
225 N Pine, Gunnison, CO 81230
Website: www.GunnisonCounty.org

August 19, 2014

Amendment 35 Grants Program
Attn: Sherryl Garcia
[PSD-A5], Colorado Department of Health & Environment
4300 Cherry Creek Drive South
Denver, CO 80246-1530

RE: Letter of Intent for RFA #1237

Dear Ms. Garcia,

The Gunnison County Department of Health & Human Services, Public Health Division, intends to submit an application for the FY16 Health Disparities Grant Program.

Lead agency: Gunnison County Department of Health & Human Services, Public Health Division

Project name: Gunnison County Community Health Worker Project

Project summary:
A Community Health Worker (CHW) will provide case coordination to increase access to health care coverage and/or services through referrals and support accessing and using the health care systems. The CHW will connect underserved minority and/or vulnerable (adult and children) populations with health disparities to: local health care providers including the local hospital and their financial assistance programs, prevention and screening programs within the Gunnison Public Health office (there is no community health clinic or FQHCC within the county) as well as Medicaid, Child Health Plan Plus (CHP+) and Connect for Health Colorado (Colorado's insurance marketplace) when applicable.

The CHW will implement outreach within Gunnison County to provide health education, community advocacy and capacity building/empowerment and connect/refer to culturally-tailored resources to reduce risk factors of the social determinants of health. This will include managing the Gunnison County Prenatal Program. Advocacy activity will include participation at the state level with the Community Health Workers work group.

The CHW may provide language interpretation and cultural brokering to assure culturally responsive services for their clients. This may include working with the local school system and local law enforcement.

Geographic area to be served: Gunnison County

Disease Category and priorities to be addressed:

- Crosscutting Category (Cancer, Cardiovascular Disease and Pulmonary Disease).
- Priority #3 Community Health Worker Case Coordination in vulnerable populations in Gunnison County.

Legislative Criteria HB 05-1262
The project will address 2 of the legislative program criteria:

- (c.) The project will implement education programs for the public and/or healthcare providers regarding the prevention, early detection and treatment of cancer, cardiovascular disease and chronic pulmonary disease.
- (d.) Provide evidence-based strategies to overcome health disparities in the prevention and early detection of cancer, cardiovascular disease and chronic pulmonary disease.

Approximate proposed dollar amount of the application for each fiscal year:
FY16 - $60,000
FY17 - $60,000
FY18 - $60,000

We look forward to submitting our application.

Sincerely,

Carol Worrall

Carol Worrall, RN, BSN
Public Health Director
Gunnison County DH&HS

GUNNISON COUNTY HEALTH EQUITY PROJECT

APPLICATION NARRATIVE

A. Application Narrative Gunnison County Health Equity Project

1. **1. Statement of Needs & Opportunities:**
2. **a.** The "Gunnison County Health Equity Project" (GCHEP) will systematically address factors that contribute to health disparities in our county. Despite the relative small population of Gunnison County (Total population 15,434[1]) health inequities exist in this frontier designated county. Geographically Gunnison is on the Western Slope where "mountainous counties of ski resorts and recreation areas…of the Western Slope have a population of varied income and education levels….Poverty is one of the social determinants of health." CDPHE 2014 Colorado Chronic Disease State Plan, pg9. According to the 2013 Health Disparities Report by CDPHE: "Health disparities are differences in health status, access to care, and quality of care among groups that differ by race, ethnicity, sexual orientation, gender identity, physical ability, place of residence, socioeconomic status, or other factors that make groups vulnerable. Health equity is achieving the highest level of health for all people by eliminating social or economic obstacles to health, equalizing the conditions for health for all groups, especially for those who have experienced socioeconomic disadvantage or historical injustices. Health equity concerns those differences in population health that can be traced to unequal economic and social conditions and are systemic and avoidable—and thus inherently unjust and unfair."

   The Gunnison County Health Equity Project will utilize evidence-based strategies such as: (1) Community Health Worker (CHW) services to assist those experiencing health disparities including strengthening an existing referral system, (2) Work with health providers to implement culturally and linguistically appropriate services (CLAS) standards, and (3) Design a robust data collection system that will inform strategies to improve health equity and support sustainability of the CHW.

[1] Kids Count, Colorado Children's Campaign 2014

Obtaining accurate numbers for individuals experiencing health inequities is challenging[2]. Without robust data on specific indicators of health status, how a particular subpopulation is doing is nearly impossible to state and can thwart efforts to make improvements. This speaks directly to the cost of "invisibility" of those experiencing health inequities and to the value of quality data. Invisibility has historically played a significant role with individuals within the sexual minority population. "Colorado has been a leader in collecting data on sexual orientation" according to the 2013 Health Disparities Report, allowing an estimation for Gunnison County to be 616. Local awareness of the sexual minority population has been non-existent and only through calculated estimates from One Colorado[3] are we able to state an actual number. While US census and other national data sources may underrepresent total subpopulations, school data including poverty rates may be the most accurate data source as most children from all groups attend school, compared to parents who may fear participation in census reports and other efforts to capture data for this population. In Gunnison County there were 18.9% children under 18 living in poverty in 2012 (slightly higher than state)[4] and uninsured children (Ages 0-18) in 2012 was 13.5% compared to state at 9.1% with those children "eligible for Medicaid or CHP+ But Not Enrolled" for 2012 for Gunnison was 20.9% and Colorado was 15.9%. "When statewide data on subpopulations are not available, different measures, local data on subpopulations, or case studies…are used" advises the 2013 Health Disparities Report. Case in point, working locally with the Nayari (Cora) population who do not have a written language and Spanish is their second language means that the disparities regarding linguistically and culturally appropriate services cannot be addressed simply through Spanish translation but require face-to-face work with a CHW.

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[2] Health Disparities 2013 Report from CDPHE
[3] http://www.one-colorado.org
[4] Kids Count, Colorado Children's Campaign 2014

Local data have been tracked for 13 years about those clients who have sought assistance with health navigation in the Multicultural Resource Services (MRS) in Gunnison County. The MRS was created in 2001 within the Public Health Division of Health & Human Services. This locally designed data system has limitations that we hope to address with technical assistance through CDPHE

"Health status is partly determined by community factors, such as pollution, residential segregation and the built environment—access to parks, good public transportation, and job opportunities"[5]. Local environmental factors that challenge health equities include very limited public transportation within the county necessitating a working vehicle to get to work, commonly running 1-3 times per day between the two population centers of Gunnison and Crested Butte.

There is no public transportation to larger cities outside of the county where medical specialists are located (nearest is 65 miles away). Lack of public transportation challenges employment security as well as presenting challenges to access medical and dental specialists outside of the area. Gunnison County is a federally designated health provider shortage area for medical, dental and mental health providers.

Lack of access to health providers due to shortages impacts everyone seeking health care. For individuals with Limited English Proficiency (LEP) and other factors influencing health disparities, access to health care is further compromised by language, poverty, lack of health insurance as well as cultural practices such as traditionally not seeking prenatal care or out-patient services prior to eminent need of care. The combined effects of no fluoride in the public drinking water with the lack of dental providers again impact all but for those more vulnerable populations, the burden of poor oral health is even greater.

[5] (Institute of Medicine 2012)" Health Disparities 2013 Report, CDPHE

Socioeconomic status has a marked influence on health[6]. Consistent, specific local income data has not been collected and will be improved upon with this project. "In Colorado…Hispanic/Latinos have the lowest household income ($38,450), are the least likely to graduate from college (7%), and are also the least likely to report good to excellent health (76%).[7]"

As part of the "Health Equity Learning Series" organized by The Colorado Trust in 2013, Dr. Anthony Iton's presentation, "Beyond Health Care: Tackling the Root Causes of Poor Health" summarized extensive data related to zip codes reflecting areas with high poverty having the lowest life expectancy and the reverse was consistently true for areas with lowest poverty having the highest life expectancy. There is poverty in Gunnison County. However there are no large areas of concentrated poverty and most of the county has the same zip code. This contributes to a high level of denial on the part of the broader community that there is poverty in our community leading to unmet social needs. A slide from Kids Count presentation in 2014 stated "What gets measured gets changed". Through funding for the GCHE project, data collection process at the local level will be enhanced so that evidence of health disparities will be identified and used with policy makers for change.

Gunnison County has a high Radon rate as does the entire state. Many members of the intended population live in house trailers eliminating the threat of high radon levels in living spaces, but the quality of housing remains poor, with inadequate insulation resulting in frequent frozen pipes (typical winter temperatures reach -30 degrees Fahrenheit) and overall crowded, poor housing quality.

Participants of other organizations have been enlisted through meeting attendance and conversations about the issues of health equities. Collaboration and referrals to other health

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[6] Institute of Medicine, 2012 Health Disparities 2013 Report, CDPHE
[7] 2013 Health Disparities Report, CDPHE

providers over many years has informed our process, such as prioritizing the need to address "No Show" rates to improve health outcomes for patients as well as improving provider willingness to participate.

Funding challenges were particularly great for a period time, reducing Multicultural Resource Services staff time. While this was a difficult period, the impact of reduced services proved informative for our partners and other organizations and their need for and appreciation of such services. An advisory group has come together at different times for the Multicultural Resource Services and with the implementation of the Gunnison County Health Equity Project this strategy will become institutionalized. Conversations with the local hospital CEO has taken place to explore local support of the MRS and strengthening further collaboration between this county office and the hospital. This was a result of attendance at several Learning Series offerings put on by The Colorado Trust that was hosted by a local non-profit, Community Foundation of the Gunnison Valley. The group attending those sessions have expressed interest in continuing to explore way of reducing health disparities and the advisory group as a part of this project is a natural evolution.

The number of individuals seeking assistance that come to MRS validates our mission and methods of providing access to health care and other services. Data from the annual report from the MRS show that over the years, 500-638 individuals have sought services in this office and the number of contacts have ranged from 2,200 to nearly 3,000.

b. program criteria

- (c.)The project will implement education programs for the public and/or healthcare providers regarding the prevention, early detection and treatment of cancer, cardiovascular disease and chronic pulmonary disease.

- (d.) Provide evidence-based strategies to overcome health disparities in the prevention and early detection of cancer, cardiovascular disease and chronic pulmonary disease.

Key staff include the Multicultural Resource Services staff (CHW) and the Public Health Director along with other collaborators, Gunnison Valley Health Hospital, Gunnison Valley Family Physicians staff, and Gunnison Valley Health Family Medicine staff. CHW will attend trainings on CLAS and from there implement training sessions for local healthcare providers as determined during the training. Public Health staff meetings will provide the platform for discussion regarding CLAS. The Community Foundation of the Gunnison Valley will be approached to follow up with those who attended The Colrado Trust Learning Series as they were a group who expressed passion about addressing health equities. Those members included County Commissioner, local hospital CEO, Director of Health and Human Services, and County Medical Officer for Public Health.

Establishing and clarifying the position of Community Health Worker is an evidence-based strategy to overcome health disparities. The individual is a trusted member of the intended population and has repeatedly demonstrated an ability to impact health inequities, both on an individual level as well as systematically. Examples include: individual presenting for counseling due to issues of sexual orientation and concerns of suicide; systematically established follow up sessions with a primary care physician for review of health screening lab work that was done through the Health Fair.

c. The intended population includes those experiencing health disparities (4,300) as well as those healthcare providers (50) who serve that population. This project will impact over 5,000 people.

The healthcare providers total approximately 50 individuals at a minimum including staff from the local hospital and two family practice offices. The hospital is a 24 bed facility with

two hospitalists on staff and nurses who work in multiple areas such as OB, ER and the in-patient area due to the small size. Services for interpreters is an ongoing struggle despite "administrative will" and support to improve upon the situation. One of the two family medicine practices has a Spanish-speaking physician.

Of the 4,300 experiencing health disparities, 1,468 individuals are uninsured and do not qualify for Medicaid or Medicare, 515 children are on free or reduced lunch programs, and 2,668 are low SES. That is nearly matched by 2,167 people with disabilities as well as 1,650 who are aging. It is estimated that there are 616 who are LGBTQ. 515 people were served last year by the MRS staff and of those 208 were identified as Cora. This group does not meet federal guidelines as "Native American/American Indian" but they are an indigenous group from a remote village in Mexico that do not have a written language, Spanish being their second language, educational level (in Spanish) averages to grade 2, primarily for the men. Resources for this group are particularly limited necessitating a greater need for support that requires a more intensive one-on-one model. For example, assistance with any paper work is more time consuming.

d. Gunnison County one of the highest rates of early prenatal care in the state (91% compared to CO at 80.2% or Boulder County 85.5%). This was not always true. Ten years ago 7 newborns in one year were flown to a large hospital as they met the high-risk criteria due to lack of prenatal care. As a trusted member of the intended population (where traditionally women have their children at home and seek no prenatal care) the CHW has worked managing the Gunnison Prenatal Program to "move the needle" significantly in the right direction. Even now, as women who experienced an uncomplicated first birth with prenatal care are now having their second child, they continue to seek prenatal care, having made a cultural shift from village health practices of no prenatal care to participating in the Gunnison Prenatal Care program.

Community need for CHW is evidenced by the City of Gunnison requesting MRS staff to participate in the planning process for their 10 year strategic plan. Issues discussed included broad needs of the low SES population in Gunnison, particularly poor housing conditions (especially in regard to temperature extremes). The local hospital invited MRS staff to participate in a Community Health Needs Assessment specifically regarding prenatal and postpartum needs of populations experiencing health disparities. When planning for sustainability, many rural CHW programs have worked to create strategic alliances between community organizations and public and private agencies[8]. Pg 14. ..some rural CHW programs have worked to develop strong partnerships in the business community...Buy-in from the business community has helped some communities to increase awareness of their program's benefits; these partners and others may be able to identify new funding sources or fund parts of the program." Pg 15

e. "Strong evidence exists that controlling risk factors will substantially reduce chronic disease. Early detection and management of chronic disease prevent complications, slow progression and improve health outcomes[9]." The use of a CHW has increased the intended populations' participation in early screenings as part of the Health Fair as well as coordinated follow up opportunities to discuss lab results with a family physician. Such activities will strengthen a healthy work force and reduce absenteeism. While the Executive Summary of the RTI International[10] found mixed effectiveness of CHW for specific health issues, in Gunnison County the impact on health behaviors can be documented. A significant number of those participating the Health Fair lab draws showed consistent reduction in cholesterol and other values over time. This coincides with increased participation at local gyms by these individuals. For over 10 years, the Gunnison County Prenatal Program has grown from

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[8] Community Health Workers Evidence-Based Models Toolbox, HRSA Office of Rural Health Policy report of 2011

[9] CO Chronic Disease State Plan, Feb. 2014 pg 29

[10] University of North Carolina at Chapel Hill Evidence-based Practice Center (RTI-UNC-EPC)

several women to 12-20 pregnant women per year with a measured impact of bringing Gunnison County to one of the highest rated counties in the state for early prenatal care (91% Kids' County 2014). The Smile Maker mobile dental van from CU School of dentistry reports seeing dramatically more kids in Gunnison than other sites (70-90 per visit). State data reveal 13% of Hispanic/Latino children had untreated cavities or decay, while 5% of White children did so[11]. These are all examples of the influence the MRS has on engaging the intended population to adopt positive health behaviors. "They (CHW) are often the bridge between the diverse populations they serve and the health care system[12]."

[11] 2008, 2009 and 2010 Colorado Child Health Survey
[12] Community Health Workers Evidence-Based Models Toolbox, HRSA Office of Rural Health Policy report of 2011. Pg 6

2. Project Design

a. Culturally and Linguistically Appropriate (CLAS) standards with the local health care system will be addressed by working with the collaborating agencies (hospital and two primary care clinics). The CHW will first attend CLAS training which will include how to implement CLAS standards within the healthcare system. During regularly scheduled meetings with collaborators, specific topics will be addressed including communication tools for: Initial contact and appointment scheduling, Registration, Procedures, Radiology and lab work, Billing, and Discussion of referrals.

Positive health behaviors including screenings for the early detection and prevention of chronic diseases will increase as those individuals with health disparities receive culturally and linguistically appropriate services by their primary care provider. As part of the GCHE project, during the regular collaborator meetings, specific positive health behaviors will be identified for assurance that these preventative behaviors will be discussed with all patients when receiving direct services[13].

b. Evidence base for this project is founded in the CHW model[14]: "Improve comprehensive primary care services that include preventive care and screenings and enhance the coordination of care and service delivery, including the use of Community Health Workers, to ensure comprehensive support for culturally, linguistically, and geographically isolated communities." The CHWs are in a unique position to engage individuals and populations that medical professionals have difficulty reaching[15]....Studies have shown that CHWs produce both positive health outcomes and financial benefits." "This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the

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[13] CDPHE, Health Disparities 2013 Report
[14] CDPHE, Health Disparities 2013 Report under Goal 3: Health System and Life Experience, Objective 3
[15] Comprehensive Health Education Fo. Report: Community Health Worker White Paper: Report & Recommendations

community to facilitate access to services and improve the quality of cultural competence of service delivery[16]."

c. The expected outcomes include: **Activity 1**: Learning how to implement CLAS within local healthcare systems will be accomplished by the CHW attending trainings to address this professional development. This will include creating a method of assessment of the healthcare system with regards to CLAS standards implementation, as informed by the training. **Activity 2:** Attending and participating in state-level meetings with other CHWs will provide an opportunity to explore "lessons learned" that can greatly inform project design and address barriers experienced by others in their efforts to reduce health disparities. State-level work will be informed by local CHW experiences and identify and strengthen the role of CHW in reducing health disparities. **Activity 3:** The establishment of a system of care will occur by establishing regular meetings with collaborators when a referral method and form will be designed by the membership. The meetings will provide a format to explore potential barriers and problem-solve solutions to reduce health disparities. **Activity 4:** In order to increase participation of vulnerable populations in early screenings and positive health behaviors, a preliminary baseline must be determined through data collection in the primary care site and participation in the communitywide Health Fair. This baseline will be collected in Year I with subsequent Years 2 &3 tracking trends for comparison to establish effectiveness of the project. **Activity 5:** Develop a comprehensive data collection and analysis system with technical assistance from CDPHE. This will measure the number of individuals who receive services that are members of the intended population as well as specific indicators (BP, BMI etc.). Specific individual identifiers will be eliminated with guidance from CDPHE. An important part of CHW activities in assisting healthcare services' navigation that directly impacts positive health outcomes is Follow Up. Methods to

[16] The American Public Health Association, 2009

collect and analyze data reflecting this work along with care coordination is challenging and will be addressed in the development of the data collection system.

d. The MRS has over 13 years of experience in serving the LEP populations linking people to services and providing the services of appropriately trained interpreters when needed[17] and we collaborate closely with the Gunnison County Senior Resource Services[18].

CLAS and Patient Navigation trainings will expand our knowledge about measures to be applied to ensure cultural and linguistic responsiveness so that staff deal effectively with clients from other cultural or linguistic backgrounds. We are aware of our less than adequate understanding of the LGBTQ portion of our population in the County in general. By working on writing this grant we contacted some professionals who we plan to invite to give presentations to expand our understanding. GCHE Project will learn about the legislation and monitor compliance.

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[17] http://www.gunnisoncounty.org/DocumentCenter/Home/View/3236

[18] http://gunnisonseniors.com/wp-content/uploads/2013/03/annual-report-2012-final1.pdf

3. Capacity/Program Infrastructure

a. The purpose of the Multi-Cultural Resources Program is to provide client services, including health navigation and assistance with access to health care, cultural competency development to residents, businesses, organizations and county department staff so they can receive and provide culturally appropriate services and responses.

b. The Multicultural Resource Services (MRS) is part of the Gunnison County Department of Health and Human Services (GCDHHS), the primary agency assessing and assuring public health and human services for low-income, uninsured and underinsured residents in Gunnison for 50 years.

The MRS was established under the Public Health (PH) Department in 2001 after receiving a prevention grant from the Colorado Department of Public Health and Environment (CDPHE). Over the years, several organizations and foundations have provided funding, including: Caring for Colorado Foundation, The Colorado Trust Immigrant Integration Initiative, and Office of Health Disparities. Currently, Caring for Colorado Foundation, El Pomar Foundation, and a Mentor's Youth Program Tobacco Education & Prevention grant fund the MRS.

Since the inception of the MRS, our efforts have focused on increasing equitable access to public services, specifically culturally and linguistically appropriate health care for minority residents with Limited English Proficiency (LEP). Consistent with the Community Health Workers (CHW) model, the MRS coordinator serves as a community resource for information, providing interpretation and translation services, and culturally appropriate health education and information, assisting people in receiving the care they need, giving informal counseling and guidance on health behaviors, and advocating for individual and community health needs. Priority is given to follow up services to assure patient comprehension of instructions as well as follow up appointments.

c. The MRS has a trusted reputation among members of vulnerable populations and among health care professionals. As part of the Public Health division, there is a natural connection to our preventative and direct personal health services. MRS serves LEP residents from Mexico and other Latin America countries (88% and 19% of its clients, respectively). Also represented are residents from Europe, Asia, Africa and the Middle East.

The MRS coordinator is often called for advice on culturally competency. For example, the City of Gunnison consulted with the MRS coordinator regarding the 10-year strategic plan. Additionally, the Hospital recently completed the OB department assessment and strategic plan with input from the MRS and the PH Director, who has over 30 years of experience.

We intend to hire a qualified bilingual, culturally competent project assistant able to translate, interpret and assist in the creation of referral systems to support client outcomes, collecting data, document coordination of care, and oversee follow-up on referrals.

d. Historically, the MRS has been grant funded. We have submitted a proposal to the Caring for Colorado grant for March 2015-March 2016 to sustain the MRS coordinator position and will submit grants locally and regionally to El Pomar Foundation, Community Foundation for the Gunnison Valley, Rotary Club, City of Gunnison, among others.

e. We plan to research local, regional, and state-wide organizations to fund projects. We also plan to work with health systems and community partners and collaborators to support client outcomes and sustainability of CHW services. We will share evaluation reports of the GCHE Project with local decision-makers and potential funders for sustainability. The Director of Public Health has worked with the MRS coordinator to form an advisory committee to address sustainability.

4. Evidence of Collaboration

a. Several organizations participate in this project. The MRS is located in the same building as DHHS, and shares space with the Center for Adult and Family Education (CAFÉ), creating a natural, safe, one-stop location for LEP clients and other vulnerable populations.

There is ongoing collaboration with all of the area's private primary and specialized care clinics in the Gunnison Valley, Gunnison Valley Health (GVH, our local Hospital), the Center for Mental Health, local and out of town dental providers, pharmacies, Schools and Child Care Centers, Early Childhood Council, Western State of Colorado University, etc. In-kind donations, grants, contributions, and cost offsets that are leveraged through the MRS add up to over $213,900.

Funding from the HD grant will help us find new ways to advance and formalize our longstanding working relationship with our collaborators: the only hospital in the County, Gunnison Valley Health (GVH), a primary care provider Gunnison Valley Family Physicians (GVFP), and the school nurse. We will establish a relationship with Gunnison Valley Health Family Medicine (GVHFM), which is a new clinic.

It has been our experience that these organizations have a commitment to provide culturally and linguistically appropriate services to reduce health disparities; therefore, we plan to share knowledge on CLAS standards and help each other apply the concepts. Funding will also allow us to increase efficiency in our systems of collaboration and build depth in how we address health equity. With the support from CDPHE, we will create referral systems and forms to support client outcomes and sustainability of CHW services. The CHW will shadow clinic personnel to learn more about the work, and we'll meet regularly at a frequency to be determined by collaborators to share information and improve services.

b. No money will be exchanged with any of our collaborators. Health equity concepts will be shared after CLAS training and the participation of the CHW in Colorado patient navigator

and CHW collaborative stakeholder workgroup meetings and subcommittees to inform and contribute to the development of coordinated work of the patient navigators and CHWs. With guidance from CDPHE, we will develop a comprehensive plan for systematic data collection. Our collaborators will participate in tracking and reporting mechanisms to collect standardized metrics, link existing patient resources, reduce barriers to access, and document coordination of care between patients, clients and providers, and oversee follow-up on referrals for services such as healthcare, human services and health insurance.

c. letters of collaboration are included

d. The collaborative partners will support the activities of the CHW by applying CLAS standards, consenting to shadowing and sharing of non-identifying information for reporting to CDPHE. They will collaborate in the creation of a referral systems and forms to support client outcomes as well as participating in regular meetings to share information that will ultimately benefit vulnerable populations by reducing health disparities and contribute ideas for sustainability of CHW services.

Information shared will include: Number of patients recruited to program and outreach sites; basic demographics of clients/patients served; type of health insurance; type of chronic health issues addressed and associated risk factors; baseline disease specific data; number of enrolled program participants; number of client referrals; documentation of client/patient follow-up, appointments made and kept (and results); and client barriers addressed/method.

e. n/a

5. Evaluation Plan

a. Proposed outcomes (Deliverables): 1: GCHE project will support adoption and implementation of CLAS standards through the attendance of the CHW at the state CLAS training to learn a method to assess CLAS in two primary care settings (such as pre/post testing) that will improve participation of intended population in preventative services offered. **2**: By participating is state level "Patient Navigator" activities, the CHW will learn two new strategies from other CHWs to inform local work of CHW. **3**: GCHE project will show evidence of relationships with collaborators by developing of system care reflected by the creation of a referral process/form that is created by the group members' participation in at least 3 collaborator meetings. **4**: GCHE project will determine effectiveness of patient education on positive health behavior changes by first determining a baseline in Year I of the number of individuals who participate in early screenings (including cholesterol, B/P and BMI, etc.) through data collected at two primary care settings and participation in the Health Fair. Year 2 will increase that number by 5%. **5:** A robust data collection system, with assistance from CDPHE, will show the effectiveness of CHW in improving health outcomes for the intended populations.

b. The GCHE project is in alignment with the HD Grant Program goals of significantly reducing the burden chronic diseases in Colorado. GCHE project will support clinical system changes by supporting the adoption and implementation of CLAS standards and by participating in state level Patient Navigator activities. Additionally, GCHE project will show evidence of relationships with collaborators by developing of system care reflected by the creation of a referral process/form with participation of group members'.

GCHE project will determine effectiveness of patient education on prevention and screening programs and positive health behavior changes by comparing baseline information with data

from the last year of the grant on number of individuals who participate in early screenings through data collected at two primary care settings and participation in the Health Fair. GCHE project will implement a robust data collection system, with assistance from CDPHE, to show the effectiveness of CHW in improving health outcomes for the intended populations. Data will be used to develop a comprehensive approach to public information and professional education.

c. GCDHHS agrees to 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.

d. The intended population is 4,300 vulnerable populations (estimates) in Gunnison County that includes low SES people, LGBTQ, aging and those with disabilities, and others who experience health disparities. Services provided include: health education for clients to self-manage cancer, cardiovascular disease, pulmonary disease and associated risk factors; support positive behavior change by connecting clients to activities and resources for chronic disease prevention and risk factor reduction

e. Using information obtained at CLAS training, we will assess our collaborators for cultural and linguistic appropriateness of services at several stages of the project. A database will be created and used to track number of patients linked to healthcare providers including health insurance services. Health and risk factor assessments will also be tracked over the grant period.

f. Key evaluation findings will be communicated at Board of Health and at the community-wide Health and Human Services Commission meetings and newspaper articles at the end of each grant year. Evaluation results will be used to inform strategies throughout the grant. Evaluation reports will be shared with local decision makers and potential funders for sustainability.

g. We selected the CHW programs approach. The desired outcome is to improve knowledge related to preventing disease in vulnerable populations to improve health outcomes. Another intervention chosen is to increase CLAS knowledge to improve health care workers' cultural and linguistic appropriate services. This was chosen to strengthen the CHW's ability to implement CLAS among local health care providers. Participation at the state level will strengthen the role of CHWs in reducing health disparities.

h. Focus on Crosscutting Category (Cancer, Cardiovascular Disease and Pulmonary Disease)

i. For over a decade, the MRS has been a leader in providing services that are culturally and linguistically appropriate and the coordinator has attended the Patient Navigator training. Funding from this grant will allow us to use strategies learned in the CLAS training and share the knowledge with our collaborators and other health care providers, as well as Public Health and Human Services staff. Cultural competency for clients will be addressed by contacting leaders of the vulnerable populations for advice.

GUNNISON COUNTY HEALTH EQUITY PROJECT

ATTACHMENT C:

PROJECT STATEMENT OF WORK

STATEMENT OF WORK
To Contract/Task Order Contract Dated **//**** - Contract Routing Number ** *** ***** - Contract Amendment Routing Number ** *** *******

These provisions are to be read and interpreted in conjunction with the provisions of the Contract/Task Order Contract specified above. The Statement of Work is designed to address a 3-Year process. Applicants must provide a plan for goals, deliverables, and activities for the period July 1, 2015 through June 30, 2018.

Agency Name: Gunnison County Department of Health and Human Services

Project Name: Gunnison County Health Equity Project

Project Term: July 1, 2015 to June 30, 2016
July 1, 2016 to June 30, 2017
July 1, 2017 to June 30, 2018

Project Description: Gunnison County Health Equity (GCHE) Project will reduce health disparities for vulnerable populations within Gunnison County. This includes individuals living in poverty, Limited English Proficiency, sexual minorities (LGBTQ), the aging populations and those with disabilities. The GCHE project is multifaceted working with healthcare providers and those receiving their services as well as working at the local level with state level participation.

GCHE Project will support culturally and linguistically appropriate services (CLAS) standards within the healthcare system by strengthening relationships with collaborators (a key deliverable of this project). This will be accomplished through staff trainings and regularly scheduled collaborator meetings. An enhanced referral system will be developed with input from members of the collaborator group. CLAS training by the Community Health Worker (CHW) of the project will guide how to implement CLAS standards within two primary care practices. Key deliverables include: Increase positive health behaviors by those populations with the highest level of health disparities. This includes early screenings to prevent chronic disease, and self-management for those with chronic disease. With implementation of CLAS standards within the healthcare system, combined with prevention education of individuals, the participation in positive health behaviors will increase.

Another key deliverable is development of a robust data collection system with technical assistance from CDPHE. This will allow tracking of preventative screenings and related behaviors. Improved data collection will raise awareness of health disparities within those unrepresented populations. Such data will enable evaluation of the CHW model as well as support sustainability efforts.

I. Performance Requirements/Deliverables:
Calendar Quarters (Q): Q1-July 1-September 30; Q2-October 1-December 31; Q3-January 1-March 31; Q4-April 1-June 30

A. **Goal Area:** The purpose of the Health Disparities Grant Program is to provide financial support for statewide initiatives that address prevention, early detection, and treatment of cancer, cardiovascular disease including diabetes or other precursors, and chronic pulmonary diseases in underrepresented populations. The goal of the program is to significantly reduce the burden of the above mentioned chronic diseases in Colorado by development of a comprehensive approach to public information and professional education, support for clinical system changes, and community-based prevention and screening programs.

Mandatory Deliverable 1- Culturally and Linguistically Appropriate Services (CLAS): By 6/30/2016, Gunnison County Department of Health and Human Services (GCDHHS) shall support adoption and implementation of the enhanced (CLAS) standards by increasing use of Culturally and Linguistically Appropriate Services to reduce language barriers for Limited English Proficiency (LEP) individuals.				
Intended Population: Program Staff				
Activity 1	**Quarters of activity**	**Measurement**	**Deadline**	**Responsible Agency**
Activity 1.1: Participate in at least one (1) CLAS training provided by CDPHE's Office of Health Equity as documented by the Colorado Department of Public Health and Environment.	Q1 – Q4	-Attend one (1) CLAS training.	June 30, 2018	Gunnison County Department of Health and Human Services (GCDHHS)

Deliverable 2: By 6/30/2016, GCDHHS support and participate in state level "Patient Navigator" activities. This work includes networking and sharing of grantees work, best practices and resources among agencies and individuals involved as patient navigators, community health workers (CHW), care coordinators or other health extenders.				
Target Population: Individuals providing similar work in communities and healthcare settings				
Activity 2	**Quarters of activity**	**Measurement**	**Deadline**	**Responsible Agency**
Activity 2.1: Participate in at least two (2) of the Colorado patient navigator and CHW collaborative stakeholder workgroup meetings and participate in at least one (1) subcommittee, as they are scheduled, to inform and contribute to the development of coordinated work of the patient navigators and CHWs.	Q1 – Q4	-Attend two (2) of the Colorado patient navigator and CHW collaborative stakeholder workgroup meetings - Participate in at least one (1) subcommittee	June 30, 2016	GCDHHS
Activity 2.2: Attend patient navigator training at level suggested by State-level Subject Matter Expert	Q1 – Q4	-Attend patient navigator training	June 30, 2016	GCDHHS

Deliverable 3: By 6/30/2016, GCDHHS will be able to show evidence of having relationships or engaging in activity to build relationships with the health care systems in their area.				
Intended Population: Individuals providing similar work in communities and healthcare settings. Ultimately benefitting vulnerable populations including African-American/Black, Asian-American/Pacific Islander, Native American/American Indian, Hispanic/Latino, Aging , Lesbian, Gay, Bisexual, Transgender, Disabled, Low Socio-Economic Status and populations with geographic health issues.				
Activity 3	**Quarters of activity**	**Measurement**	**Deadline**	**Responsible Agency**
Activity 3.1: Establish contact with Gunnison County health care providers	Q1, Q2	-List of health systems (and PCMHs) that CHWs are working with to link patients to community resources	December 30, 2015	GCDHHS
Activity 3.2. Work with health systems and community partners to create referral systems to support client outcomes and sustainability of CHW services.	Q2,	-Number and description of partners who work with CHWs (including referrals) for inclusion in a statewide resource portal.	December 30, 2015	GCDHHS
Activity 3.3. Develop referral forms in collaboration with CDPHE	Q2,	-Referral forms developed and used	December 30, 2015	GCDHHS
Activity 3.4. Shadow staff at Hospital, Health care clinics and school nurse to improve understanding that will inform collaboration	Q1, Q2, Q3, Q4	-1 day shadowing at each of the collaborators -Description of new knowledge/new partnership	June 30, 2016	GCDHHS
Activity 3.5 Meet regularly with collaborators.	Q2, Q4	-Scheduled meetings as suggested by collaborators. -Meeting minutes.	June 30, 2016	GCDHHS

Deliverable 4: By 6/30/2016, GCDHHS will develop and implement health education, risk-factor assessment and referral plans that promotes positive behavior changes with regard to chronic disease prevention (healthy eating active living), and/or chronic disease screening and self-management.				
Intended Population: Vulnerable populations including African-American/Black, Asian-American/Pacific Islander, Native American/American Indian, Hispanic/Latino, Aging, Lesbian, Gay, Bisexual, Transgender, Disabled, Low Socio-Economic Status and populations with geographic health issues.				
Activity 4	**Quarters of activity**	**Measurement**	**Deadline**	**Responsible Agency**
Activity 4.1: Provide health education and support to client to self-manage cancer, cardiovascular disease, pulmonary disease and associated risk factors	Q2, Q3, Q4	Measures of change at the individual level, i.e., observed or self-reported physical activity, screening, referral to resources	June 30, 2016	GCDHHS
Activity 4.2: Support positive behavior change by connecting clients to culturally-appropriate and evidence-based outreach activities and resources for chronic disease prevention and risk factor reduction such as the Diabetes Prevention Program, shopping demonstrations, cooking classes on a budget, walking groups, exercise classes, and active transportation.	Q2, Q3, Q4	-Measures of change at the individual level, i.e., observed or self-reported physical activity, screening, referral to resources -Report Media impressions and other ways of communication on opportunities for positive behavior change	June 30, 2016	GCDHHS
Activity 4.3: Perform health and risk factor assessments such as blood pressure, cardiovascular disease and diabetes risk assessment, BMI, weight, etc.	Q2, Q3, Q4	-Documentation of data obtained.	June 30, 2016	GCDHHS
Activity 4.4: Connect clients to patient-centered medical home or primary care provider for quality care with referrals for direct services, such as medical/clinical screenings for high cholesterol, glucose or A1c, blood pressure, cardiovascular disease risk assessment, cancer, etc.	Q1, Q2, Q3, Q4	- Documentation of number and type of referrals made. -Percent of referral follow-throughs by type	June 30, 2016	GCDHHS
Activity 4.5: Connect clients to Medicaid, CHP+ services (or other health plans) in alignment with the Patient Protection and Affordable Care Act (ACA)	Q1, Q2, Q3, Q4	- Documentation of number and type of referrals made, percent of referral follow-throughs by type	June 30, 2016	GCDHHS

Deliverable 5: By 6/30/2016, GCDHHS will utilize a systematic data collection process, incorporating specific standardized metrics with guidance from CDPHE.				
Intended Population: Individuals providing similar work in communities and healthcare settings; Vulnerable populations including African-American/Black, Asian-American/Pacific Islander, Native American/American Indian, Hispanic/Latino, Aging , Lesbian, Gay, Bisexual, Transgender, Disabled, Low Socio-Economic Status and populations with geographic health issues.				
Activity 5.	**Quarters of activity**	**Measurement**	**Deadline**	**Responsible Agency**
Activity 5. 1: Contact CDPHE for guidance to develop a systematic data collection process	Q1, Q2	-CDPHE contacted and guidance received -Evidence of a data collection form or system	December 30, 2015	GCDHHS
Activity 5. 2: Use database or other data tracking system with written and/or electronic tracking and reporting mechanisms to collect standardized metrics, link existing patient resources, reduce barriers to access, and document coordination of care between patients, clients and providers, and oversee follow-up on referrals for services such as healthcare, human services and health insurance.	Q1, Q2, Q3, Q4	-Data submitted at least yearly to CPDHE	June 30, 2016	GCDHHS

The following deliverables should be completed in YEAR TWO of the grant

Deliverable 1: By 01/30/2017, GCDHHS will complete a mid-cycle progress report
Target Population: Vulnerable populations and Collaborators

Deliverable 2: By 06/30/2017, GCDHHS, in partnership with the collaborators and supporters will reinforce adoption and implementation of the enhanced (CLAS) standards by increasing use of Culturally and Linguistically Appropriate Services to reduce language barriers for Limited English Proficiency (LEP) individuals.
Intended Population: Program Staff, Collaborators, Supporters

Deliverable 3: By 06/30/2017, GCDHHS will participate in at least two (2) of the Colorado patient navigator (PN) and community health worker (CHW) collaborative stakeholder and in at least one (1) subcommittee to inform and contribute to the development of coordinated work of the CHWs.
Target Population: Individuals providing similar work in communities and healthcare settings

Deliverable 4: By 06/30/2017, GCDHHS will be able to show evidence of continuous collaboration with health systems and community partners by using referral systems to support client outcomes and sustainability of CHW services.
Intended Population: Individuals providing similar work in communities and healthcare settings. Ultimately benefitting vulnerable populations

Deliverable 5: By 06/30/2017, GCDHHS will implement health education, risk-factor assessment and referral plans that promotes positive behavior changes with regard to chronic disease prevention (healthy eating active living), and/or chronic disease screening and self-management.
Intended Population: Vulnerable populations

Deliverable 6: By 06/30/2017, GCDHHS will be able to show evidence of continuous collaboration with health systems and community partners by researching sustainability of CHW services.
Intended Population: Individuals providing similar work in communities and healthcare settings.

Deliverable 7: By 06/30/2017, GCDHHS will utilize a systematic data collection process, incorporating specific standardized metrics developed in YEAR 1 with guidance from CDPHE
Intended Population: Vulnerable populations

The following deliverables should be completed in YEAR THREE of the grant

Deliverable 1: By 01/30/2018, Gunnison County Department of Health and Human Services (GCDHHS) will complete a final report
Target Population: Vulnerable populations and Collaborators

Deliverable 2: By 06/30/2018, GCDHHS, in partnership with the collaborators and supporters will reinforce adoption and implementation of the enhanced (CLAS) standards by increasing use of Culturally and Linguistically Appropriate Services to reduce language barriers for Limited English Proficiency (LEP) individuals.
Intended Population: Program Staff, Collaborators, Supporters

Deliverable 3: By 06/30/2018, GCDHHS will participate in at least two (2) of the Colorado PN and CHW collaborative stakeholder and in at least one (1) subcommittee to inform and contribute to the development of coordinated work of the CHWs.
Target Population: Individuals providing similar work in communities and healthcare settings

Deliverable 4: By 06/30/2018, GCDHHS will be able to show evidence of continuous collaboration with health systems and community partners by using referral systems to support client outcomes.
Intended Population: Individuals providing similar work in communities and healthcare settings.

Deliverable 5: By 06/30/2018, GCDHHS will continue implementing health education, risk-factor assessment and referral plans that promotes positive behavior changes with regard to chronic disease prevention (healthy eating active living), and/or chronic disease screening and self-management.
Intended Population: Vulnerable populations

Deliverable 6: By 06/30/2018, a sustainability plan for CHW services will be developed.
Intended Population: Individuals providing similar work in communities and healthcare settings.

Deliverable 7: By 06/30/2018, GCDHHS will continue using systematic data collection process, incorporating specific standardized metrics developed in YEAR 1 with guidance from CDPHE
Intended Population: Vulnerable populations

GUNNISON COUNTY HEALTH EQUITY PROJECT

ATTACHMENT D:

BUDGET WITH JUSTIFICATION FORM

Colorado Department of Public Health and Environment

Colorado Department of Public Health and Environment
PREVENTION SERVICES DIVISION- BUDGET WITH JUSTIFICATION FORM
Contract Routing

Contractor Name	**Gunnison County**
Budget Period	**7/1/2015 to 6/30/2016**
Project Name	**Gunnison County Health Equity Project**

Program Contact Name, Title, Phone and Email	**Carol Worrall, Director Public Health 970 641-0209, cworrall@gunnisoncounty.org**
Fiscal Contact Name, Title, Phone and Email	**Jane Wyman, Senior Accountant 970-641-7671, jwyman@gunnisoncounty.org**

Expenditure Categories

Personal Services
Salaried Employees

Position Title/Employee Name	Description of Work	List SOW deliverable/ primary task number(s) this budget item supports	Gross or Annual Salary	Fringe	Percent of Time on Project	Match or In-Kind (If Required by RFA)	Total Amount Requested from CDPHE
							$0.00
							$0.00
							$0.00
							$0.00
							$0.00
							$0.00
							$0.00
							$0.00
							$0.00

Personal Services
Hourly Employees

Position Title/Employee Name	Description of Work	deliverable/ primary task number(s) this budget item supports	Hourly Wage	Hourly Fringe	Total # of Hours on Project	Match or In-Kind (If Required by RFA)	Total Amount Requested from CDPHE
Ellen Pedersen, CHW	Coordinates the project, manages the grant, works with colaborators to overcome health disparities	All	$23.39	$6.21	2080.00		$61,561
Project Assistant	Assist in the creation of referral systems to support client outcomes, collecting data and document coordination of care between patients, clients and providers, and oversee follow-up on referrals for services such as healthcare, human services and health insurance. Translation and interpretation services.	All	$15.00	$3.75	1040.00		$19,500

Colorado Department of Public Health and Environment

Colorado Department of Public Health and Environment
PREVENTION SERVICES DIVISION- BUDGET WITH JUSTIFICATION FORM
Contract Routing

Contractor Name	**Gunnison County**
Budget Period	**7/1/2015 to 6/30/2016**
Project Name	**Gunnison County Health Equity Project**

Program Contact Name, Title, Phone and Email	**Carol Worrall, Director Public Health 970 641-0209, cworrall@gunnisoncounty.org**
Fiscal Contact Name, Title, Phone and Email	**Jane Wyman, Senior Accountant 970-641-7671, jwyman@gunnisoncounty.org**

	Benefits Note: Gunnison County charges exact fringe benefits based on their selection and applicable employment benefits. Fringe includes all applicable employment and benefit expenses per Gunnison County's Personnel Policies (workers' comp insurance, unemployment insurance, accident insurance, critical illness insurance, short-term disability insurance, and the employer portion of FICA, retirement, health and dental insurance, basic and supplemental life insurance, employee assistance program). Average = 25% of salaries"						$0
							$0
							$0
							$0
							$0
							$0
							$0
					Total Personal Services (including fringe benefits)	**$0**	**$81,061**

Colorado Department of Public Health and Environment

Colorado Department of Public Health and Environment
PREVENTION SERVICES DIVISION- BUDGET WITH JUSTIFICATION FORM
Contract Routing

Contractor Name	**Gunnison County**
Budget Period	**7/1/2015 to 6/30/2016**
Project Name	**Gunnison County Health Equity Project**

Program Contact Name, Title, Phone and Email	**Carol Worrall, Director Public Health 970 641-0209, cworrall@gunnisoncounty.org**
Fiscal Contact Name, Title, Phone and Email	**Jane Wyman, Senior Accountant 970-641-7671, jwyman@gunnisoncounty.org**

Supplies & Operating Expenses

Item	Description of Item	List SOW deliverable/ primary task number(s) this budget item supports	Rate	Quantity	Match or In-Kind (If Required by RFA)	Total Amount Requested from CDPHE
Office Supplies	photocopies		$ 0.08	500		$40
Educational materials	Educational materials		$ 40.00	10		$400
Office Supplies	toner for printer		$ 95.00	1		$95
						$0
						$0
						$0
						$0
				Total Supplies & Operating Expenses	**$0**	**$535**

Travel

Item	Description of Item	List SOW deliverable/ primary task number(s) this budget item supports	Rate	Quantity	Match or In-Kind (If Required by RFA)	Total Amount Requested from CDPHE
Mileage	CHW will attend two mandatory trainings in Denver. Round trip is approximately 203 miles x 2 trips = 812 miles. Reimbursement at $.56/mile.	1, 2	$ 0.56	812		$455
Meals	CHW will attend two mandatory trainings in Denver. Meal estimate is based on current Gunnison County per diem rate of $36. Meals are not being provided during the trainings. We are anticipating four days of travel per diem for each training. (4x$36=$144 x 2 trips= $288)	1, 2	$ 144.00	2		$288
Lodging	Overnight stay for CHW to attend two mandatory meetings in Denver. Estimate is based on current government per diem rate for Denver. $149/night x 3 nights x 2 trainings	1, 2	$ 149.00	6		$894
Parking	Parking downtown Denver for two mandatory meetings - $10/day x 6 days.	1, 2	$ 10.00	6		$60
						$0
						$0
						$0

Colorado Department of Public Health and Environment

Colorado Department of Public Health and Environment
PREVENTION SERVICES DIVISION- BUDGET WITH JUSTIFICATION FORM
Contract Routing

Contractor Name	**Gunnison County**
Budget Period	**7/1/2015 to 6/30/2016**
Project Name	**Gunnison County Health Equity Project**

Program Contact Name, Title, Phone and Email	**Carol Worrall, Director Public Health 970 641-0209, cworrall@gunnisoncounty.org**
Fiscal Contact Name, Title, Phone and Email	**Jane Wyman, Senior Accountant 970-641-7671, jwyman@gunnisoncounty.org**

						$0
						$0
						$0
						$0
						$0
				Total Travel	**$0**	**$1,697**
Contractual						
Subcontractor Name	**Description of Item**	**List SOW deliverable/ primary task number(s) this budget item supports**	**Rate**	**Quantity**	**Match or In-Kind (If Required by RFA)**	**Total Amount Requested from CDPHE**
	n/a					$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0
				Total Contractual	**$0**	**$0**
					SUB-TOTAL BEFORE INDIRECT	**$83,292**

Colorado Department of Public Health and Environment

Colorado Department of Public Health and Environment
PREVENTION SERVICES DIVISION- BUDGET WITH JUSTIFICATION FORM
Contract Routing

Contractor Name	**Gunnison County**
Budget Period	**7/1/2015 to 6/30/2016**
Project Name	**Gunnison County Health Equity Project**

Program Contact Name, Title, Phone and Email	**Carol Worrall, Director Public Health 970 641-0209, cworrall@gunnisoncounty.org**
Fiscal Contact Name, Title, Phone and Email	**Jane Wyman, Senior Accountant 970-641-7671, jwyman@gunnisoncounty.org**

Indirect			
Item	**Description of Item**	**Match or In-Kind (If Required by RFA)**	**Total Amount Requested from CDPHE**
Negotiated Indirect cost rate (Federal, State, or CDPHE)			
Indirect rate (other):	Indirect Cost includes supervision, financial services, phone, office use, etc. 10% of Total Direct Cost		$8,329
Indirect (modified or additional base)			
	Total Indirect	**$0**	**$8,329**
	TOTAL MATCH OR IN KIND	**$0**	
		TOTAL	**$91,622**

Proposed Project Period

Start Date: **7/1/2015** End Date: **6/30/2018**

BUDGET SUMMARY

	YEAR 1	YEAR 2*	YEAR 3*	TOTAL PROJECT COSTS
TOTAL PROJECT COSTS	**$91,622**	**$91,622**	**$91,622**	**$274,866**

Justification for changes in Years 2 and 3

If year 2 and/or year 3 budget totals are different from year 1, please provide a brief summary describing the contributing factors affecting the change in budget estimates.

GUNNISON COUNTY HEALTH EQUITY PROJECT

COPY OF CDPHE NEGOTIATED

INDIRECT RATE AGREEMENT

COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

COLORADO LOCAL PUBLIC HEALTH AGENCY
INDIRECT COST NEGOTIATION AGREEMENT

Local Public Health Agency

Gunnison County Public Health
& Family Planning
200 East Virginia
Gunnison, CO 81230

DATE: September 16, 2013

FILING REF: This replaces the
Negotiation Agreement for the
1-1-13 to 12-31-13 Indirect Rate

The indirect cost rate(s) contained herein is for use on grants and contracts with the Colorado Department of Public Health and Environment to which the Office of Management and Budget Circular A-87 applies subject to the limitations contained in Section II, A., of this agreement. The rate(s) was negotiated by Gunnison County Public Health & Family Planning and the Colorado Department of Public Health and Environment.

SECTION I: RATES

Type	Effective Period From	To	Rate*	Locations	Applicable To
Fixed:	1/1/2014	12/31/2014	60.12%	All	All programs

*Base: Total Direct Costs

Treatment of Fringe Benefits: Fringe benefits applicable to direct salaries and wages are treated as direct costs.

SECTION II: GENERAL

A. LIMITATIONS: Use of the rate(s) contained in this agreement is subject to any statutory or administrative limitations and is applicable to a given grant or contract only to the extent that funds are available. Acceptance of the rate(s) agreed to herein is predicated upon the conditions: (1) that no costs other than those incurred by the grantee/contractor or allocated to grantee/contractor via an approved Central Service cost allocation plan were incurred in its indirect cost pool as finally accepted and that such incurred costs are legal obligations of the grantee/contractor and allowable under the governing cost principles, (2) that the same costs that have been treated as indirect costs have not been claimed as direct costs, (3) that similar types of costs have been accorded consistent treatment, and (4) that the information provided by the grantee/contractor which was used as a basis for acceptance of the rate(s) agreed to herein is not subsequently found to be materially inaccurate.

B. AUDIT: Adjustments to amounts resulting from audit of the cost allocation plan upon which the negotiation of this agreement was based will be compensated for in a subsequent negotiation.

C. CHANGES: If a fixed or predetermined rate(s) is contained in this agreement it is based on the organizational structure and the accounting system in effect at the time the proposal was submitted. Changes in the organizational structure or changes in the method of accounting for costs which affect the amount of reimbursement resulting from the use of the rate(s) in this agreement require the prior approval of the authorized representative of the Colorado Department of Public Health and Environment. Failure to obtain such approval may result in subsequent audit disallowances.

D. FIXED RATE(S): The fixed rate(s) contained in this agreement is based on an estimate of the costs which will be incurred during this period for which the rate applies. When the actual costs for such period have been determined, an adjustment will be made in the negotiation following such determination to compensate for the difference between that cost used to establish the fixed rate and that which would have been used were the actual costs known at the time.

E. NOTIFICATION TO OTHER LOCAL PUBLIC HEALTH AGENCIES: Copies of this document may be provided to other local public health agencies if requested by them.

F. SPECIAL REMARKS: Colorado Department of Public Health and Environment programs currently reimbursing indirect costs to this Local Public Health Agency by means other than the rate(s) cited in this agreement should be credited for such costs and the applicable rate cited herein applied to the appropriate base to identify the proper amount of indirect costs allocable to the program.

Local Public Health Agency	Colorado Department of Public Health and Environment
Matthew Birnie	Patricia Theriot
Name	Name
County Manager	Internal Auditor
Title	Title
10/01/2013	9/16/13
Date	Date

GUNNISON COUNTY HEALTH EQUITY PROJECT

ATTACHMENT E: W9

Form **W-9**
(Rev. August 2013)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

Name (as shown on your income tax return)
Gunnison County

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:
☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶

☑ Other (see instructions) ▶ Government Entity

Exemptions (see instructions):
Exempt payee code (if any)
Exemption from FATCA reporting code (if any)

Address (number, street, and apt. or suite no.)
200 E. Virginia Ave.

Requester's name and address (optional)

City, state, and ZIP code
Gunnison, CO. 81230

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number
☐☐☐ - ☐☐ - ☐☐☐☐

Employer identification number
8 4 - 6 0 0 0 7 7 0

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below), and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here **Signature of U.S. person ▶** Jane Wyman **Date ▶** 9/5/2014

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. The IRS has created a page on IRS.gov for information about Form W-9, at *www.irs.gov/w9*. Information about any future developments affecting Form W-9 (such as legislation enacted after we release it) will be posted on that page.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, payments made to you in settlement of payment card and third party network transactions, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct.

Note. If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7)

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.