Executive Summary
Yampa Valley Medical Center

COMMUNITY HEALTH NEEDS ASSESSMENT
EXECUTIVE SUMMARY

OVERVIEW

The Center for Health Administration (CHA) at the University of Colorado Denver was retained to conduct data collection for the 2012 Community Health Needs Assessments (CHNA) for Yampa Valley Medical Center per Internal Revenue Code requirements. As part of the Affordable Care Act of 2010, each freestanding non-profit (501-c3) hospital is required to conduct a CHNA every three years. This report is the first CHNA on behalf of Yampa Valley Medical Center that complies with the IRS mandate. This CHNA describes the health status of the hospital’s community and is to be used by the hospital and other collaborators when it develops an implementation plan that addresses the identified community needs. The CHNA will be submitted to the IRS with the implementation plan.

METHODOLOGY

Data for the Community Health Needs Assessment (CHNA) was predominantly collected from the Colorado Department of Public Health and Environment (CDPHE). The CDPHE’s Colorado Behavioral Risk Factor Surveillance System Survey was used to determine information about adult behaviors that impact health, such as substance abuse, eating and exercise habits, and smoking. The national Youth Risk Behavior Survey was consulted to determine behaviors that impact the health of students in 9th through 12th grades. The CDPHE’s data base was also probed for information on mortality rates for a variety of health indicators. Many other sources were also used to provide information relevant to each topic area.

This report mirrors applicable parts of the CDPHE’s 10 Winnable Battles which identifies key health issues where progress can be made in the next five years. By aligning with the CDPHE, Yampa Valley Medical Center joins forces with an ally in efforts to make an impact on improving the health of its hospitals’ communities. Through this process, Yampa Valley Medical Center also meets stipulations set by the Affordable Care Act (ACA) that requires hospitals to collaborate with their Public Health Departments to improve their communities’ health.

To ensure alignment with publically available CDPHE data, Colorado counties make up the geographic area for the 2013 CHNA. The Primary Service Area for Yampa Valley Medical Center (VVH) is Routt County and Moffat County. When county data was unavailable, Health Statistic Region data is substituted.
HEALTH INDICATORS

The health indicators that were chosen for this report were selected based on publically available CDPHE data, and many were also identified as part of Colorado’s 10 Winnable Battles. The health indicators are as follows:

- Access
- Cancer
- Communicable Disease
- Diabetes
- Heart Disease and Cerebrovascular Disease
- Injury
- Mental Health
- Obesity, Nutrition and Physical Activity
- Oral Health
- Overall Health Status
- Sexual Health and HIV/AIDS
- Substance Abuse
- Tobacco
The following Community Health Needs Assessment (CHNA) Summary Table shows, at a glance, the health status of the counties in the hospital’s primary service area. Each health indicator has several measurements that are rated in comparison to the state average. Indicator rates that are worse than the state average are given a red square, indicator rates that are better than the state average are given a green square, and indicator measurements that are within 1.0% of the state average have a yellow square.

If county data is not available, no comparison is made. Unavailable data is typically due to absent data or a small sample size that cannot demonstrate statistical significance.
## Yampa Valley Medical Center

### CHNA

<table>
<thead>
<tr>
<th>Health Issue</th>
<th>Health Indicator</th>
<th>Moffat</th>
<th>Routt</th>
<th>HSR 11</th>
<th>State</th>
<th>Nation</th>
<th>State Goal</th>
<th>HP Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access</strong></td>
<td>Health care coverage</td>
<td>79.9%</td>
<td>83.9%</td>
<td>-</td>
<td>84.3%</td>
<td>85.0%</td>
<td>-</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>Eligible adults not enrolled in Medicaid</td>
<td>28.2%</td>
<td>50.5%</td>
<td>-</td>
<td>24.8%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Eligible children not enrolled in Medicaid</td>
<td>14.2%</td>
<td>27.2%</td>
<td>-</td>
<td>12.8%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Eligible children not enrolled in CHP+</td>
<td>51.6%</td>
<td>57.6%</td>
<td>-</td>
<td>37.2%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Cancer</strong></td>
<td>Clinical breast exam and mammogram</td>
<td>77.2%</td>
<td>65.0%</td>
<td>-</td>
<td>66.5%</td>
<td>77.9%</td>
<td>80.0%</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Had PAP smear in last 3 years</td>
<td>90.6%</td>
<td>-</td>
<td>93.0%</td>
<td>81.3%</td>
<td>81.1%</td>
<td>90.0%</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Colonoscopy (within 10 years)/Sigmoidoscopy (within 5 years)/FOBT (Within 1 year)</td>
<td>58.6%</td>
<td>54.6%</td>
<td>-</td>
<td>62.4%</td>
<td>-</td>
<td>80.0%</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Use method of sun protection - adult</td>
<td>-</td>
<td>-</td>
<td>43.2%</td>
<td>37.4%</td>
<td>-</td>
<td>72.0%</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Use method of sun protection - children</td>
<td>-</td>
<td>-</td>
<td>65.1%</td>
<td>68.2%</td>
<td>-</td>
<td>72.0%</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Mortality rate breast cancer</td>
<td>17.2%</td>
<td>14.3%</td>
<td>-</td>
<td>11.3%</td>
<td>22.9%</td>
<td>-</td>
<td>20.6%</td>
</tr>
<tr>
<td></td>
<td>Mortality rate cancer cervix uteri</td>
<td>0</td>
<td>0</td>
<td>-</td>
<td>0.9%</td>
<td>2.2%</td>
<td>-</td>
<td>2.2%</td>
</tr>
<tr>
<td></td>
<td>Mortality rate cancer colon &amp; rectum</td>
<td>24.8%</td>
<td>18.8%</td>
<td>-</td>
<td>12.4%</td>
<td>17%</td>
<td>-</td>
<td>14.5%</td>
</tr>
<tr>
<td></td>
<td>Mortality rate cancer melanoma skin</td>
<td>25.8%</td>
<td>0</td>
<td>-</td>
<td>3.3%</td>
<td>2.7%</td>
<td>-</td>
<td>2.4%</td>
</tr>
<tr>
<td></td>
<td>Mortality rate cancer prostate</td>
<td>0</td>
<td>0</td>
<td>-</td>
<td>9.5%</td>
<td>23.5%</td>
<td>-</td>
<td>21.2%</td>
</tr>
<tr>
<td></td>
<td>Mortality rate trachea, bronchus, lungs</td>
<td>39.1%</td>
<td>30.1%</td>
<td>-</td>
<td>37.1%</td>
<td>50.6%</td>
<td>-</td>
<td>45.5%</td>
</tr>
<tr>
<td><strong>Communicable Diseases</strong></td>
<td>Had a flu shot in past 12 months</td>
<td>38.8%</td>
<td>42.8%</td>
<td>-</td>
<td>42.8%</td>
<td>40.5%</td>
<td>-</td>
<td>80.0%</td>
</tr>
<tr>
<td></td>
<td>Ever had pneumonia vaccination</td>
<td>22.0%</td>
<td>17.8%</td>
<td>-</td>
<td>25.8%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
# Executive Summary

## Hepatitis A Incidence
- 4.9% (Moffat)
- 0% (Routt)
- 0% (State)
- 0.8% (Nation)
- 0.3% (Goal)

## Acute Hepatitis B Incidence
- 0% (Moffat)
- 1.4% (Routt)
- 0% (State)
- 0.8% (Nation)
- 1.5% (Goal)

## Tuberculosis Incidence
- 0% (Moffat)
- 0% (Routt)
- 1.3% (State)
- 3.6% (Nation)
- 1% (Goal)

## New Pertussis Cases
- 2.5% (Moffat)
- 1.4% (Routt)
- 4.5% (State)
- 4.2% (Nation)
- - (Goal)

## Diabetes
- Adults told by doctors that they have diabetes (excludes gestational diabetes)
  - 6.9% (Moffat)
  - 1.9% (Routt)
  - 5.1% (State)
  - 7.9% (Nation)
  - - (Goal)

## Diabetes Death Rates
- 4.2% (Moffat)
- 2.8% (Routt)
- 17.2% (State)
- 20.8% (Nation)
- - (Goal)

## Heart Disease / Cerebrovascular Disease
- Ever been told by a doctor, nurse, or other health professional that you have high blood pressure
  - 26.3% (Moffat)
  - 19.9% (Routt)
  - 20.4% (State)
  - 26.7% (Nation)
  - 26.9% (Goal)

- Checked cholesterol in the past 5 years
  - 77.8% (Moffat)
  - 77.8% (Routt)
  - 73.4% (State)
  - 74.4% (Nation)
  - 82.1% (Goal)

- High cholesterol rates
  - 39.7% (Moffat)
  - 25.5% (Routt)
  - 33.1% (State)
  - 36.0% (Nation)
  - - (Goal)

- Heart disease deaths
  - 116.8 (Moffat)
  - 140.6 (Routt)
  - 144.5 (State)
  - 179.8 (Nation)
  - 100.8 (Goal)

- Cerebrovascular disease deaths
  - 33.7 (Moffat)
  - 45.8 (Routt)
  - 37.9 (State)
  - 38.9 (Nation)
  - 33.8 (Goal)

## Injury
- Seat belt use
  - 75.2% (Moffat)
  - 84.9% (Routt)
  - 83.3% (State)
  - 84.0% (Nation)
  - 92.4% (Goal)

- Motor vehicle deaths
  - 36.6 (Moffat)
  - 21.8 (Routt)
  - 11.3 (State)
  - 11.7 (Nation)
  - - (Goal)

- Fall related hospitalizations among older adults (age 65+)
  - 1340.5 (Moffat)
  - 1052.2 (Routt)
  - 1912.8 (State)
  - - (Nation)
  - - (Goal)

## Mental Health
- Mental health not good for 1-7 days in the last month
  - 16.9% (Moffat)
  - 23.6% (Routt)
  - 22.4% (State)
  - - (Nation)
  - - (Goal)
<table>
<thead>
<tr>
<th></th>
<th>Moffat</th>
<th>Routt</th>
<th>HSR 11</th>
<th>State</th>
<th>Nation</th>
<th>State Goal</th>
<th>HP Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Obesity</strong></td>
<td></td>
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</tr>
<tr>
<td>Overweight and obese adults</td>
<td>61.1%</td>
<td>50.3%</td>
<td>-</td>
<td>-</td>
<td>56.2%</td>
<td>-</td>
<td>50.0%</td>
</tr>
<tr>
<td>Overweight and obese youth</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>18.2%</td>
<td>27.8%</td>
<td>17.0%</td>
</tr>
<tr>
<td>Overweight and obese children</td>
<td>-</td>
<td>-</td>
<td>25.6%</td>
<td>25.8%</td>
<td>-</td>
<td>20.0%</td>
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<tr>
<td><strong>Nutrition</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Adults fruit and vegetable consumption 5 or more a day</td>
<td>24.6%</td>
<td>34.0%</td>
<td>-</td>
<td>24.8%</td>
<td>23.4%</td>
<td>75.0%</td>
<td>75.0%</td>
</tr>
<tr>
<td>Youth fruit and vegetable consumption 5 or more a day</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>24.4%</td>
<td>22.0%</td>
<td>75.0%</td>
<td>75.0%</td>
</tr>
<tr>
<td>Children who ate fruit 2 or more times and vegetables 3 or more times in a day</td>
<td>22.8%</td>
<td>14.5%</td>
<td>10.1%</td>
<td>75.0%</td>
<td>75.0%</td>
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</tr>
<tr>
<td>Youth who drank sweetened beverages on or more times a day</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>24.6%</td>
<td>29.0%</td>
<td>-</td>
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</tr>
<tr>
<td>Children who drank sweetened beverages one or more times per day</td>
<td>-</td>
<td>-</td>
<td>33.9%</td>
<td>23.4%</td>
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<tr>
<td><strong>Physical Activity</strong></td>
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<tr>
<td>Adults: any physical activity in the past 30 days</td>
<td>72.3%</td>
<td>92.1%</td>
<td>-</td>
<td>82.5%</td>
<td>76.8%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Adults: 30 minutes of moderate activity per day</td>
<td>56.7%</td>
<td>63.6%</td>
<td>-</td>
<td>55.9%</td>
<td>-</td>
<td>-</td>
<td>47.9%</td>
</tr>
<tr>
<td>Youth: physical activity for 60 minutes per day</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>26.9%</td>
<td>18.4%</td>
<td></td>
<td>20.2%</td>
</tr>
<tr>
<td>Children who were physically active at least 60 minutes/day for the past 7 days</td>
<td>-</td>
<td>-</td>
<td>52.1%</td>
<td>33.8%</td>
<td>-</td>
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<tr>
<td>Yampa Valley Medical Center CHNA</td>
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<tr>
<td><strong>Overall Health Status</strong></td>
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</tr>
<tr>
<td>Children who watched TV, played videogames or on computer at least 2 hours a day or less</td>
<td>69.6%</td>
<td>73.5%</td>
<td>-</td>
<td>-</td>
<td>86.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General health is fair or poor</td>
<td>Moffat</td>
<td>Routt</td>
<td>HSR 11</td>
<td>State</td>
<td>Nation</td>
<td>State Goal</td>
<td>HP Goal</td>
</tr>
<tr>
<td>17.7%</td>
<td>4.7%</td>
<td>-</td>
<td>12.0%</td>
<td>-</td>
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<td></td>
</tr>
<tr>
<td>Physical health not good for 1-7 days in the past 30 days</td>
<td>Moffat</td>
<td>Routt</td>
<td>HSR 11</td>
<td>State</td>
<td>Nation</td>
<td>State Goal</td>
<td>HP Goal</td>
</tr>
<tr>
<td>17.4%</td>
<td>23.5%</td>
<td>-</td>
<td>22.2%</td>
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<tr>
<td>Physical health not good for 8 or more days in the past 30 days</td>
<td>Moffat</td>
<td>Routt</td>
<td>HSR 11</td>
<td>State</td>
<td>Nation</td>
<td>State Goal</td>
<td>HP Goal</td>
</tr>
<tr>
<td>17.2%</td>
<td>5.8%</td>
<td>-</td>
<td>11.0%</td>
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</tr>
<tr>
<td>Birth Rates</td>
<td>Moffat</td>
<td>Routt</td>
<td>HSR 11</td>
<td>State</td>
<td>Nation</td>
<td>State Goal</td>
<td>HP Goal</td>
</tr>
<tr>
<td>82</td>
<td>57.2%</td>
<td>-</td>
<td>68.2</td>
<td>-</td>
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<tr>
<td><strong>Oral Health</strong></td>
<td></td>
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<tr>
<td>Condition of teeth fair or poor (children)</td>
<td>Moffat</td>
<td>Routt</td>
<td>HSR 11</td>
<td>State</td>
<td>Nation</td>
<td>State Goal</td>
<td>HP Goal</td>
</tr>
<tr>
<td>-</td>
<td>10.6%</td>
<td>12.6%</td>
<td>8.4%</td>
<td>-</td>
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</tr>
<tr>
<td>Third grade children with untreated tooth decay</td>
<td>Moffat</td>
<td>Routt</td>
<td>HSR 11</td>
<td>State</td>
<td>Nation</td>
<td>State Goal</td>
<td>HP Goal</td>
</tr>
<tr>
<td>21.0%</td>
<td>17.8%</td>
<td>-</td>
<td>24.5%</td>
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<tr>
<td>Third grade children with sealants</td>
<td>Moffat</td>
<td>Routt</td>
<td>HSR 11</td>
<td>State</td>
<td>Nation</td>
<td>State Goal</td>
<td>HP Goal</td>
</tr>
<tr>
<td>30.8%</td>
<td>42.6%</td>
<td>-</td>
<td>35.0%</td>
<td>39.0%</td>
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</tr>
<tr>
<td>Infants who get a checkup by age 1 year</td>
<td>Moffat</td>
<td>Routt</td>
<td>HSR 11</td>
<td>State</td>
<td>Nation</td>
<td>State Goal</td>
<td>HP Goal</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>3.5%</td>
<td>-</td>
<td>4.6%</td>
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<td></td>
</tr>
<tr>
<td>Adults with tooth loss due to tooth decay and gum disease</td>
<td>Moffat</td>
<td>Routt</td>
<td>HSR 11</td>
<td>State</td>
<td>Nation</td>
<td>State Goal</td>
<td>HP Goal</td>
</tr>
<tr>
<td>44.2%</td>
<td>22.2%</td>
<td>-</td>
<td>35.6%</td>
<td>-</td>
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</tr>
<tr>
<td>Community Water Fluoridation</td>
<td>Moffat</td>
<td>Routt</td>
<td>HSR 11</td>
<td>State</td>
<td>Nation</td>
<td>State Goal</td>
<td>HP Goal</td>
</tr>
<tr>
<td>75%</td>
<td>75%</td>
<td>-</td>
<td>73.9%</td>
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<td>-</td>
<td>75.0%</td>
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<tr>
<td><strong>Sexual Health and HIV/AIDS</strong></td>
<td></td>
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</tr>
<tr>
<td>Unintended pregnancy</td>
<td>Moffat</td>
<td>Routt</td>
<td>HSR 11</td>
<td>State</td>
<td>Nation</td>
<td>State Goal</td>
<td>HP Goal</td>
</tr>
<tr>
<td>-</td>
<td>27.4%</td>
<td>32.1%</td>
<td>37.4%</td>
<td>-</td>
<td>-</td>
<td>30.0%</td>
<td></td>
</tr>
<tr>
<td>Teen fertility rate</td>
<td>Moffat</td>
<td>Routt</td>
<td>HSR 11</td>
<td>State</td>
<td>Nation</td>
<td>State Goal</td>
<td>HP Goal</td>
</tr>
<tr>
<td>21.6%</td>
<td>6.5%</td>
<td>-</td>
<td>17.2</td>
<td>21.7</td>
<td>18</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Sexually active adults using birth control</td>
<td>Moffat</td>
<td>Routt</td>
<td>HSR 11</td>
<td>State</td>
<td>Nation</td>
<td>State Goal</td>
<td>HP Goal</td>
</tr>
<tr>
<td>-</td>
<td>-</td>
<td>-</td>
<td>75.7%</td>
<td>-</td>
<td>80.0%</td>
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<td></td>
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</tbody>
</table>
### Yampa Valley Medical Center

#### CHNA

<table>
<thead>
<tr>
<th></th>
<th>Moffat</th>
<th>Routt</th>
<th>HSR 11</th>
<th>State</th>
<th>Nation</th>
<th>State Goal</th>
<th>HP Goal</th>
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<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Sexually active youth using birth control</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>26.4%</td>
<td>-</td>
<td>30.0%</td>
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</tr>
<tr>
<td>New Chlamydia incidence per 100,000</td>
<td>1210.7</td>
<td>573.4</td>
<td>-</td>
<td>1514.7</td>
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<tr>
<td>New Gonorrhea incidence per 100,000</td>
<td>63.1</td>
<td>34.6</td>
<td>-</td>
<td>234.4</td>
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<tr>
<td>Tested for HIV</td>
<td>35.5%</td>
<td>35.3%</td>
<td>-</td>
<td>39.7%</td>
<td>-</td>
<td>-</td>
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</tr>
<tr>
<td>New cases of HIV</td>
<td>-</td>
<td>4.3</td>
<td>3</td>
<td>5.6</td>
<td>-</td>
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<td>-</td>
<td>6</td>
<td>-</td>
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<td>-</td>
</tr>
<tr>
<td><strong>Tobacco</strong></td>
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<td></td>
<td></td>
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<tr>
<td>Smoking rates</td>
<td>22.0%</td>
<td>10.0%</td>
<td>-</td>
<td>18.1%</td>
<td>17.0%</td>
<td>-</td>
<td>12.0%</td>
</tr>
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Overview/Methodology
Yampa Valley Medical Center
COMMUNITY HEALTH NEEDS ASSESSMENT

Center for Health Administration
University of Colorado Denver
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INTRODUCTION

The Center for Health Administration (CHA) at the University of Colorado Denver was retained to conduct data collection for the 2013 Community Health Needs Assessments (CHNA) for Yampa Valley Medical Center per Internal Revenue Code ("Code") requirements.

Per Internal Revenue Service Notice 2011-52:

- The CHNA requirements are among several new requirements that apply to section 501(c)(3) hospital organizations under section 501(r), which was added to the Code by section 9007(a) of the Patient Protection and Affordable Care Act ("Affordable Care Act"), Pub. L. No. 111-148, 124 Stat. 119, enacted March 23, 2010.

- Section 9007 of the Affordable Care Act added sections 501(r) and 4959 to the Code and amended section 6033(b). These provisions are applicable to "hospital organizations" described in new section 501(r)(2). Section 501(r)(1) provides that hospital organizations described in section 501(r)(2) will not be treated as described in section 501(c)(3) unless they satisfy the requirements specified in section 501(r), including the CHNA requirements described in section 501(r)(3).

- Section 501(r)(2)(A) defines a "hospital organization" as (i) an organization that operates a facility required by a State to be licensed, registered, or similarly recognized as a hospital ("State-licensed hospital facility"), and (ii) any other organization that the Secretary determines has the provision of hospital care as its principal function or purpose constituting the basis for its exemption under section 501(c)(3).

- If a hospital organization operates more than one hospital facility, section 501(r)(2)(B)(i) requires the organization to meet all of the section 501(r)(i)requirements, including the CHNA requirements, separately with respect to each hospital facility. Section 501(r)(2)(B)(ii) provides that the organization will not be treated as described in section 501(c)(3) with respect to any hospital facility for which such requirements are not separately met.

Data reports supplied by CHA constitute one phase of a multi-phase Community Health Needs Assessment process being conducted at Yampa Valley Medical Center. The data reports describe the health needs of the hospital community based on the criteria described in this overview. In accordance with Affordable Care Act, the data will be used by Yampa Valley Medical Center as a foundation to engage stakeholders within the community, prioritize issues, create a local health plan, and implement and monitor that plan.

---

Data reports were created for the Yampa Valley Medical Center facility.

DEFINITION OF THE COMMUNITY SERVED BY HOSPITAL FACILITY

CHA met with representatives of the Colorado Department of Public Health and Environment (CDPHE) to gain an understanding of available vital event and health survey data in Colorado. In 2008, CDPHE created 21 Health Statistic Regions. These 21 regions are aggregations of counties developed by the CDPHE Health Statistics Section in partnership with state and local public health professionals, and are used by CDPHE to create Colorado Health Disparities Regional Profiles. In more heavily populated areas, Health Statistic Regions are made up entirely of one county. In rural areas, Health Statistic Regions include multiple Counties.

To ensure alignment with publically available CDPHE data, Yampa Valley Medical Center leaders decided that Colorado counties would make up the geographic area for the 2013 CHNA. Yampa Valley Medical Center then examined their primary market areas and identified Colorado counties in which at least 10% of their patient population resided. The counties identified by the facility comprise the “Primary Service Area” used in the data reports. When county data was unavailable, Health Statistic Region data is substituted. The following is a list of Primary Service Areas selected for the Yampa Valley Medical Center facility, defined by both county and Health Statistic Region.

<table>
<thead>
<tr>
<th>Hospital Facility</th>
<th>Counties</th>
<th>Health Statistic Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yampa Valley Medical Center</td>
<td>Moffat County</td>
<td>HSR 1</td>
</tr>
<tr>
<td></td>
<td>Routt County</td>
<td>HSR 11</td>
</tr>
</tbody>
</table>

http://www.chd.dphe.state.co.us/HealthDisparitiesProfiles/dispHealthProfiles.aspx
The following map shows Colorado Counties and corresponding Health Statistic Regions.³

---

DEMOGRAPHICS OF THE COMMUNITY

Demographic descriptions for the primary services areas of each hospital are described in the Demographic Report. Demographic information was gathered primarily from the U.S. Census 2010 and is grouped by county. The Demographics Report describes information regarding:

- Population: current and percent change over the past decade
- Age: counties that are older and younger
- Race and ethnicity; language other than English spoken at home
- Gender
- Education
- Income; poverty levels; causes of poverty
- Marital status
- Housing
- Unemployment

³ http://www.chd.dphe.state.co.us/HealthIndicators/
EXISTING RESOURCES WITHIN THE COMMUNITY

After Yampa Valley Medical Center prioritizes the health needs in their communities, they can then partner with community organizations that are dedicated to improving a particular area of health. Yampa Valley Medical Center can quickly learn about potential community partners by consulting the Resource Inventory at the end of each health indicator section. The Resource Inventory lists the community organizations that are currently involved in the prevention or treatment of specific health indicators. Community resource information generally includes the name of the resource; the city and county where it resides and/or serves; its email, website, address, and phone number; and program description.

HOW DATA WAS OBTAINED

IDENTIFYING HEALTH NEEDS OF THE COMMUNITY

COLORADO HEALTH INDICATORS DATABASE

CDPHE publishes data on selected health indicators that includes county, regional and state level data on a variety of health, environmental and social topics. These data are used in Colorado’s Health Assessment and Planning System (CHAPS). CHAPS is a standard process created to help local public health agencies meet assessment and planning requirements. According to CDPHE, these indicators are useful for anyone who needs Colorado health data for a community health assessment or for other research purposes. CHAPS focuses on the indicators selected specifically to facilitate standardized health assessment across all jurisdictions in Colorado. The indicators are organized according to a Health Equity Model which takes into account a wide range of factors that influence health. This model groups the social determinants of health into:

- **Life course perspective**: how populations are impacted differently during the various stages of life
- **Social determinants of health**: societal influence, such as economic opportunity, physical environment and social factors that play critical roles in the length and quality of life
- **Health factors**: components of health behaviors and conditions, mental health and access, utilization and quality of health care
- **Population health outcomes**: measures of quality of life, morbidity, mortality and life expectancy

4 [http://www.chd.dphe.state.co.us/HealthIndicators/Default.aspx](http://www.chd.dphe.state.co.us/HealthIndicators/Default.aspx)
In 2012, CDPHE implemented the “Winnable Battles” model identified as a best practice by the Centers for Disease Control. To keep pace with emerging public health challenges and to address the leading causes of death and disability, CDC initiated an effort to achieve measurable impact quickly in a few targeted areas.\(^5\) CDC’s Winnable Battles are public health priorities with large-scale impact on health and with known, effective strategies to address them.

**Colorado’s Winnable Battles** are key public health and environmental issues where progress can be made in the next three years. These ten Winnable Battles were selected because they provide Colorado’s greatest opportunities for ensuring the health of citizens and visitors and the improvement and protection of the environment. Many of Colorado’s Winnable Battles align with the Centers for Disease Control and Prevention’s (CDC) Winnable Battles or are consistent with the Seven Priorities for EPA’s Future, while others reflect Colorado’s own unique priorities.

According to CDPHE, these broad topic areas can be customized by counties and cities based on local priorities and authorities, or by agencies and other organizations whose missions overlap.

The ten Colorado Winnable Battles included environmental issues -- clean air, clean water, and safe food--which were considered beyond the purview of the Yampa Valley Medical Center CHNA. The remaining issues, Infectious Disease Prevention, Injury Prevention, Mental Health and Substance Abuse, Obesity, Oral Health, Tobacco, and Unintended Pregnancy, were selected by Yampa Valley Medical Center to be included in the 2013 CHNA.

### HEALTH INDICATORS SELECTED

The health indicators selected are as follows:

- Overall Health Status
- Access
- Cancer
- Diabetes
- Heart Disease and Cerebrovascular Disease
- HIV/AIDS
- Communicable Disease
- Injury
- Mental Health
- Obesity, Nutrition and Physical Activity
- Oral Health
- Sexual Health
- Substance Abuse
- Tobacco

\(^5\) [http://www.cdc.gov/winnablebattles/](http://www.cdc.gov/winnablebattles/)
HEALTH NEEDS OF UNINSURED PERSONS, LOW-INCOME PERSONS, AND MINORITY GROUPS

When available, demographic information for uninsured persons, low-income persons, and minority groups was collected by CHA and included with data for each health indicator.

BENCHMARKING

The Yampa Valley Medical Center facility data report includes health indicators from the hospital Primary Service Area. When available, state and national data were reported for comparison as well as Colorado 2016 Winnable Battle goals. In addition, Healthy People 2020 objectives were reviewed for applicability to Colorado Health Indicators. Healthy People is a set of goals and objectives with 10-year targets designed to guide national health promotion and disease prevention efforts to improve the health of all people in the United States.⁶

DATA SOURCES

HEALTH INDICATORS WAREHOUSE – DEPARTMENT OF HEALTH AND HUMAN SERVICES

National benchmarking data was obtained from the Health Indicator Warehouse (HIW). The HIW is a collaboration of many Agencies and Offices within the Department of Health and Human Services.⁷ The HIW is maintained by the CDC’s National Center for Health Statistics.

BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM

The Colorado Behavioral Risk Factor Surveillance System (BRFSS) is housed within the Health Statistics Section at CDPHE. Colorado participated in BRFSS with point-in-time surveys in 1982 and 1987. Since 1990, the department has entered into a yearly cooperative agreement with the Centers for Disease Control and Prevention (CDC) to develop and implement the BRFSS survey in Colorado. Data are collected through telephone interviews on a random sample of non-institutionalized adults. The Survey Research Unit now completes more than 1,000 BRFSS surveys a month with adult residents of Colorado. Additional information on the BRFSS is available at http://www.cdphe.state.co.us/hs/brfss/

⁷ http://healthindicators.gov/About/AboutTheHIW
PREGNANCY RISK ASSESSMENT MONITORING SYSTEM

The Colorado Pregnancy Risk Assessment Monitoring System (PRAMS) is a population-based risk factor surveillance system designed to monitor selected self-reported maternal behaviors and experiences that occur before, during and after pregnancy among women who deliver a live-born infant. Colorado PRAMS is housed within the Health Statistics Section at CDPHE. The PRAMS questionnaire is revised periodically to reflect changing priorities and emerging issues. PRAMS uses a combination of two data collection approaches: statewide mailings of the surveys and telephone follow-up with women who do not return the survey by mail. Approximately 240 women in Colorado will receive the survey each month, with an expected response rate of at least 70%. Additional information on PRAMS is available at http://www.cdphe.state.co.us/hs/prams/

CHILD HEALTH SURVEY

The Colorado Child Health Survey (CHS) was designed to fill the health data gap in Colorado that exists for children ages 1-14 and was initiated in 2004. Participants who complete the BRFSS are asked if they have a child in the target age range and about their willingness to complete the child health survey. Approximately 10 days later, the parent is called to complete the survey on a variety of topics including their child's physical activity, nutrition, access to health and dental care, behavioral health, school health, sun safety, injury and many others. Data are collected over the calendar year. At the end of the year, data are cleaned and weighted to reflect the general population of children 1-14 years old. Approximately 1,000 surveys are completed each year. Additional information is available at http://www.cdphe.state.co.us/hs/yrbs/ChildHealth.html

YOUTH RISK BEHAVIOR SURVEY

The Colorado Youth Risk Behavior Survey (YRBS) is one component of the Youth Risk Behavior Surveillance System (YRBSS) developed by the Centers for Disease Control and Prevention. The YRBS monitors six categories of priority health-risk behaviors among youth and young adults including behaviors that contribute to unintentional injuries and violence, tobacco use, alcohol and other drug use, sexual behaviors that contribute to unintended pregnancies and sexually transmitted diseases, unhealthy dietary behaviors and physical inactivity. In addition, the YRBS monitors the prevalence of obesity and asthma among youth and young adults. The YRBS is a school-based state survey that is administered to students in grades 9-12 in Colorado. This self-administered survey is anonymous and completed voluntarily by students. Additional information is available at http://www.cdphe.state.co.us/hs/yrbs/yrbs.html
SEXUALLY TRANSMITTED INFECTION / HIV SURVEILLANCE PROGRAM

The STI/HIV Surveillance Program conducts surveillance and research to characterize and track STI/HIV infections in Colorado. There are three units within this program: 1) STI/HIV Surveillance, 2) HIV Incidence, 3) STI/HIV Registry. The program ensures compliance with and completeness of STI/HIV reporting, investigates HIV cases with no identified risk, provides blood borne pathogen information to first responders, health care workers, law enforcement and corrections personnel, and conducts HIV incidence and prevalence studies. The Registry Unit collects, compiles and disseminates information on gonorrhea, syphilis, chlamydia, and HIV infection, and contacts health care providers to ensure that clients receive adequate treatment. Staff identifies disease outbreaks and coordinates the response by CDPHE, collaborating agencies, and health care providers. The program synthesizes data from multiple sources to develop annual Colorado STI/HIV epidemiological profiles. These reports are used to inform and guide the state STI/HIV programs, and are disseminated to care providers, local health departments, community planning groups, researchers and the public.

BIRTH CERTIFICATE DATA

Information on Colorado births is collected from the Certificate of Live Birth. Data items are presented as reported on the certificate. Completeness and accuracy of items on the birth certificate may vary by facility and year. Data for all births that occurred within the state of Colorado, resident and nonresident, are collected; however, at this time, the Colorado Health Information Dataset (CoHID) reports data only for Colorado resident births. Resident births are births to those individuals who reported being residents of Colorado, even if the birth occurred to residents while outside of Colorado. Interstate agreements allow for the exchange of vital information about births to Colorado residents that occurred in other states. Additional information is available at http://www.cdphe.state.co.us/hs/vs/

DEATH CERTIFICATE DATA

Death data are compiled from information reported on the Certificate of Death, collected by the Vital Statistics Unit at the Department of Public Health. Data items are presented as reported. Information on the certificate concerning time, place and cause of death is typically supplied by medical personnel or coroners. Demographic information, such as age, race/ethnicity or occupation, is generally reported on the certificate by funeral directors from information supplied by the available next of kin. Training of physicians, coroners, other medical personnel and funeral directors is conducted on an ongoing basis to maintain and improve the quality of data supplied on death certificates. Resident deaths are deaths to those individuals who reported being residents of Colorado, even if the death occurred to residents while outside of Colorado. Interstate agreements...
allow for the exchange of vital information about deaths to Colorado residents that occurred in other states.

All causes of death listed on a death certificate must be coded. The underlying cause of death is defined by World Health Organization as the disease or injury that initiated the sequence of events leading directly to the death, or the circumstance of the accident or violence that caused the injury. When more than one death cause is listed on the death certificate, the underlying cause is determined by rules that take into account the sequence of conditions on the certificate and provisions of the ICD-10. Additional information is available at http://www.cdphe.state.co.us/hs/vs/

**INFORMATION GAPS**

**STRENGTH OF DATA**

Despite aggregation of data into Health Statistic Regions, some counties are small and/or have low populations, and the data from these areas is often very minimal. As a result, they often post very low numbers each year for some of the less common indicators. In some cases, data is just missing from various years, as it was either not collected at all or the sample size was so small that the county was not included less it have a misleading result.

To compensate for small sample size, we have combined multiple years and averaged the results to provide a more accurate comparison with the other larger counties. Even with this approach (which is also used by the CDHE), the data can be weak, so we have indicated those times in the footnotes. In these cases, the weak data is typically due to 1) a sample size of three to four people per reporting year, or 2) only one to two years of reported data out of a potential sample size of four to five years. Strong data typically encompasses 1) five or more people per reporting year, and in most cases “n” is in the double digits, or 2) three or more years of data reported in the average.

Counties that are not included in some charts are because their sample sizes were typically less than three occurrences or the data was simply not collected.

**LACK OF REGIONAL DATA**

As noted throughout the data reports, for some health issues, regional county data is not available, or if it is, sample size is not large enough to demonstrate statistical significance.
GUIDE TO CHARTS

The charts can have a variety of characteristics that serve as guidelines for interpretation. These markings typically consist of colored lines, flags or bars.

- Red vertical lines represent state averages.
- Green flags represent Healthy People 2020 goals and are included when available. (In most cases, Healthy People 2020 goals use different measurement parameters and cannot be compared to state data.)
- Red flags indicate a Colorado Winnable Battle Goal for 2016.
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<td>POPULATION</td>
<td>3</td>
</tr>
<tr>
<td>Total Population</td>
<td>3</td>
</tr>
<tr>
<td>Population Change</td>
<td>4</td>
</tr>
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<td>AGE</td>
<td>5</td>
</tr>
<tr>
<td>Youth</td>
<td>5</td>
</tr>
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<td>Older</td>
<td>6</td>
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<td>RACE</td>
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<tr>
<td>ETHNICITY</td>
<td>9</td>
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<td>10</td>
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<td>11</td>
</tr>
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<td>EDUCATION</td>
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<td>14</td>
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<td>21</td>
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<tr>
<td>HOUSING</td>
<td>23</td>
</tr>
<tr>
<td>UNEMPLOYMENT</td>
<td>24</td>
</tr>
</tbody>
</table>
DEMOGRAPHICS

OVERVIEW

Hospital planners incorporate their communities’ demographic profiles into decisions regarding service development and its related allocation of resources. Young, growing populations typically require more obstetrics, pediatrics and family practice services while older populations require more expensive services, such as oncology and cardiology services. Within orthopedics alone, younger populations require services related to sports-related injuries, while older groups have greater demands for hip and knee replacements.

In this Demographics Report, the greatest demand for youth oriented services is along the Front Range, and is generally found in counties that are experiencing the most growth. The mountain resort communities have significant needs for services oriented towards an active, younger and middle-aged demographic. The southern part of the state has a larger percentage of older residents, thus requiring more resources for these populations. Nevertheless, the entire population in Colorado is aging, and all hospitals must plan for this eventuality.

Higher education drives income levels up, thus facilitating access to health services for prevention and treatment, and creating a healthier populace as a result. Higher education is also associated with higher marital rates, creating more stable families that are less likely to experience poverty. Communities with high education and income levels generally have lower unemployment rates, too.

The counties with the greatest poverty rates are in the southern rural areas, although several urban counties also have high poverty areas. Lower income communities tend to have higher concentrations of elderly, diverse races and ethnic groups, and lower education levels. Communities with large percentages of Latino and Hispanic populations drive the need for Spanish speaking providers and educational tools written in Spanish.

This report provides details about these demographic characteristics, as well as other demographic information about Centura Health’s primary service areas. The information focuses on the counties in Centura’s primary service areas and was mostly derived from the United States Census of 2010.
TOTAL POPULATION

Routt County has a larger population than Moffat, which is fueled by the greater migration of people wanting to live in the greater Steamboat Springs area.

![Population Graph](image)

*Figure 1 Population*

---

1 Source: US Census 2010
In the past decade, Routt County experienced significant growth, most likely due to people moving into the county. Moffat County’s rate of growth was below the state average. On a similar note, one quarter of Colorado counties lost population over the last decade from 2000 to 2010. Most of these counties are located in south-central Colorado and on the Eastern Plains.

Source: US Census 2010

Figure 2 Population: Percent Change 2000 to 2010
Moffat County has a younger population than Routt County and exceeds the state averages. As a result, Moffat County may likely have a greater need for pediatric, family practice and obstetrical services per population.

Figure 3 Counties with the Youngest Populations

Source: US Census 2010
Moffat County has a higher percentage of residents over age 65 compared to Routt County, but similar to the state average. Hospitals attending to these populations must provide services for chronic disease management and the more expensive cancer and cardiovascular services.

Figure 4 Persons 65 Years and Over

4 Source: US Census 2010
The population in both counties is predominantly of White race, which includes Hispanics self-identifying White race on the 2010 census. (Percent of Latino and Hispanic ethnicity is listed later.) Counties in resort areas tend to have a greater percentage of White residents than the state.

![Race](image)

Figure 5 Race

Source: US Census 2010. Note: First five categories include persons reporting only one race. Races include Hispanic or Latino origin.
Routt and Moffat Counties have very few people of Black race. They also have only a small percentage of Asian residents.

Figure 6 Black Population: Top Ten Counties

Figure 7 Asian Population: Top Ten Counties

6 Source: US Census 2010
7 Ibid.
On the other hand, Moffat and Routt Counties have larger rates of people of Hispanic ethnicity, but still under the state average.

![Persons of Hispanic or Latino Origin](Yampa Valley Medical Center)

**Figure 8 Hispanic or Latino Origin**

Many of the counties that have large Hispanic populations also have large populations that speak languages other than English in their homes. Moffat County has a larger bilingual and/or non-English speaking population, consistent with its larger Hispanic population. Providers serving these populations need to make sure that their communication methods and materials are in Spanish (the most likely language).

Figure 9 Language Other Than English Spoken at Home

9 Source: US Census 2010
Mountain resort communities typically have larger male populations, as demonstrated in Routt County.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Routt</th>
<th>Moffat</th>
<th>State</th>
<th>Nation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>47%</td>
<td>48.8%</td>
<td>49.9%</td>
<td>50.8%</td>
</tr>
<tr>
<td>Female</td>
<td>53%</td>
<td>51.2%</td>
<td>50.1%</td>
<td>49.2%</td>
</tr>
</tbody>
</table>

Source: US Census 2010

Figure 10 Gender
Routt County has higher education levels than Moffat County. This is fairly typical for resort areas that are home to high income, second home owners. Moffat County has rates that are close to the nation for high school graduates, but below both the national and state rates for those with bachelor’s degrees or higher.

![Education Graph](Image)

*Figure 11 Education"

---

"Source: US Census 2010"
Routt County’s median household income rate exceeds the state average, consistent with many resort areas. Counties reporting high median incomes typically have high education levels, too.

![Median Household Income](image_url)

**Figure 12 Median Household Income**

Source: US Census 2010
Routt County has poverty levels below the state average, while Moffat County’s rates are close to the state’s. Counties with higher poverty levels tend to have greater numbers of elderly, diverse races and ethnicity, and lower education levels. Many of the poverty characteristics in Colorado are similar to the national characteristics listed in the table on the following page.

Figure 13 Persons Below Poverty Level

Source: US Census 2010
Poverty is frequently high within single parent households, in which the parents have low education levels, are foreign born, and are unemployed.

<table>
<thead>
<tr>
<th>Demographic Category</th>
<th>Most Common Characteristic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Female</td>
</tr>
<tr>
<td>Age</td>
<td>Under 18 years</td>
</tr>
<tr>
<td>Race</td>
<td>Black or African American</td>
</tr>
<tr>
<td></td>
<td>American Indian and Alaska Native</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Hispanic or Latino origin (of any race)</td>
</tr>
<tr>
<td>In family households</td>
<td>In female householder, no husband present households</td>
</tr>
<tr>
<td>Population 25 years and over</td>
<td>Less than high school graduate</td>
</tr>
<tr>
<td>Citizen status</td>
<td>Foreign born</td>
</tr>
<tr>
<td>Population 16 to 64 years</td>
<td>Did not work</td>
</tr>
</tbody>
</table>

Figure 14 Selected Characteristics of People in Poverty

An important note to consider when examining Federal Poverty Guidelines is that they do not include government assistance. An average of $9,000 year in means-tested assistance is given to low-income American families in the form of cash, food, housing, medical care, and social services. These welfare programs totaled about $871 billion nationally in 2010.15 16

2012 Annual Federal Poverty Guidelines

<table>
<thead>
<tr>
<th>48 Contiguous States and DC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Household size</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>6</td>
</tr>
<tr>
<td>7</td>
</tr>
<tr>
<td>8</td>
</tr>
<tr>
<td>For each additional person, add</td>
</tr>
</tbody>
</table>

Figure 15 2012 Annual Federal Poverty Guidelines

15 This figure does not include Social Security or Medicare, which are not means-tested.
17 Ibid.
CAUSES OF POVERTY

The most effective way to reduce poverty is to address the causes and not merely the symptoms of a declining capacity for self-support in low-income communities. The original goal of President Johnson’s War on Poverty in 1964 was to help Americans become self-sufficient and prosperous through their own efforts, and not to artificially prop up living standards through reliance on government aid. The intent of Johnson’s War on Poverty was to make “taxpayers out of taxeaters.”

An unforeseen result of the War on Poverty has been the continual expansion of the welfare state. The provision of welfare benefits began to replace the husband’s role of provider, and low-income marriage began to disappear. Today, a major, if not the most important, cause of poverty is the collapse of marriage and the growth of single-parent homes. It is estimated that about 80 percent of all poverty now occurs in single-parent homes.

When President Johnson launched the War on Poverty, 7 percent of American children were born out of wedlock. Today the number of children born out-of-wedlock is over 40 percent. The War on Poverty created a destructive loop: welfare undermined marriage and then created continued need for welfare for single mothers.

“In 2008, nonmarital births accounted for 41 percent of all births in the United States. Although roughly half of these nonmarital births are to cohabiting couples, these unions tend to be less stable and have fewer economic resources compared with married couples. Therefore, declining marriage rates put more children at risk of growing up poor, which can have lasting consequences for their health and future economic prospects.”

---

The percentage of children born to unwed women is highest among those of Black race, followed by Hispanics.

Figure 17 Warning: Married Fathers an Endangered Species

The second most significant cause of poverty is the lack of parental work. Before the recession, it is estimated that the average low-income family worked about 16 hours a week, hardly enough to provide an adequate standard of living.

Reducing the causes of poverty should entail addressing the perverse incentives in the current welfare state so that marriage would be rewarded rather than penalized. It’s estimated that if poor women married the fathers of their children, two-thirds would instantly be raised out of poverty. In addition, if one adult worked full time throughout the year, the poverty rate in these families would fall by two thirds.

One proposed solution to reducing poverty is that when the current recession ends, able-bodied people should be prepared for work, or required to work, as a condition of receiving aid. Another option is to continue the current welfare state through increased taxation and/or borrowing in the name of fairness.

This chart shows that Moffat County has a higher proportion of female households with children and no husbands present when compared to Routt County and the state.

**Female Householder, No Husband Present, With Own Children**

Yampa Valley Medical Center

<table>
<thead>
<tr>
<th></th>
<th>Routt</th>
<th>Moffat</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5.8</td>
<td>8.2</td>
<td>6.0</td>
</tr>
</tbody>
</table>

*Figure 18 Female Householder, No Husband Present, With Own Children* *US Census 2010.*

---

*US Census 2010.*
Fifty one percent of all Coloradans are married, compared to 31% who have never married. In Colorado, Asians have the highest rates of marriage, followed by those of White race. American Indians and African Americans have the lowest rates of marriage.

Figure 19 Marital Status

Figure 20 Married and Never Married by Race/Ethnicity

---


27 Ibid.
The percentage of people who have never married has been increasing throughout the country while marital rates have been decreasing. The table below shows the declining percentage of marriage among young adults. (This chart does not take into account those who marry at a later age, which still remains at about 90%.)

Reasons for declining marriage rates among this group are: increase in women’s education and labor force participation, rise in cohabitation, and the discouraging effects of potential divorce.

Many women’s higher earning capacity, combined with declining economic prospects of young men without college degrees, is another disincentive to marriage. Many unemployed young adults with poor employment prospects are delaying marriage until they feel more financially stable. In a reverse of earlier trends, many college graduates are more likely to get married than those without college degrees.

Marriage Rates Among Young Adults Ages 25-34, 1965-2010 (Percent)

---

30 Ibid.
Rising cohabitation rates in lieu of marriage may be influenced by the declining role of traditional religion in American's lives. Americans identifying themselves as Protestant has been declining since the 1960s, from the high 60% to low 70% range to 55-57% since 2000. Those identifying themselves as Roman Catholics have stayed within the 20-30% range for the past sixty years. The decline of those professing to be Christian is offset by the growth of those who do not identify with any religion or identify with a non-Christian religion.

Figure 22 Religious Identification

---

33 http://www.google.com/imgres?imgurl=http://sas-origin.onstreammedia.com/origin/gallupinc/GallupSpaces/Production/Cms/POLL/hlxwc8ajku6fwuaahylq.gif&imgrefurl=http://www.gallup.com/poll/117409/easter-smaller-percentage-americans-christian.aspx&usg=__kmfbW6qMtWlcZYSnLX1dS3jZwQE=&h=439&w=565&sz=22&hl=en&start=135&zoom=1&tnid=Jh1hrVAvs7i6phM:&tbnh=104&tbnw=134&ei=WViBT_3MJPDo2gWZuZGgCA&prev=/search%3Fq%3Ddecline%2Bin%2Breligion%2Bstatistics%26start%3D126%26hl%3Den%26sa%3DN%26rlz%3D1T4ADFA_eunUS457US457%26tbm%3Disch%26prmd%3Divns&itbs=1
Figure 23 Percentage of Americans with No Religious Identification: 1948-2008

Gallup Poll yearly aggregates


---

Housing is more expensive in the mountain resort communities than in many other areas of the state. Many counties reporting high incomes also have high housing costs, as shown in this report. Housing costs are highest in areas with robust employment and/or great housing demand and limited supply.

**Median Value of Owner-Occupied Housing Units**

Yampa Valley Medical Center

- Routt: $434,700
- Moffat: $178,400
- State: $234,100
- Nation: $185,400


---

Unemployment rates are somewhat higher in Routt and Moffat Counties than in the state, but very similar to the nation’s rates. Although not shown, Lake County has the highest rate in the state, at 12.6%.

---

As an aside, Pueblo County has consistently demonstrated some of the highest unemployment rates over the past five years. In contrast, the Fort Collins-Loveland area, as well as the Boulder-Longmont area (not shown), has steadily had the lowest unemployment rates. Both of these areas are home to major universities. Areas with robust employment have the highest demand for housing, too, as discussed earlier.

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OVERALL HEALTH STATUS

OVERVIEW

Health is defined by the World Health Organization in 1948 as a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity. Various measures of general health status provide information about the larger population. Healthy People 2020 assesses general health status of the U.S. population by monitoring the following indicators:

- Life expectancy
- Healthy life expectancy
- Years of potential life lost
- Physically and mentally unhealthy days
- Self-assessed health status
- Limitation of activity
- Chronic disease prevalence

In the U.S., life expectancy is up for all races and both sexes, with White females living the longest. A significant cause for this increase in life expectancy is that cigarette consumption has decreased significantly since the mid-1980s. Prior to this time, per capita cigarette consumption was greater in the United States than the rest of the developed world.

Figure 1 U.S. Life Expectancy Up

---

1 http://www.definitionofwellness.com/dictionary/health.html
2 http://www.healthypeople.gov/2020/about/GenHealthAbout.aspx
4 Centers for Disease Control and Prevention
Life expectancy is a mortality measure that is often used to describe the overall health status of a population. Life expectancy is defined as the average number of years a person of a certain age is expected to live, if age-specific death rates and morbidity rates remain constant throughout one’s life. The following charts show the life expectancy for men and women in Colorado. Douglas County has the highest life expectancy for men. The mountain resort communities also have high life expectancy, while the Eastern Plains and Southern Colorado counties have the shortest life expectancy.

Figure 2 Male Life Expectancy, 2007

---

http://www.pophealthmetrics.com/content/9/1/16
Women live longer than men, with the mountain resort communities for both genders showing the greatest longevity. Douglas County has the highest life expectancy for the Denver metro area. The Eastern Plains shows a decline in life expectancy from 1997 to 2007.

Figure 3 Female Life Expectancy, 2007

---

http://www.pophealthmetrics.com/content/9/1/16
LEADING CAUSES OF PREMATURE DEATH

The leading causes of premature death in Colorado are cancer, heart disease, and unintentional injuries. Suicide is the fourth leading cause of premature death.

Figure 2.4. Leading causes of years of potential life lost before life expectancy — Colorado, 2008

Data source: Vital Statistics, Health Statistics Section, CDPHE. Cause of death includes the primary (underlying) cause of death only, not the contributing causes.

---

TOP TEN CAUSES OF DEATH IN COLORADO

Cardiovascular disease, which includes heart disease and strokes, is responsible for the most deaths in Colorado. Within this group, strokes are responsible for about 5% of all deaths, and are the leading cause of disability. Cardiovascular disease and cancer comprise almost 50% of all deaths. Respiratory diseases and unintentional injuries are responsible for about 7% each of all deaths.

![Top Ten Causes of Death, 2010](figure5.png)

Figure 5 Top Ten Causes of Death Colorado

---

8 Colorado Department of Public Health and Environment
http://www.cdphe.state.co.us/scripts/htmsql.exe/cohid/deathquick1.hsql.

---
GENERAL HEALTH IS FAIR OR POOR

*BRFSS Survey Question: How is your general health? (Answer: Fair or Poor)*

Self-assessed health status measures how a person rates his or her health, whether it is excellent, very good, good, fair, or poor. Self-assessed health status is an accurate indicator of health and is useful for comparing populations.

Moffat County had the highest percentage of people saying that their general health was fair or poor. On the other hand, Routt County’s rate of people stating that their general health was fair or poor was below the state average.

---

Figure 6 General Health is Fair or Poor

---

Females report fair/poor general health significantly more than males.

People are significantly more likely to experience fair/poor general health status as they age.

People of White race are significantly less likely to experience fair/poor general health in comparison to other races and ethnicities. Conversely, Hispanics are more likely to experience fair/poor general health status in comparison to those of White race.

---


11 Ibid.

12 Ibid.
Lower income and education levels were significantly associated with fair/poor general health status. Improvements in general health status were reported as income and education levels increased.

Figure 10 Fair/Good General Health by Income

Figure 11 Fair/Poor General Health by Education

Figure 12 Fair/Poor General Health by Marital Status

Fair/poor general health status was significantly more likely with those who are divorced, separated or widowed.

---

14 Ibid.
15 Ibid.
SHORT-TERM PHYSICAL HEALTH

BRFSS Survey Question:  For how many days during the past 30 days was your physical health not good? (Answer: 1 to 7 days; 8 or more days)

Routt County had the greatest percentage of people reporting poor short-term physical health. Moffat County’s rate was less than the state average.

Figure 13 Physical Health Not Good 1-7 Days in Last Month

LONG-TERM PHYSICAL HEALTH

**BRFSS Survey Question:**  For how many days during the past 30 days was your physical health not good? (Answer: 1 to 7 days; 8 or more days)

The largest percentage of people who thought their long-term physical health was not good live in Moffat County; its rate was higher than the state average. Routt County’s rate was below the state average.

![Physical Health Not Good for 8+ Days in Past Month](image)

*Figure 14 Physical Health Not Good for 8+ Days in Past Month*[^17]

Females report fair to poor physical health more frequently than males on both a short- and long-term basis.

![Figure 15 Fair/Poor Short and Long Term Physical Health by Gender](image1)

While young people report fair/poor physical health more frequently on a short-term basis, older people report fair/poor physical health more often on a long-term basis. Differences among races and ethnicity were not significant.

![Figure 16 Fair/Poor Short-Term Physical Health by Age](image2)

![Figure 17 Fair/Poor Long-Term Physical Health by Age](image3)

---

19 Ibid.
20 Ibid.
Rising income and education are significant positive influencers of long-term physical health, but not short-term health. Conversely, those with low income and education levels report fair to poor health more frequently.

When examining marital status, people who have never married report fair to poor health more frequently on a short-term basis, whereas those who are divorced/separated/widowed report fair/poor health more frequently on a long-term basis.

---

**Figure 18 Fair/Poor Long Term Physical Health by Income**

<table>
<thead>
<tr>
<th>Income Level</th>
<th>2009/2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>$50,000 and above</td>
<td>7.4%</td>
</tr>
<tr>
<td>$25,000 - $49,999</td>
<td>12.2%</td>
</tr>
<tr>
<td>Less than $25,000</td>
<td>20.7%</td>
</tr>
</tbody>
</table>

**Figure 19 Fair/Poor Physical Health by Education**

<table>
<thead>
<tr>
<th>Education Level</th>
<th>2009/2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some College or More</td>
<td>9.9%</td>
</tr>
<tr>
<td>High School Graduate</td>
<td>12.6%</td>
</tr>
<tr>
<td>&lt;High School</td>
<td>17.3%</td>
</tr>
</tbody>
</table>

**Figure 20 Fair/Poor Short Term Physical Health by Marital Status**

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>2009/2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never Married</td>
<td>27.7%</td>
</tr>
<tr>
<td>Married/Couple</td>
<td>21.8%</td>
</tr>
<tr>
<td>Divorced/Separated/...</td>
<td>20%</td>
</tr>
</tbody>
</table>

**Figure 21 Fair/Poor Long Term Physical Health by Marital Status**

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>2009/2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never Married</td>
<td>9.1%</td>
</tr>
<tr>
<td>Married/Couple</td>
<td>10.4%</td>
</tr>
<tr>
<td>Divorced/Separated/...</td>
<td>16.8%</td>
</tr>
</tbody>
</table>

---

22 Ibid.
23 Ibid.
24 Ibid.
While not a direct measure of overall health, birth rates help gauge which county populations will grow through non migratory measures. Moffat County has the highest birth rate of the counties shown. Routt County’s birth rate is less than the state average.

Figure 22 Birth Rates

---

25 Chart Source: Colorado Department of Health and Environment. Rates are live births per 1,000 female population in each age group. http://www.cdphe.state.co.us/scripts/broker.exe
INTERVENTIONS

See specific health indicators for relevant interventions.

RESOURCE INVENTORY

See specific health indicators for relevant resources.
Access
Yampa Valley Medical Center
COMMUNITY HEALTH NEEDS ASSESSMENT
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In 2010, the number of nonelderly, uninsured in America reached 49.1 million in the United States. Between 2008 and 2010, the uninsured rate among the nonelderly adults and children increased by 4.9 million. The recession that started in 2008 and continues to this day contributed to this sharp increase. During this time, many people were laid off, losing their health insurance as well as their source of income. As a result, more than one in five adults under the age of 65 was uninsured in 2010.¹

As health insurance costs rise for employers, many of them are dropping coverage altogether, resulting in only 56% of the nonelderly population being covered by employer-sponsored coverage. Many businesses that continue to offer health insurance raised their worker’s share of premium to an average annual 28% in 2011, making health care more expensive for those who have insurance.²

For those who recently lost coverage, Medicaid and the Child Health Insurance Program (CHIP) help fill the gap, and have been crucial in providing health care to children during the recession. However, income eligibility for adults wanting to qualify for Medicaid is much more limited. The Affordable Care Act (ACA) is designed to extend Medicaid eligibility to almost all people with incomes at or below 138% of poverty.³

² Ibid.
³ Ibid.
USE OF PREVENTIVE SERVICES BY INSURANCE STATUS

Many of those who are uninsured do not obtain necessary preventive services, leading to more advanced disease and worse outcomes by the time they do obtain health services. The following chart shows the percent difference between the uninsured and insured in obtaining preventive care.4

Figure 1 Percentage of Adults NOT Receiving Preventive Services


5 Ibid.
DISEASE ADVANCEMENT BY INSURANCE STATUS

The next chart compares the advancement of disease, breast cancer in particular, between the uninsured and the insured. It also shows the higher relative risk of death for the uninsured. Having health insurance is estimated to reduce mortality rates by 10-15\%.\(^6\)

---

**Figure 10**

**Stage of Breast Cancer at Time of Diagnosis by Insurance Status**

- **Distribution of Women with Breast Cancer by Disease Stage at Time of Diagnosis**
  - Uninsured
  - Privately Insured

- **Relative Risk of Death from Breast Cancer by Age and Insurance Status**
  - Adjusted Relative Risk of Death
    - Uninsured: 1.6
    - Insured: 1.4
  - Equal chance of death

**Stages of Disease**

- Local: 44%
- Regional: 43%
- Distant: 12%
- Local: 54%
- Regional: 38%
- Distant: 7%

**Note:** Distribution is overweighted disease.

**Source:** McArdle JZ, Koil R, BA, Abe T, Eppolito AM, 1993

---

**Figure 2** Stage of Breast Cancer at Time of Diagnosis by Insurance Status\(^7\)

---


\(^7\) Ibid.
# BARRIERS TO HEALTH CARE BY INSURANCE STATUS

Lack of insurance can adversely affect a person’s physical health because it frequently hinders a person’s ability or desire to get needed help. The following chart shows the many ways that the high cost of health care prohibits receiving medical attention, especially for the uninsured. Even if all health care is purchased by self-payment, catastrophic illnesses can have devastating effects on a person’s financial stability.8

![Barriers to Health Care Among Nonelderly Adults by Insurance Status, 2010](image)

---


9 Chart Source: KCMU analysis of 2010 NHIS data. Note: In past 12 months. All differences between the uninsured and the two insurance groups are statistically significant (p<0.05). Respondents who said their usual source of care was the emergency room were included among those not having a usual source of care.
HEALTH INSURANCE

**BRFSS Survey Question:** Do you have any kind of health care coverage?

The chart shows the percentage of people who have any kind of health insurance. People living in Moffat County have lower rates of health insurance compared to other mountain resort communities. Counties reporting higher incomes, such as Routt County, typically have higher percentages of insured residents. The Healthy People 2020 goal is for all people to have some type of health insurance.

---

\[Figure 4 Has Health Insurance^{10}\]

---

DEMOGRAPHICS

Insurance coverage increases with age because Medicare provides coverage for those over 65 years of age. Many young people do not have insurance coverage, either due to choice, lack of insurance through employment, or unemployment.

Females are more likely to have insurance coverage than males. People who have never married are least likely to have insurance while those who are married are significantly more likely to have health insurance.

---

12 Ibid.
13 Ibid.
Insurance coverage is the lowest for those of Hispanic ethnicity. Those of White race are most likely to have health insurance.

![Any Insurance Coverage by Race/Ethnicity](image)  
**Figure 8 Any Insurance Coverage by Race/Ethnicity**

Insurance coverage significantly increases for people with higher education and incomes, partly reflecting the coverage that comes with employment.

![Any Insurance Coverage by Education](image)  
**Figure 9 Any Insurance Coverage by Education**

![Any Insurance Coverage by Income](image)  
**Figure 10 Any Insurance Coverage by Income**

---


15 Ibid.
ELIGIBLE BUT NOT ENROLLED

ELIGIBLE ADULTS NOT ENROLLED IN MEDICAID

Medicaid is a publicly financed health insurance program for low-income children, parents of dependent children, adults 65 and over, and individuals with disabilities in Colorado. Eligible adults who are not enrolled in Medicaid tend to be more numerous in the higher income, mountain resort areas, such as Routt County. Moffat County has done a better job in making sure its qualifying adults are enrolled in state assistance programs.

Figure 11 Eligible Adults Not Enrolled in Medicaid

---

16 Ibid.
17 Chart Source: Enrollment data from Colorado Department of Health Care Policy and Financing. Uninsured estimates from CHI analyses of 2008 and 2009 American Community Surveys. Adults 19-64 years of age.
ELIGIBLE CHILDREN NOT ENROLLED IN MEDICAID

The following chart is an estimate of uninsured children who are eligible but not enrolled in Medicaid. Many of these children reside in counties with higher income levels and with potentially greater resources to devote to increasing their Medicaid enrollment. Routt County’s rate for eligible children not enrolled in Medicaid is much worse than the state rate, while Moffat County’s rate is slightly higher than the state.

---

Figure 12 Eligible Children Not Enrolled in Medicaid

---

ELIGIBLE CHILDREN NOT ENROLLED IN CHP+

The Child Health Plan Plus (CHP+) program offers low cost health insurance for Colorado’s uninsured children who come from families who earn or own too much to qualify for Medicaid, but cannot afford private insurance. Estimates of uninsured children ages 18 and under who are eligible but not enrolled in the CHP+ program is shown in the nearby chart. Routt and Moffat Counties can increase their numbers of insured younger populations through enhanced efforts to educate their residents about CHP+.

Figure 13 Eligible Children Not Enrolled in CHP+ ¹⁹ Adults not enrolled in Medicaid

INTERVENTIONS

The following list of programs and resources are available in Colorado for children, pregnant women, Americans over age 65, the disabled, and people with health conditions that are uninsurable. Other people can utilize these resources if they meet specific program guidelines. The web links can be accessed through the web site in the footnote.\(^2\)

“Benefits Check-Up” – BenefitsCheckUp is a free online service that helps thousands of people every day to connect to government programs that can help them pay for prescription drugs, health care, utilities, and other needs.

**Colorado Access** - A nonprofit health plan that provides healthcare coverage for low-income people and people with disabilities in Colorado. If you receive Medicaid, you can choose Access Health Plan as your health plan.

**Colorado Health Plan Plus (CHP+)** - low-cost health insurance program for uninsured Colorado children ages 18 and under whose families earn or own too much to qualify for Medicaid but cannot afford private insurance. CHP+ also offers benefits to pregnant women and new borns. The CHP+ prenatal care program offers free health insurance to uninsured Colorado pregnant women who live in households that meet certain income requirements.


**Colorado Indigent Care Program** – state program that provides partial reimbursement to providers for offering medical care to eligible underinsured and uninsured residents. This is **not** a health insurance program. Services are restricted to participating hospitals and clinics throughout the state. To qualify, you must have income and resources combined at or below 185% of the Federal Poverty Level (FPL), and cannot be eligible for Medicaid. See site for more details.

**CoverColorado** – non-profit entity created by the Colorado Legislature to provide medical insurance for eligible Colorado residents who, because of a pre-existing medical condition, are unable to get coverage from private insurers. In addition, CoverColorado also serves as the state’s plan for individuals who are eligible under the Health Insurance Portability and Accountability Act, otherwise known as HIPAA.

\(^2\) http://www.coloradohealthinsurancebrokers.com/public-private-assistance-resources/
Getting Us Covered - Introduced in 2010, this temporary coverage is available to US citizens who have been uninsured for 6 months or more AND were denied coverage because of a pre-existing condition. There may be as many as 4,000 people in Colorado that are eligible for this federally sponsored program. Getting Us Covered is run by CoverColorado, Colorado's high risk insurance pool.

Joblessguide.net - This web site was launched by a group of local Colorado residents to help others in the region face challenges due to a loss of a job or other economic difficulties because of the faltering local and national economy. This unique website provides a wealth of information aimed at reducing the hardships that many people in Colorado face.

Medicaid General Information – Medicaid is a health care program for low income Coloradans. Applicants must meet eligibility criteria for one of the Medicaid Program categories in order to qualify for benefits. Major program categories include Aid to Families with Dependent Children/Medicaid Only, Colorado Works/TANF (Temporary Assistance for Needy Families), Baby Care/Kids Care, Aid to the Needy Disabled, Aid to the Blind, and Old Age Pension. To apply for Medicaid, contact your local County Departments of Social/Human Services.

Medicaid Eligibility for Families and Children – clients must meet financial, medical, and program criteria to access waivered services. The applicant’s income must be less than $1,635 (300%, or three times the monthly standard maintenance allowance) per month and countable resources less than $2,000. The applicant must also be at risk of institutional placement in a nursing facility, hospital, or ICF/MR (intermediate care facility for the mentally retarded). See site for more details.

Medicaid Eligibility for Long Term Care for the Elderly, Blind, and Disabled – the resource limit is $2000 for an individual. The home, a vehicle, a burial fund and household and personal goods worth $2000 are exempt. For further information about countable and exempt resources, refer to Section 8.110.51. If the applicant is married, and his/her spouse is not in a nursing facility or not on Medicaid, spousal protection rules apply. See site for more details.

Medicaid Disability Determination Information – applications and other resources

Medicaid Federal Site – has some useful information and also a handy list of Colorado’s Medicaid office address and phone numbers

Medicare - Medicare Part A (Hospital Insurance) helps cover your inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice care and some home health care. You must meet certain conditions. Most people don’t have to pay a monthly payment, called a premium, for Part A. This is because they or a spouse paid Medicare
taxes while they were working. Medicare Part B (Medical Insurance) helps cover your doctors’ services and outpatient hospital care. It also covers some other medical services that Part A doesn’t cover, such as some of the services of physical and occupational therapists, and some home health care. You pay the Medicare Part B premium each month* ($66.60 in 2004). In some cases, this amount may be higher if you didn’t sign up for Part B when you first became eligible. The cost of Part B may go up 10% for each 12-month period that you could have had Part B but didn’t sign up for it, except in special cases. You will have to pay this extra amount as long as you have Part B.

Medicare Prescription Part D Drug Plans – resources to help you find the right Medicare prescription plan for your needs. You might also want to use the Medicare Rx plan finder web based tool.

Medicare Rights Center – resource to help weave your way through the Medicare maze.

Prescription Drug Assistance – get financial assistance for prescription drugs through the Partnership for Prescription Assistance. PPA has links to over 475 assistance programs and 150 pharmaceutical company programs.

Retirement Benefits Calculator - great resource to help you plan for your golden years.

Rx Outreach – plan to help middle class and low income Coloradans with the increasing costs of prescription drugs

Social Security – government web site that is quite a nice resource and easy to use.

Social Security Benefits Screening Tool - see what programs you might qualify for.

Social Security Benefits for the Disabled – explains what benefits are available, how you can qualify, and who can receive benefits on your earnings record.


Veterans – application for Veteran’s benefits.

WIC - special Supplemental Nutrition Program for Women, Infants and Children”^21

[^21]: http://www.coloradohealthinsurancebrokers.com/public-private-assistance-resources/
<table>
<thead>
<tr>
<th>County</th>
<th>City</th>
<th>Provider</th>
<th>Contact Person</th>
<th>Email</th>
<th>Website</th>
<th>Address</th>
<th>Phone Number</th>
<th>Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorado</td>
<td>State-wide</td>
<td>Denver</td>
<td>Caring For Colorado</td>
<td>Chris Wiant</td>
<td><a href="mailto:cwiant@caringforcolorado.org">cwiant@caringforcolorado.org</a></td>
<td><a href="http://www.caringforcolorado.org">http://www.caringforcolorado.org</a></td>
<td>4100 E Mississippi Avenue Suite 605 Denver, CO 80246</td>
<td>720.524.0770</td>
</tr>
<tr>
<td>Colorado</td>
<td>State-wide</td>
<td>Denver</td>
<td>Child Health Plan Plus Division</td>
<td>*</td>
<td>*</td>
<td><a href="http://www.cchp.org/">http://www.cchp.org/</a></td>
<td>4500 Cherry Creek S Dr, Denver, CO 80246</td>
<td>(800) 359-1991</td>
</tr>
<tr>
<td>Colorado</td>
<td>State-wide</td>
<td>Denver</td>
<td>Colorado Community Health Network: Access and Enrollment Project</td>
<td>Brittney Petersen Project Manager</td>
<td><a href="mailto:brittney@cchn.org">brittney@cchn.org</a></td>
<td><a href="http://www.cchn.org/ckf/aboutus.php">http://www.cchn.org/ckf/aboutus.php</a></td>
<td>600 Grant Street, Suite 800, Denver, CO 80203</td>
<td>(303) 867-9514</td>
</tr>
<tr>
<td>Health Care Program</td>
<td>Location</td>
<td>Contact Information</td>
<td>Website</td>
<td>Address</td>
<td>Phone</td>
<td>Description</td>
<td></td>
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</tr>
<tr>
<td>Yampa Valley Medical Center</td>
<td>Aurora</td>
<td>Michelle Mills, Chief Executive Officer</td>
<td><a href="http://corvallethealth.org/">http://corvallethealth.org/</a></td>
<td>303 S. Parker Rd., Ste. 606, Aurora, CO 80014</td>
<td>303.832.7493 or 800.851.6782</td>
<td>Advocacy, education, referral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colorado State-wide Critical Access Hospital</td>
<td>Englewood</td>
<td>Devin Detwiler, Program Manager</td>
<td><a href="http://www.cfmc.org/">http://www.cfmc.org/</a></td>
<td>23 Inverness Way East Suite 100 Englewood, CO 80112</td>
<td>303.695.3300</td>
<td>Colorado Foundation for Medical Care is Colorado's healthcare quality improvement organization. CFMC works with government programs, health providers, and managed care companies to improve the quality of healthcare.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colorado State-wide Critical Access Hospital</td>
<td>Denver</td>
<td>Stephen Tool, Executive Director</td>
<td>*</td>
<td>Department of Health Care Policy and Financing, 1570 Grant Street Denver, CO 80203</td>
<td>303.866.2993</td>
<td>The Colorado Indigent Care Program (CICP) is not a health insurance. The CICP provides funding to clinics and hospitals so that medical services can be provided at a discount to Colorado residents that meet the eligibility requirements for the CICP.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colorado State-wide Critical Access Hospital</td>
<td>Lakewood</td>
<td>Donna Christiansen, Representative</td>
<td><a href="mailto:info@healthcareforallcolorado.org">info@healthcareforallcolorado.org</a></td>
<td>PO Box 280767 Lakewood, CO 80228</td>
<td>(720) 837-2315</td>
<td>Health Care for All Colorado (HCAC) is a nonprofit organization in Colorado working to inform Coloradans about advantages of the single-payer system of financing health care, create a coalition that will develop strategies for achieving comprehensive, affordable and high quality health care for all Coloradans, and build a grassroots movement that will campaign for the single-payer system in Colorado. Serves as a single access or entry point where a current or potential long term care client can obtain long term care information, screening, assessment of need, and referral to appropriate long term care programs and case management. Primarily Medicaid long term care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Location</td>
<td>City</td>
<td>Organization</td>
<td>Contact Person</td>
<td>Email</td>
<td>Website</td>
<td>Address</td>
<td>Phone</td>
<td>Description</td>
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<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Grand, Jackson, Moffat, Rio Blanco, and Routt, Counties</td>
<td>Steamboat Springs</td>
<td>NW Colorado Assoc. for the Education of Young Children</td>
<td>Kim Martin, Director</td>
<td><a href="mailto:kim@youngtracks.com">kim@youngtracks.com</a></td>
<td><a href="http://coloradoeyc.org/category/district-group-updates/northeast-colorado/">http://coloradoeyc.org/category/district-group-updates/northeast-colorado/</a></td>
<td>P.O. Box 771765 Steamboat Springs, CO 80477</td>
<td>970-879-2506</td>
<td>Serves and acts on behalf of the needs, rights, and well-being of children, families and Early Childhood Educators. Promotes developmentally appropriate, affordable, accessible Early Childhood care and educational services for Colorado children birth to 8. Offers professional development opportunities to Early Childhood Educators. Advocates for improved working conditions, wages, and recognition for individuals in the Early Childhood field. Communicates to policymakers and public leaders regarding the mission and goals of CAEYC. Cooperates with other local, state, a national organizations and agencies having compatible goals in working with young children.</td>
</tr>
<tr>
<td>Routt</td>
<td>Steamboat Springs</td>
<td>Young Tracks Preschool &amp; Child Care Center</td>
<td>Kim Martin, Director</td>
<td><a href="mailto:kim@youngtracks.com">kim@youngtracks.com</a></td>
<td><a href="http://www.youngtracks.com">www.youngtracks.com</a></td>
<td>1647 Mid Valley Drive Steamboat Springs, CO 80487</td>
<td>970-879-5790</td>
<td>Quality rated, licensed childcare center available for children between 2 months and 6 years old. Focus on the individual child and a developmentally appropriate atmosphere. There is an Infant Program, a Toddler Program, and a Preschool Program. Scholarships may be available to qualifying families.</td>
</tr>
<tr>
<td>Routt</td>
<td>Steamboat Springs</td>
<td>Doak Walker Care Center - YVMC - Yampa Valley Medical Center</td>
<td>Mrs. Lee Dickey, Administrator</td>
<td><a href="mailto:lee.dickey@yvmc.org">lee.dickey@yvmc.org</a></td>
<td><a href="http://www.yvmc.org">www.yvmc.org</a></td>
<td>1100 Central Park Drive Steamboat Springs, CO 80487</td>
<td>970-870-1113</td>
<td>Mission: To optimize the health of everyone we serve through excellence in the delivery of safe, personalized, quality health care services.</td>
</tr>
<tr>
<td>Routt, Jackson, Moffat and Rio Blanco Counties</td>
<td>Steamboat Springs</td>
<td>Child Care Network - Family Development Center</td>
<td>Sharon Butler, Director</td>
<td><a href="mailto:ccn@familydevelopmentcenter.org">ccn@familydevelopmentcenter.org</a></td>
<td><a href="http://www.familydevelopmentcenter.org">www.familydevelopmentcenter.org</a></td>
<td>2875 Village Dr. Steamboat Springs, CO 80477</td>
<td>970-879-7330</td>
<td>Providing resources for child care providers and the community. Referrals for parents searching for child care in Northwest Colorado.</td>
</tr>
<tr>
<td>Routt</td>
<td>Steamboat Springs</td>
<td>Baby Care/Kids Care - Routt County Department of Human Services</td>
<td>Fran Jenkins, Case Manager</td>
<td><a href="mailto:fjenkins@co.routt.co.us">fjenkins@co.routt.co.us</a></td>
<td>co.routt.co.us</td>
<td>135 6th Street Steamboat Springs, CO 80477</td>
<td>970-879-1540</td>
<td>This program provides medical assistance for children and for pregnant mothers.</td>
</tr>
<tr>
<td>Routt</td>
<td>Steamboat Springs</td>
<td>Family Health (Routt County) - Northwest Colorado Visiting Nurse Association</td>
<td>Stephanie Anderson</td>
<td><a href="mailto:sanderso@nwcovnna.org">sanderso@nwcovnna.org</a></td>
<td><a href="http://www.nwcovnna.org">www.nwcovnna.org</a></td>
<td>940 Central Park Drive Suite 101 Steamboat Springs, CO 80487</td>
<td>(970) 879-1632</td>
<td>Programs for Young Families include: -Prenatal Care -NFP - Nurse Family Partnership -New Arrivals -WIC (Women, Infants, and Children Nutrition Program) -School Health -CHP (Child Health Plan Plus - health and dental care for uninsured children) medical eligibility and enrollment immunization</td>
</tr>
<tr>
<td>Routt</td>
<td>Steamboat Springs</td>
<td>CHP+ - Routt County Department of Human Services</td>
<td>Fran Jenkins, Case Manager</td>
<td><a href="mailto:fjenkins@co.routt.co.us">fjenkins@co.routt.co.us</a></td>
<td>co.routt.co.us</td>
<td>135 6th Street Steamboat Springs, CO 80477</td>
<td>970-879-1540</td>
<td>CHP+ or Child Health Plan Plus is a full-coverage health plan for uninsured children. Coverage for outpatient and inpatient services including: check-ups and shots, immunizations, medical office visits, teen services, prescriptions, glasses and hearing aids; dental care and mental health care including hospitalization and outpatient substance abuse treatments. If you applied for Baby Care/Kids Care and did not qualify, your application will</td>
</tr>
<tr>
<td>Routt</td>
<td>Steamboat Springs</td>
<td>Medicaid - Routt County Department of Human Services</td>
<td>Clarise Corriveau, Supervisor</td>
<td><a href="mailto:ccorriveau@co.routt.co.us">ccorriveau@co.routt.co.us</a></td>
<td>135 6th Street Steamboat Springs, CO 80477</td>
<td>970-870-5252</td>
<td>Medicaid is a health care benefits program offered to income eligible families (mother, father, children, pregnant women). Colorado Medicaid pays for most health care services including, but not limited to, inpatient and outpatient hospitalization, physician services, family planning, immunizations, transportation to medical services, and community mental health services.</td>
<td></td>
</tr>
<tr>
<td>Routt</td>
<td>Steamboat Springs</td>
<td>Lift-Up of Routt County - Food Bank and Emergency Assistance</td>
<td>Sherry Mc Knight, Food Bank and Case Manager</td>
<td><a href="mailto:foodbank@springsips.com">foodbank@springsips.com</a></td>
<td>2125 Curve Ct. Steamboat Springs, CO 80487</td>
<td>970-870-8804</td>
<td>Homeless services, food bank, emergency assistance and financial help including medical, dental, prescription, rent, mortgage and utility assistance for families, consumers, and individuals.</td>
<td></td>
</tr>
<tr>
<td>Rio Blanco</td>
<td>Rangely</td>
<td>Rangely District Hospital - Rangely District Hospital</td>
<td>Didier Roux e, CEO</td>
<td><a href="http://www.hospitalsoup.com/rangely">www.hospitalsoup.com/rangely</a></td>
<td>511 S White Ave Rangely, CO 81648</td>
<td>970-695-5016 ext 228</td>
<td>Rangely District Hospital is a small, rural facility which offers inpatient, swing bed, ER, Level IV Trauma, ambulance, outpatient services, home health, physical therapy, and family practice physician's clinic.</td>
<td></td>
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</table>

automatically be forwarded to CHP+.
<table>
<thead>
<tr>
<th>County</th>
<th>Location</th>
<th>Organization Name</th>
<th>Office Name</th>
<th>Contact Information</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rio Blanco</td>
<td>Rangely</td>
<td>Pioneer Medical Center</td>
<td>Robert Omer, CEO</td>
<td><a href="http://www.pioneershospital.org">www.pioneershospital.org</a></td>
<td>345 Cleveland St Meeker, Co 81641 970-878-5047 24 hour hospital service with 6 provides two Nurse Practitioners, two Medical Doctors, and two Osteopaths.</td>
</tr>
<tr>
<td>Rio Blanco</td>
<td>Rangely</td>
<td>Home Health Services - Pioneer Medical Center</td>
<td>Betty Lou Moye r, Director</td>
<td><a href="http://www.pioneershospital.org">www.pioneershospital.org</a></td>
<td>345 Cleveland St Meeker, Co 81641 970-878-9265 Home Health delivers patient care to qualifying persons in their homes. Assistance includes skilled nursing, Certified Nurse Aid for personal care and home assistance. Occupational and physical therapy is also available. Some cases are eligible for Medicare and Medicaid payment. Offers 24 hour on-call response center for emergency assistance through a lifeline program that can install in their home.</td>
</tr>
<tr>
<td>Rio Blanco</td>
<td>Rangely</td>
<td>Medical Assistance Program - Rio Blanco County Department of Social Services</td>
<td>Rhonda Hilkey, Paula Davis (Rangely), Eligibility Specialist</td>
<td><a href="http://www.co.rio-blanco.co.us/socialservices/">http://www.co.rio-blanco.co.us/socialservices/</a></td>
<td>345 Market Street Meeker, Co 81641 970-878-9640 Rio Blanco County's Dept. Of Social Service's mission is to promote family and individual independence and well being.</td>
</tr>
<tr>
<td>Routt County, Moffat County, Northwest Colorado</td>
<td>Steamboat Springs</td>
<td>Yampa Valley Community Foundation</td>
<td>Jennifer Shea, Program Manager</td>
<td><a href="mailto:jennifer@yvcf.org">jennifer@yvcf.org</a></td>
<td><a href="http://www.yvcf.org">www.yvcf.org</a> 465 Anglers Dr. Suite 2G Steamboat Springs, CO 80487 970-879-8632 The mission of the Yampa Valley Community Foundation is to develop annual and growing funds to support organizations and innovative programs that preserve traditions and maintains the character of the community we serve, while respecting the wishes of our donors. Yampa Valley Community Foundation provides grants to organizations, not individuals. We connect people who care with causes that matter.</td>
</tr>
<tr>
<td>County</td>
<td>Town</td>
<td>Service Organization</td>
<td>Contact Person</td>
<td>Contact Information</td>
<td>Address</td>
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</tr>
<tr>
<td>Moffat</td>
<td>Dinosaur</td>
<td>Moffat County Social Services</td>
<td>Carmen McKay, Office Assistant</td>
<td><a href="mailto:carmen.mckay@state.co.us">carmen.mckay@state.co.us</a></td>
<td>330 Highway 64 Dinosaur, CO 81610</td>
</tr>
<tr>
<td>Moffat</td>
<td>Craig</td>
<td>Northwest Colorado Community Health Center</td>
<td>Ms. Gisela Garrison, Clinic Director</td>
<td><a href="http://www.nwco">www.nwco</a> vna.org</td>
<td>745 Russell St Craig, CO 81625</td>
</tr>
<tr>
<td>Steamboat Springs, Moffat, Routt, Rio Blanco, Jackson, Grand</td>
<td>Craig</td>
<td>Northwest Colorado Dental Coalition</td>
<td>Janet Pearce, Executive Director</td>
<td>nwcodental@qwest office.net</td>
<td>485 Yampa Street Craig, CO 81625</td>
</tr>
<tr>
<td>Craig and Moffat County</td>
<td>Craig</td>
<td>The Memorial Hospital -</td>
<td>Jennifer Riley, Chief of Organizational Excellenc e</td>
<td>jennifer.riley@tmhcr aig.org</td>
<td>785 Russell Street Craig, CO 81625</td>
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<tr>
<td><strong>Moffat County, Routt County, Wyoming, Rio Blanco</strong></td>
<td><strong>Craig</strong></td>
<td><strong>Craig VA Telehealth Clinic</strong></td>
<td><strong>April Branstetter, RN, BSN, CPAN</strong></td>
<td><strong><a href="http://www.grandjunction.va.gov/visitors/craigtelehealth.asp">http://www.grandjunction.va.gov/visitors/craigtelehealth.asp</a></strong></td>
<td><strong>785 Russell St. Suite 400</strong> Craig, CO 81625</td>
</tr>
<tr>
<td><strong>Jackson County</strong></td>
<td><strong>Walden</strong></td>
<td><strong>Medicaid /CHP+ - Jackson County Social Services</strong></td>
<td><strong>Jaime ViefhauZak</strong></td>
<td><strong><a href="mailto:Jamie.ViefhauZak@state.co.us">Jamie.ViefhauZak@state.co.us</a></strong></td>
<td><strong><a href="http://www.cchp.org/">http://www.cchp.org/</a></strong></td>
</tr>
<tr>
<td><strong>Jackson County</strong></td>
<td><strong>Walden</strong></td>
<td><strong>Jackson County Social Services</strong></td>
<td><strong>Glen Chambers, Director</strong></td>
<td><strong><a href="mailto:Jamie.ViefhauZak@state.co.us">Jamie.ViefhauZak@state.co.us</a></strong></td>
<td><strong><a href="http://www.colorado.gov/cs/Satellite/CDHS-Main/CBO/N/1251590215770">http://www.colorado.gov/cs/Satellite/CDHS-Main/CBO/N/1251590215770</a></strong></td>
</tr>
<tr>
<td><strong>Grand County</strong></td>
<td><strong>Walden</strong></td>
<td><strong>Assisted Medical Insurance - Grand County Department of Social Services</strong></td>
<td><strong>Glen Chambers, Director</strong></td>
<td><strong><a href="http://co.grand.co.us/contents.html">http://co.grand.co.us/contents.html</a></strong></td>
<td><strong>620 Hemlock St</strong> Hot Sulphur Springs, CO 80451</td>
</tr>
</tbody>
</table>

Veteran Health Administration Outreach clinic that does primary care, mental health, retinal, wound care, physical assessments, MOVE (weight loss) tele-surgical -all through a telehealth (video)-via Grand Junction VA Medical Center (GJVAMC) providers. By appointment only. No walk-ins.

Medicaid is a health care benefits program for minor children, parents of minor children, pregnant women, low income adults over age 65 and disabled persons of any age. CHP+ is an comprehensive health insurance program for children and pregnant women who are not eligible for Medicaid.

State and Federal programs offered through Social Services, which assist individuals and families to achieve self-sufficiency and social well-being. Three main areas include financial assistance, child protection and adult protection. Financial assistance programs include LEAP, TANF, Food Stamps, Old Age Pension and Medicaid.

Government Social Services Agency that provides programs and assistance to the people of Grand County. These programs include Medicaid, CHP Plus.
<table>
<thead>
<tr>
<th>County</th>
<th>Town</th>
<th>Service</th>
<th>First Name</th>
<th>Last Name</th>
<th>Email Address</th>
<th>Address</th>
<th>Phone Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grand County</td>
<td>Hot Sulphur Springs</td>
<td>ACHES - Grand County Rural Health Network</td>
<td>Jen</td>
<td>Fanning</td>
<td><a href="mailto:jfanning@co.grand.co.us">jfanning@co.grand.co.us</a></td>
<td>416 Byers Ave Hot Sulphur Springs, CO 80451</td>
<td>970-725-3477</td>
<td>Advocacy for Children's Health and Education Service (ACHES): The ACHES program is a voucher program that helps uninsured families with children under the age of 18 to obtain medical and mental health services for acute, non-emergency medical, dental, or mental health care.</td>
</tr>
<tr>
<td>Grand County</td>
<td>Hot Sulphur Springs</td>
<td>Health Advocacy - Mountain Family Center</td>
<td>Lindsay</td>
<td>Watson</td>
<td><a href="http://www.mountainfamilycenter.org">www.mountainfamilycenter.org</a></td>
<td>612 Hemlock Hot Sulphur Springs, CO 80451</td>
<td>970-725-3257</td>
<td>The Health Advocacy program assists individuals with investigating and navigating financial assistance resources for health care.</td>
</tr>
<tr>
<td>Grand County</td>
<td>Hot Sulphur Springs</td>
<td>Grand County Public Health</td>
<td>Brene</td>
<td>Belew-LaDue</td>
<td><a href="mailto:bbelew@co.grand.co.us">bbelew@co.grand.co.us</a></td>
<td>150 Moffat Ave Hot Sulphur Springs, CO 80451</td>
<td>970-725-3288</td>
<td>Public Health Nursing service providing Public Health and Home Health services in Grand County.</td>
</tr>
<tr>
<td>Grand County</td>
<td>Granby</td>
<td>Granby Medical Center</td>
<td>Thomas</td>
<td>Mulder</td>
<td><a href="mailto:thomasmuller@centura.org">thomasmuller@centura.org</a></td>
<td>480 East Agate Ave. Granby, Co 80446</td>
<td>970-887-7400 24-hour line</td>
<td>24 Hour emergency medical center. Family practice/Family Medicine center. Specialty provider clinics.</td>
</tr>
<tr>
<td>Grand County</td>
<td>Hot Sulphur Springs</td>
<td>Cavity Free at Three - Grand County Public Health</td>
<td>Brene</td>
<td>Belew-LaDue</td>
<td><a href="mailto:bbelew@co.grand.co.us">bbelew@co.grand.co.us</a></td>
<td>150 Moffat Ave Hot Sulphur Springs, CO 80451</td>
<td>970-725-3288</td>
<td>Cavity Free at Three is a statewide effort to prevent oral disease in young children. Works with pregnant women, new mothers, and children with dental care and education.</td>
</tr>
</tbody>
</table>

Yampa Valley Medical Center | 24
<table>
<thead>
<tr>
<th>Grand County</th>
<th>Winter Park</th>
<th>7-Mile Medical Clinic - 7-Mile Medical Clinic</th>
<th>Casey Malon</th>
<th><a href="mailto:carolynmalon@centura.org">carolynmalon@centura.org</a></th>
<th>145 Parsenn Road Winter Park, CO 80482</th>
<th>970-887-7470</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grand County</td>
<td>Hot Sulphur Springs</td>
<td>PAINS - Grand County Rural Health Network</td>
<td>Jen Fanning, Director</td>
<td><a href="mailto:jfanning@co.grand.co.us">jfanning@co.grand.co.us</a></td>
<td><a href="http://www.gcruralhealth.com">www.gcruralhealth.com</a></td>
<td>416 Byers Ave Hot Sulphur Springs, CO 80451</td>
</tr>
<tr>
<td>Grand County</td>
<td>Hot Sulphur Springs</td>
<td>Free Prescription Discount Card - Grand County Public Health</td>
<td>Brene Bellew-LaDue, Public Health Director</td>
<td><a href="mailto:bbelew@co.grand.co.us">bbelew@co.grand.co.us</a></td>
<td>co.grand.co.us</td>
<td>150 Moffat Ave Hot Sulphur Springs, CO 80451</td>
</tr>
<tr>
<td>Grand County</td>
<td>Hot Sulphur Springs</td>
<td>Emergency Assistance Services - Mountain Family Center</td>
<td>Jill Korkowski, Executive Director</td>
<td><a href="mailto:mtnfamilyctr@rkmtnhi.com">mtnfamilyctr@rkmtnhi.com</a></td>
<td><a href="http://www.mountainfamilycenter.org">www.mountainfamilycenter.org</a></td>
<td>612 Hemlock Hot Sulphur Springs, CO 80451</td>
</tr>
<tr>
<td>Grand County</td>
<td>Granby</td>
<td>Grand County Workforce Center</td>
<td>Lisa Peder son, Employment Specialist</td>
<td><a href="mailto:cindy.hovern@cwfc.net">cindy.hovern@cwfc.net</a></td>
<td><a href="http://www.coworkforce.com">www.coworkforce.com</a></td>
<td>469 East Topaz Granby, CO 80446</td>
</tr>
</tbody>
</table>

7-Mile Medical Clinic is a Level V trauma center and Community Clinic & Emergency Center, located in a rural, mountainous region at the base of the Winter Park Resort and 67 miles from the nearest hospital in Denver, Colorado.

Partners for Adults In Need of Services (P.A.I.N.S.) will provide medical vouchers for acute, non-emergent medical care to uninsured adults who qualify financially. Qualifying factors include monthly income, and number of individual in a family based on poverty guidelines. Limited to 3 per family member per year.

Public Health helps to distribute NACO drug discount cards to help consumers save money on prescription medications. Cards can be used at any participating retail pharmacy.

Provides emergency assistance services including Homeless prevention, Food Bank, Coat Closet, Utility Assistance, Budgeting classes, Case management, school supply program and toy closet, and occasional budgeting classes available.

The Workforce Center provides easy access to a wide array of employment and training services. Following the trend initiated by the US Department of Labor, Colorado has consolidated the many
components of Job Service and Employment and Training services to maximize its ability to serve job seekers as well as area employers. The office partners with the State Vocational Rehabilitation Department and County Social Services Agencies. Also deals with all aspects of unemployment, both employer and employee issues. Veterans are encouraged to utilize all work-force centers.
Cancer
Yampa Valley Medical Center
COMMUNITY HEALTH NEEDS ASSESSMENT

Center for Health Administration
University of Colorado Denver
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CANCER

OVERVIEW

Cancer is a term used for diseases in which abnormal cells divide without control and are able to invade other tissues.¹ Cancer cells can spread to other parts of the body through the blood and lymph systems. Cancer is not just one disease, but many diseases. There are more than 100 different types of cancer.

The number of new cancer cases can be reduced, and many cancer deaths can be prevented.² Research shows that screening for cervical and colorectal cancers as recommended helps prevent these diseases by finding precancerous lesions so they can be treated before they become cancerous. Screening for cervical, colorectal, and breast cancers also helps find these diseases at an early, often highly treatable stage. Making cancer screening, information, and referral services available and accessible to all Americans can reduce cancer incidence and deaths.

Vaccines also help reduce cancer risk.³ The human papillomavirus (HPV) vaccine helps prevent most cervical cancers and some vaginal and vulvar cancers, and the hepatitis B vaccine can help reduce liver cancer risk. A person’s cancer risk can be reduced in other ways by receiving regular medical care, avoiding tobacco, limiting alcohol use, avoiding excessive exposure to ultraviolet rays from the sun and tanning beds, eating a diet rich in fruits and vegetables, maintaining a healthy weight, and being physically active.⁴

Cancer is the second leading cause of death in the United States, accounting for almost one in every four deaths.⁵ Twenty-two percent of all deaths in Colorado in 2005 were due to cancer. The American Cancer Society estimates that 19,190 new cases of cancer were diagnosed in Colorado in 2007, including 1,790 new cases of colorectal cancer and 2,660 new cases of breast cancer in women.

Inequities in cancer incidence, stage at diagnosis, survival, mortality, and quality of life are shown to exist across the entire range of social groups.⁶ The interplay of many factors leads to cancer health disparities such as race/ethnicity; socioeconomic status or SES (income, education, etc.); insurance status; access to quality health care; behavioral choices; immigrant status; language and literacy; geographic place of residence; environmental issues; disability status; age; sex; and sexual orientation. All these variables and others form a complex set of interactions that create and reinforce cancer health disparities in Colorado and the U.S.

The Colorado Department of Public Health and Environment did not identify specific cancer goals for inclusion in the Colorado 2016 Winnable Battles.

¹ http://www.cdc.gov/cancer/dcpc/prevention/index.htm
² Ibid.
³ Ibid.
⁴ Ibid.
⁵ http://www.cdc.gov/chronicdisease/states/pdf/colorado.pdf
COLORADO CANCER COALITION

The Colorado Cancer Coalition (CCC) is a gathering of organizations and individuals with interest in the prevention and control of cancer in Colorado. The Colorado Cancer Plan 2010-2015 objectives for reducing the cancer burden in Colorado are based on Colorado surveillance data and the national objectives, as well as issues unique to Colorado. The goals of the CCC include:

- Promoting the collection and use of information about cancer
- Improving healthy behaviors
- Increasing screening rates
- Improving access to the full spectrum of cancer diagnosis and care
- Increasing health equity
- Setting targets to improve cancer prevention and control
- Supporting policies to facilitate these efforts

The CCC places great emphasis on aligning goals and objectives with national partners. The National Comprehensive Cancer Control Program at the Centers for Disease Control and Prevention developed the following priorities to be a compass and, like the Colorado Cancer Plan, to be a living document. As the comprehensive cancer control environment evolves and changes, these priorities will be modified accordingly. The National Comprehensive Cancer Control Program priorities include:

- Emphasizing the primary prevention of cancer
- Coordinating early detection and treatment activities
- Addressing the public health needs of cancer survivors
- Using policy, systems and environmental changes to guide sustainable cancer control
- Promoting health equity as it relates to cancer control
- Demonstrating outcomes through evaluation

RISK REDUCTION

- Avoidance of tobacco use and exposure to secondhand smoke are the key to reducing lung cancer morbidity & mortality.\(^7\)
- Studies suggest that 30% to 35% of cancers are diet-related. Risk varies with the type of diet.\(^9\)
- Screening interventions that result in early detection will have a proportionally greater impact on cancer mortality since early-stage disease is more likely to be cured by treatment.\(^10\)

---

\(^7\) [http://www.coloradocancerplan.org/index.php/introduction/overview](http://www.coloradocancerplan.org/index.php/introduction/overview)
BREAST CANCER SCREENING

BRFSS Survey Question: Have you had a clinical breast exam and mammogram in the past 2 years?

Breast cancer is the most common life-threatening cancer in Colorado women and the third leading cause of cancer death (after lung cancer and colorectal cancer). One in seven Colorado women will have breast cancer at some point in their lifetime.

The prevalence rate of breast cancer screening in women over fifty in Colorado is lower than the Nation.

Moffat County has a breast cancer screening prevalence rate in adult women that is above the State rate.

Routt County has a breast cancer screening prevalence rate in adult women that is below the State rate.

Significant improvement is needed to achieve the CCC goal of 80% percent of adult women over 50 receiving screening for breast cancer.

Figure 1 Breast Cancer Screening

11 http://www.coloradocancerplan.org/index.php/selected-cancers/breast-cancer
BREAST CANCER SCREENING DEMOGRAPHICS

Significantly more women in the 50-64 age group receive breast cancer screening than women 65 and above.

![Breast Exam and Mammogram By Age](image)

Figure 2: Breast Cancer Screening by Age\(^{13}\)

There are no significant differences in breast cancer screening prevalence rates by race/ethnicity.

![Breast Exam and Mammogram By Race/Ethnicity](image)

Figure 3: Breast Cancer Screening by Race/Ethnicity\(^{14}\)

As income rises, so do breast cancer screening prevalence rates in adult women. Differences are statistically significant.

![Breast Exam and Mammogram By Income](image)

Figure 4: Breast Cancer Screening by Income\(^{15}\)

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\(^{13}\) Chart Source: Behavioral Risk Factor Surveillance System, Colorado Department of Public Health and Environment.

\(^{14}\) Ibid.

\(^{15}\) Ibid.
Adults with higher education levels had higher rates of breast cancer screening. All differences are statistically significant.

Figure 5: Breast Cancer Screening by Education

BREAST CANCER SCREENING TRENDS

Breast cancer screening rates in Colorado in 2010 were significantly lower than 2004.

Figure 6: Breast Cancer Screening Trends, Colorado and the United States

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17 Ibid.
CERVICAL CANCER SCREENING

BRFSS Survey Question: Have you had a pap smear within the past 3 years?

Cancer of the cervix is the 13th most commonly diagnosed cancer among females in Colorado. Despite the fact that nearly all cervical cancer cases can be prevented, Colorado still averages about 160 new cervical cancer cases and about 40 cervical cancer deaths each year.

The prevalence rate of women 18 and older who have received a pap smear within the last three years is slightly higher in Colorado than the Nation. HSR 11 and Moffat County have pap smear screening prevalence rates in adult women that are higher than the State.

No data is available for Routt County. HSR 11 and Moffat Counties are meeting the CCC Colorado 2015 goal.

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Chart Source: Behavioral Risk Factor Surveillance System, Colorado Department of Public Health and Environment. Data is for women 18 older.
CERVICAL CANCER SCREENING DEMOGRAPHICS

The prevalence rate of women who have received a pap smear within the last three years is significantly higher in the 40-49 age group.

There are no significant differences in the prevalence rate of women who have received a pap smear within the last three years by race/ethnicity.

The prevalence rate of women who have received a pap smear increases with income. There are significant differences between all income categories.

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21 Ibid.
22 Ibid.
The prevalence rate of women who have received a pap smear within the last three years is significantly higher in the some college or more group.

Figure 11: Cervical Cancer Screening by Education

CERVICAL CANCER SCREENING TRENDS

Cervical cancer screening rates in Colorado in 2010 were significantly lower than 2008.

Figure 12: Cervical Cancer Screening Trends

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24 Ibid.
**COLON CANCER SCREENING**

**BRFSS Survey Question:** Sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the bowel for signs of cancer or other health problems. Have you ever had either of these exams?

The identification and removal of colorectal polyps is the single most effective strategy to prevent colorectal cancer.\(^{25}\)

Moffat and Routt Counties have colon cancer screening prevalence rates in adults that are below the State.

Significant improvement is needed to achieve the CCC Goal of 80% percent of adults over 50 receiving screening for colon cancer.

**Figure 13: Colon Cancer Screening**\(^{26}\)


\(^{26}\) Chart Source: Behavioral Risk Factor Surveillance System, Colorado Department of Public Health and Environment. Data is for adults 50 and older.
**COLON CANCER SCREENING DEMOGRAPHICS**

There is no significant difference in prevalence rates of colon cancer screening by gender.

Figure 14: Colon Cancer Screening by Gender

Significantly fewer adults aged 50-59 receive colon cancer screening than older age groups.

Figure 15: Colon Cancer Screening by Age

Adults in the “other” and Hispanic race/ethnicity categories have significantly lower prevalence rates of colon cancer screening than Black and White adults. White adults have a higher prevalence rate than black adults.

Figure 16: Colon Cancer Screening by Race/Ethnicity

---

57 Chart Source: Behavioral Risk Factor Surveillance System, Colorado Department of Public Health and Environment. Note that demographic information is taken from a slightly different question – Ever had sigmoidoscopy/colonoscopy.

58 Ibid.
The prevalence rate of adults who have been screened for colon cancer increases with income. There are significant differences between all income categories.

Figure 17: Colon Cancer Screening by Income

**COLON CANCER SCREENING TRENDS**

Colon cancer screening rates are increasing in Colorado and the Nation. In Colorado, each year has seen a significant increase.

Figure 18: Colon Cancer Screening, Colorado and the United States

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39 Ibid.
41 Ibid.

Yampa Valley Medical Center | Cancer
SKIN CANCER PROTECTION - ADULTS

BRFSS Survey Question: The percent of adults who always or nearly always use sunscreen or sunblock when they go outside on a sunny summer day for more than an hour.

Skin cancer is the most common form of cancer in the United States. Exposure to ultraviolet (UV) radiation appears to be the chief preventable risk factor for non-melanoma skin cancer and may be responsible for more than 90% of cases. Colorado requires special care for UV protection because of its high elevation and 300+ days of sunshine per year.

HSR 11 has a prevalence rate of adults using sun protection higher than the State. Data for Moffat and Routt Counties is not available. HSR 11 needs significant improvement to achieve the CCC Colorado 2015 goal. Demographic and trend data is not available.

Figure 19: Adults Using Sun Protection

32 http://www.coloradocancerplan.org/index.php/selected-cancers/melanoma
SKIN CANCER PROTECTION – CHILDREN

Colorado Child Health Survey: The percent of children who always/nearly always used sunscreen, stayed in the shade, or wore clothing to cover most of their arms and legs when they were outside for more than 15 minutes on a sunny summer day.

![Children Who Always/Nearly Always Use Method of Sun Protection](chart).

The prevalence rate of children who always/nearly always use a method of sun protection in Colorado is 68.2%. The HSR 11 prevalence rate is below the State and well below the Colorado 2015 goal. No data is available for Moffat or Routt Counties.

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34 Chart Source: Colorado Child Health Survey, Colorado Department of Public Health and Environment.
CANCER MORTALITY RATES

Survey: Death Certificates with Cancer (Breast, Cervix/Uterus, Colon/Rectum, Melanoma, Prostate, Trachea, Lung, Bronchus) as Underlying Cause of Death

Cancer death rates from common types of cancer are significantly lower in Colorado compared to the Nation.

Moffat County has cancer death rates that are higher than the State.

Routt County has cancer death rates that are lower than the State.

Figure 21: Cancer Death Rates

---

35 Chart Source: Certificate of Death, Colorado Department of Public Health and Environment. Rates are per 100,000 population and are adjusted using the direct method applied to 10-year age groups. Population figures are 2007-based estimates from the Demography Section, Colorado Department of Local Affairs. County-specific data are for deaths reported as occurring for residents of those counties. Rates reported in this chart are for common types of cancer and do not represent death from all types of cancer reported. National data is an average of 2006-2008. Breast and Cervix / Uterus rates are for females only. Prostate rates are for males only.
The death rate from breast cancer is above the State in both Moffat and Routt Counties, but below the Healthy People 2020 goal. The death rate for colon / rectum cancer in both Moffat and Routt Counties is above the State, Nation, and Healthy People 2020 goal. The death rate from melanoma is well above the State, Nation, and Healthy People 2020 goal in Moffat County. The death rate from cancer of the trachea/bronchus/lungs is higher in Moffat County than the state, but is meeting the Healthy People 2020 goal.

---

**Figure 22: Cancer Death Rates Compared to Healthy People 2020 Goals**

<table>
<thead>
<tr>
<th></th>
<th>Breast</th>
<th>Cervix / Uterus</th>
<th>Colon / Rectum</th>
<th>Melanoma</th>
<th>Prostate</th>
<th>Trachea / Bronchus / Lungs</th>
</tr>
</thead>
<tbody>
<tr>
<td>HP 2020 Goals</td>
<td>20.6</td>
<td>2.2</td>
<td>14.5</td>
<td>2.4</td>
<td>21.2</td>
<td>45.5</td>
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<td>22.9</td>
<td>2.2</td>
<td>17.0</td>
<td>2.7</td>
<td>23.5</td>
<td>50.6</td>
</tr>
<tr>
<td>State</td>
<td>11.3</td>
<td>0.9</td>
<td>12.4</td>
<td>3.3</td>
<td>9.5</td>
<td>37.1</td>
</tr>
<tr>
<td>Moffat</td>
<td>17.2</td>
<td>0.0</td>
<td>24.8</td>
<td>25.8</td>
<td>0.0</td>
<td>39.1</td>
</tr>
<tr>
<td>Routt</td>
<td>14.3</td>
<td>0.0</td>
<td>18.8</td>
<td>0.0</td>
<td>0.0</td>
<td>30.1</td>
</tr>
</tbody>
</table>

* Chart Source: Certificate of Death, Colorado Department of Public Health and Environment. Rates are per 100,000 population and are adjusted using the direct method applied to 10-year age groups. Population figures are 2007-based estimates from the Demography Section, Colorado Department of Local Affairs. County-specific data are for deaths reported as occurring for residents of those counties. Rates reported in this chart are for common types of cancer and do not represent death from all types of cancer reported. National data is an average of 2006-2008. Breast and Cervix / Uterus rates are for females only. Prostate rates are for males only.*
Death rates from the most common types of cancer are holding steady in Colorado. No significant changes in overall death rates occurred from 2006 to 2010, however; melanoma death rates appear to be trending upward.

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**Figure 23: Trends in Cancer Death Rates**

[Chart showing trends in cancer death rates for various types of cancer in Colorado from 2006 to 2010.]

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37 Chart Source: Certificate of Death, Colorado Department of Public Health and Environment. Rates are per 100,000 population and are adjusted using the direct method applied to 10-year age groups. Population figures are 2007-based estimates from the Demography Section, Colorado Department of Local Affairs. County-specific data are for deaths reported as occurring for residents of those counties. Rates reported in this chart are for common types of cancer and do not represent death from all types of cancer reported.
Mortality rates for melanoma in Colorado have been significantly higher than U.S. rates for several years. The 2000-2006 Colorado melanoma incidence rate was 18% higher for males than the U.S. rate, and 22% higher for females. It is important for statewide prevention and early detection efforts to particularly target males.

Figure 24: Trends in Melanoma Death Rates

http://www.coloradocancerplan.org/index.php/selected-cancers/melanoma

Ibid.
CANCER AND POVERTY

Coloradans with lower incomes were more likely to smoke tobacco, to be obese, to be less physically active, and to not participate in screening tests for breast, cervical, or colorectal cancer.\(^4\) For most cancers, Coloradans who lived in poorer neighborhoods and had no health insurance were more likely to have had a more advanced stage of cancer at the time of diagnosis. For most cancers, Coloradans who lived in poorer neighborhoods were more likely to die within the first 5 years following cancer diagnosis.

CHILDHOOD CANCER

More than 12,500 children and young adults are diagnosed with cancer each year in the United States, and the numbers are rising.\(^4\) Colorado is one of only four states to develop a comprehensive plan to address cancer as it applies to the pediatric and young adult population. Data availability on pediatric cancer rates in Colorado is limited.

Figure 25: Top Five Cancer Types Diagnosed in Childhood\(^4\)

\(^4\) http://www.cdphe.state.co.us/pp/ccpc/cancerpoverty08.pdf
\(^4\) Ibid.
COLORADO CANCER COALITION GOALS AND OBJECTIVES

The goals of the CCC include:
- Promoting the collection and use of information about cancer
- Improving healthy behaviors
- Increasing screening rates
- Improving access to the full spectrum of cancer diagnosis and care
- Increasing health equity
- Setting targets to improve cancer prevention and control
- Supporting policies to facilitate these efforts

For a complete list of goals, objectives, and strategies developed by the Colorado Cancer Coalition, see:

BREAST CANCER

By 2015, increase to 80% the proportion of women age 40 and older reporting that they received a mammogram in the past two years.

Strategies:

According to the Community Guide (usa.gov, 2009), evidence-based interventions shown to increase breast cancer screenings include:

- **Client reminder systems** – 16 studies confirm that client reminder systems increase breast cancer screening. Interventions may include use of letters, postcards or phone calls to alert clients that it is time for their cancer screening.

- **Small media** – 17 studies confirm that small media efforts (such as videos, printed materials, letters, brochures and newsletters) increase breast cancer screening. Tailored interventions may include videos and printed materials geared towards specific individuals, specific populations or general audiences.

- **One-on-one education** – 25 studies confirm that one-on-one education increases breast cancer screening. Health care providers can deliver one-on-one education in clinical settings, at home, by phone or in local gathering places. Some studies indicate that physicians may be less likely to recommend mammography to low-income, less educated women (O’Malley et al., 2001).

- **Reducing structural barriers** – Seven studies confirm that reducing structural barriers increases breast cancer screening. Barriers include distance from screening location, limited hours of operation, lack of day care for children, and language and cultural factors. Other barriers identified in Colorado include fear of diagnosis/treatment, immigrant status and lack of understanding medical terminology (Komen Community Profile Report, 2009).

- **Reducing out-of-pocket costs** – Eight studies confirm that reducing out-of-pocket costs increases breast cancer screening. Interventions may include providing free or low-cost services, reimbursing clients or clinics, and/or reducing health insurance premiums or co-payments.

Information about why these strategies are important can be found in the references and resources section.
By 2015, increase to 98% the proportion of women who complete diagnostic evaluation of abnormal breast findings in 60 days or less.

Strategies:

EVIDENCE-BASED INTERVENTIONS TO INCREASE TIMELY FOLLOW-UP ON ABNORMAL FINDINGS

Few studies have evaluated interventions that may improve women’s compliance with follow-up on abnormal breast cancer screenings, but amongst those studies some strategies are outlined including:

- **Reducing anxiety after an abnormal result** – nearly 50% of women who have abnormal mammograms report symptoms of anxiety three weeks after completing follow-up. Interventions to reduce this anxiety include immediate feedback from the mammography facility and avoiding periodic follow-up 3-6 months after the initial screening. Educational interventions did not decrease women’s anxiety after an abnormal result (Barton, Morley, Moore, Allen, Kleinman, Emmons & Fletcher, 2004).

- **Case management/patient navigation** – Women who receive evidenced-based case management services are 6.4 times more likely to be adherent with completing follow-up care (Vourlekis, Ell & Padgett, 2005) and are more likely to complete follow-up care in a timely fashion (Wells et al., 2008; Psooy, Schreuer, Borgaonkar & Caines, 2004). Interventions may include making telephone reminders, providing systems navigation, performing assessments of individual-level barriers and mental health assessments. Individual-level barriers may include lack of understanding what follow-up procedures are required, fear of cancer, cultural beliefs, emotional state, competing priorities, lack of social support and lack of usual source of health care (Vourlekis, et al., 2005).

Several studies have found that patient navigation services provide better outcomes for breast cancer patients; however, studies are limited and provide little information regarding their efficiency or cost-effectiveness (Wells et al., 2008). One study reported that the length of time from diagnosis to treatment was shorter for women receiving patient navigation services (Schwaderer et al., 2008). Women may also experience fewer treatment interruptions when receiving patient navigation services (Peteriet et al., 2008). According to Wells et al. (2008), patient navigators may assist with:

- Overcoming health system barriers such as coordinating care with multiple providers and facilitating patient provider communication
- Providing health education on topics like genetic testing, treatment options and treatment side-effects
- Overcoming patient barriers by addressing issues such as lack of transportation, financial and insurance barriers, lack of child care or language translation, and low health literacy.
- Providing psychosocial support that may be done either directly or by referring patients to social workers or cancer support groups

Information about why these strategies are important can be found in the references and resources section.
BY 2015, SUPPORT THE DEVELOPMENT AND IMPLEMENTATION OF CANCER SURVIVORSHIP CARE PLANS.

Strategies:

EVIDENCE-BASED INTERVENTIONS ASSOCIATED WITH CANCER SURVIVORSHIP CARE PLANS

Establishing a more comprehensive cancer survivorship plan is one way to prevent the disconnect between initial cancer treatment, long-term survivorship issues and reducing breast cancer mortality. Treatment of breast cancer is a complex process that requires consultation with multiple medical specialists in multiple settings. The use of cancer survivorship care plans cannot be considered an evidence-based practice that improves health outcomes yet, more research is needed to demonstrate the effectiveness of this strategy (Gilbert et al., 2007). However, the Institute of Medicine (2005) and the National Institutes of Health (2008) recommend that certain key components be addressed in cancer survivorship care plans:

- Summary of all cancer treatments received with short and long-term side effects and toxicities, and contact information from treating institutions and providers
- Detailed cancer specific information such as tumor sites, stage, grade, hormonal status, and marker information
- Likely course of recovery
- Recommended preventative treatments
- Language about what each health care provider is responsible for
- Evidenced – based standards of care for future cancer screenings
- Psychosocial, nutritional, and other supportive services required
- Identification of key point of contact and coordinator for continuing care

CERVICAL CANCER

BY 2015, INCREASE TO 90% THE NUMBER OF COLORADO WOMEN AGE 18 AND OLDER REPORTING HAVING HAD A PAP SMEAR IN THE PAST THREE YEARS.

Strategies:

1. Implement evidence-based community interventions to increase screening and modify risk behaviors into the Colorado health care system.
2. Educate primary care screening providers (generalists, OB/Gyn, Family Practice) on client evidenced-based strategies that increase screenings.
3. Actively refer eligible women to Women’s Wellness Connection (WWC) who will provide services for low income, uninsured women between 40 and 64 years of age.
4. Provide cervical cancer education to women that are not routine users of the health care system and may have disparities that prevent access to the health care system.
5. Develop partnerships with STD clinics, correctional, domestic abuse, homeless shelters and other community-based organizations that may have contact with women who are rarely or never screened for cervical cancer. Provide assistance to organizations on where screening services can be obtained in the Colorado health care system.
By 2015, increase HPV vaccination coverage (>1 HPV vaccine dose) to 44% for females 13-17 years of age.

Baseline Data

The National Immunization Survey (NIS) is sponsored by the National Center for Immunizations and Respiratory Diseases (NCIRD) and conducted jointly by the NCIRD and the National Center for Health Statistics (NCHS). In 2007, NIS HPV vaccination coverage was reported for the first time and showed that 25.1% of U.S. females 13-17 years of age had received at least one HPV vaccination. In 2008, the NIS assessed state-level vaccination coverage and reported Colorado’s HPV vaccination (>1 HPV vaccine dose) coverage level for females 13-17 years of age is 34% compared to the national rate of 37%.

Social Determinants Associated with HPV

There are several emerging studies that demonstrate differences in populations that receive the vaccine, those that need and are receptive to education about the vaccine, and persistent myths about HPV vaccine.

2. Barriers to vaccination are cost and access to vaccine and concern that immunization with the vaccine may promote adolescent sexual behavior. HPV vaccine programs should emphasize high vaccine effectiveness, the high likelihood of HPV infection, and physicians' recommendations, and address barriers to vaccination. (Predictors of HPV vaccine acceptability: a theory-informed, systematic review. Brewer NT, Fazekas KI. Preventive Med. 2007 Aug-Sep;45(2-3):107-14. Epub 2007 Jun 2.)

- Teenage girls surveyed indicated no increased interest in risky sexual behavior if they were to be vaccinated. (Attitudes about human papillomavirus vaccine in young women. (Kahn JA, et al. Int J STD AIDS. 2003 May;14(5):300-6.)

Evidenced-based Interventions to Increase HPV vaccination Rates

According to findings of the CDC Guide to Community Preventive Services (http://www.thecommunityguide.org/index.html), there are no specific evidence-based interventions for increasing HPV vaccination at this time. Therefore, the following proven interventions are being recommended for increasing HPV vaccination coverage:

- Provider Reminder Systems: Provider reminders let providers or other appropriate staff knows when individual clients are due for vaccinations, through notations, stickers, or other prompts in clients’ charts, or through computer databases or registries. Reminders can be directed to the primary healthcare provider or clinic staff.
- Interventions that should be implemented in combination:
  1. Expanded access in healthcare settings;
  2. Reducing patient out-of-pocket costs;
  3. Patient or family incentives;
4. Patient reminder/recall systems;
5. Clinic-based patient education;
6. Community-wide education;
7. Vaccination requirements;
8. Provider assessment and feedback;
9. Provider education; and
10. Standing orders.


Based on information presented, the following are Cervical Cancer Plan 2015 Strategies to Increase HPV Vaccination Coverage:

1. Educate healthcare providers about the Advisory Committee on Immunization Practices (ACIP) recommendations for HPV vaccination.
2. Provide technical assistance to healthcare providers to implement the Standards for Child, Adolescent, and Adult Immunization Practices.
3. Recruit non-traditional vaccination providers (OB/GYNs, etc.) into the Vaccines for Children (VFC) Program to increase HPV vaccination coverage among uninsured and underinsured females 18 years of age and under.
4. Support activities that recruit non-traditional vaccination providers into the Colorado Immunization Information System (CIIS) so that HPV vaccination records are accurate, complete, and accessible.

1. Educate providers about the importance of implementing systems to remind parents/guardians, patients, and staff when vaccinations are due.
2. Develop targeted, culturally specific media messages about HPV vaccination and disseminate through provider offices, health departments and community organizations. Messaging should focus on:
   1. Emphasizing the high likelihood of HPV infection if sexually active;
   2. Educating parents of adolescents about high vaccine effectiveness;
   3. Educating parents about the myths related to increase sexual activity in vaccinated adolescents;
   4. Addressing barriers to vaccine access; and
   5. Educate vaccine recipients about the need for continued regular screening with Pap tests.

**COLORECTAL 1**

By 2015, 80 % of Coloradans ages 50 and older will be in compliance with ACS colorectal cancer screening guidelines.

**Strategies for the Public:**

- Facilitate/encourage public awareness at the local level, across all populations, about colorectal cancer:
  1. Include messages both for average risk persons and for persons at higher risk due to their family history of colorectal cancer or adenomas.
  2. Engage advocates, such as survivors, caregivers, and navigators in development and distribution of CRC screening messaging.
  3. Develop and use messaging that is consistent with other organizations in Colorado, as well as nationally, including ACS/CCGC/USPSTF guidelines.
4. Determine outreach to populations who are pre-screening age to begin to raise awareness.

5. Include messaging to ensure public awareness about new Colorado legislation mandating colorectal cancer screening.

6. Encourage the use of evidence-based strategies for community mobilization.

7. Hold regular meetings with key stakeholders to update progress and introduce newer strategies.

8. Coordinate lifestyle messaging with other organizations, such as COLORADO ON THE MOVE and LIVEWELL COLORADO, with similar goals.

Strategies for Providers:

- Continue the statewide educational campaign to increase knowledge of Colorado health care providers about colorectal screening options, specifically including information about guidelines for the use of high sensitivity FOBT’s and the age for stopping screening.

1. Collection of comprehensive family history.

2. Communicate ACS/CCGC/USPSTF screening guidelines, emphasizing commonalities of recommendations.

- Encourage practice changes that facilitate increased screening through measures such as:

  1. Patient education about the importance of screening and the screening process.
  
  2. Patient navigation – scheduling, education, coordinate services, assistance with barriers to screening, follow-up.
  
  3. In-reach to eligible patient populations.

- Support the development and use of easy-to-use tools to assist physicians reaching high-risk populations.
- Support the incorporation of quality standards for endoscopic screening into electronic endoscopy reports.
- Educate the primary care provider community to recognize and expect to be provided with data documenting high-quality endoscopic screening.
- Assist the endoscopic provider community to ensure that the data to assess the quality of endoscopic services is available to endoscopists and their referral network.
- Facilitate provider-generated strategies to increase screenings and preventative care

Strategies for Health Care Systems:

- Support development of “in-office pathways” that reduce delays in diagnosis of colorectal cancer (iron deficiency, positive stool test, etc.)
- Collaborate with employers and health insurers, such as the Colorado Business Group on Health and Association of Health Plans, to increase screening rates among their insured, particularly the underinsured.

1. Reduce or eliminate co-pays for CRC screening.

2. Collaborate with employers to improve benefit selection and reduce and /or eliminate cost barriers for CRC screening.

Sustain funding for a program to provide colorectal screening for uninsured and underinsured Coloradans.
• Encourage the next revision of CCGC guidelines to address quality of endoscopic screens.
• Assure adequate capacity in Colorado for colorectal screening services:
  1. Encourage lower fees for self-pay patients.
  2. Increase CRC screening capacity in rural Colorado and ensure high quality screenings.
  3. Promote preventative colorectal screening in the primary care environment, via a medical home.
• Encourage the development of cost-effective strategies for CRC screening.

**Strategies for Policy/Advocacy:**

• Ensure screening for uninsured and undocumented Coloradans.
• Engage survivors and family members to become advocates for education and screening.
• Develop messaging addressed to legislators, funders, insurers, employers, etc. to create the business case for CRC screening.
• Support development of policy and legislation to secure payment coverage for diagnostic and treatment services for low-income, uninsured Coloradans diagnosed with colorectal cancer.

Support development of policy and legislation to pay for patient navigation and community health workers in the primary care setting.

**Increase the number of individuals receiving genetic counseling who have a high risk of carrying an inherited predisposition to colorectal cancer.** This includes those with a personal or family history of:

• Colorectal cancer, especially under age 60
• Endometrial cancer, especially under age 60
• Ovarian cancer at any age
• Multiple colon polyps (10 or more on a single screening)
• Hereditary Non-Polyposis Colorectal Cancer (HNPCC, aka Lynch syndrome); Familial Adenomatous Polyposis (FAP); or MYH-Associated Polyposis (MAP)
• Inherited mutations to MLH1, MSH2, MSH6, PMS2, APC, or MYH genes

Two to four percent of all colorectal cancer diagnoses are due to an inherited predisposition to colorectal and endometrial cancers. Important screening tools for Lynch syndrome include:

• Family history as outlined above
• Screening colon tumor tissue with MSI, IHC, and/or BRAF lab testing. Tissue screening is more sensitive and specific than family history in detecting Lynch syndrome. Tissue lab screening can be coordinated through most pathology labs. (Genetics In Medicine • Volume 11, Number 1, January 2009, pp 35-41.)

**MELANOMA**

By 2015, increase by 5% the percentage of schools that have established sun safety guidelines, procedures or policies for their students. (Baseline: 62%, 2007 Sun Safe Schools Project)

**Strategies**

• Maintain and promote the Sun Safe Colorado website for access by schools and parents.
• Conduct outreach and provide resources for schools and school districts.
• Support schools and school districts in the adoption and implementation of sun safety guidelines, procedures or policies.
• Support the development of a sustainable mechanism for collecting the data needed to monitor the objective.

MELANOMA 2

By 2015, revise state legislation to restrict indoor UV tanning usage by minors.
(Baseline: no Colorado age restrictions, 2010)

Strategies:
• Increase public knowledge about the skin cancer risks associated with indoor tanning.
• Encourage development of, secure sponsorship for, and promote passage of legislation.
• Educate indoor UV tanning facility operators about state regulations and legislation.
• Support the development of a sustainable mechanism for collecting the data needed to monitor the objective.

MELANOMA 3

By 2015, increase by 5% the percentage of workplaces that have established sun safety guidelines, procedures or policies for their outdoor workers.
(Baseline: 50%, 2007 Colorado Sun Protection Workplace Survey)

Strategies:
• Maintain and promote the Sun Safe Colorado website for access by workplaces and employees.
• Conduct outreach and provide resources for workplaces with outdoor workers.
• Support employers in the adoption and implementation of sun safety guidelines, procedures, or policies.
• Support the development of a sustainable mechanism for collecting the data needed to monitor the objective.

MELANOMA 4

By 2015, reduce to 35% the percentage of adults who report having had sunburn in the past year. (Baseline: 40.4%, 2006 Colorado BRFSS)

Strategies:
• Implement educational programs and distribute information to educate adults about sunburns and skin cancer prevention.
• Support the distribution of sun protection products at public events, parks and other outdoor venues.
• Maintain and promote the Sun Safe Colorado website for access by workplaces and employees.
• Promote the installation of shade structures in areas where people congregate for social or recreational purposes.
• Support the development of a sustainable mechanism for collecting the data needed to monitor the objective.
**MELANOMA 5**

By 2015, reduce to 45% the percentage of parents reporting their children having had a sunburn in the past year. *(Baseline: 50.7%, 2006 Child Health Survey)*

**Strategies:**
- Implement educational programs and distribute information to educate children and adolescents about sunburns and sun safety.
- Support the distribution of sun protection products at public events, parks and other outdoor venues.
- Maintain and promote the Sun Safe Colorado website for access by schools and parents.
- Promote the installation of shade structures in areas where people congregate outdoors for social and recreational purposes.
- Support the development of a sustainable mechanism for collecting the data needed to monitor the objective.

**MELANOMA 6**

By 2015, increase to 72% the percentage of adults reporting use of at least one method of sun protection when outside during a sunny summer day for more than one hour. *(Baseline: 66.3%, 2006 Colorado BRFSS)*

**Strategies:**
- Implement educational programs and distribute information to educate adults about sun protection strategies.
- Support the distribution of sun protection products at public events, parks and other outdoor venues.
- Maintain and promote the Sun Safe Colorado website for access by workplaces and employees.
- Promote the installation of shade structures in areas where people congregate outdoors for social and recreational purposes.
- Support the development of a sustainable mechanism for collecting the data needed to monitor the objective.

**MELANOMA 7**

By 2015, increase to 78% the percentage of children using at least one method of sun protection when outside for more than 15 minutes between 11 am and 3 pm on a sunny summer day. *(Baseline: 73.1%, 2006 Child Health Survey)*

**Strategies:**
- Implement educational programs and distribute information to educate adults about sun protection strategies.
• Support the distribution of sun protection products at public events, parks and other outdoor venues.
• Maintain and promote the Sun Safe Colorado website for access by schools and parents.
• Promote the installation of shade structures in areas where people congregate outdoors for social and recreational purposes.
• Support the development of a sustainable mechanism for collecting the data needed to monitor the objective.

MELANOMA 8

By 2015, increase the proportion of melanomas detected "early" by physicians to 84%; "early" is defined as less than or equal to 1.00 mm Breslow depth or in-situ stage. (Baseline: 79%, 2006 Colorado Central Cancer Registry)

Strategies:
• Implement educational programs and distribute information to educate adults about early detection of skin cancer.
• Maintain and promote the Sun Safe Colorado website.
• Promote skin self-examination by persons at high risk of developing skin cancer.
• Support skin cancer screenings for the public.
• Increase physician education.

MELANOMA 9

By 2015, increase by 5% the percentage of preschools and child care centers that have established sun safety guidelines, procedures or policies for their students. (Baseline: 81%, 2010 Survey of Child Care Centers)

Strategies:
• Conduct statewide outreach and provide resources for preschools and child care centers.
• Support preschools and child care centers in the adoption and implementation of sun safety guidelines, procedures, or policies.
• Support the development of a sustainable mechanism for collecting the data needed to monitor the objective.
• Maintain and promote the Sun Safe Colorado website for access by preschools, child care centers and parents.
CLINICAL RECOMMENDATIONS

The following clinical recommendations come from the US Preventive Services Task Force (USPSTF).

GENETIC RISK ASSESSMENT AND BRCA MUTATION TESTING FOR BREAST AND OVARIAN CANCER SUSCEPTIBILITY

The U.S. Preventive Services Task Force (USPSTF) recommends that women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes be referred for genetic counseling and evaluation for BRCA testing.

SCREENING FOR BREAST CANCER

The U.S. Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women aged 50 to 74 years.

SCREENING FOR CERVICAL CANCER

The U.S. Preventive Services Task Force (USPSTF) strongly recommends screening for cervical cancer in women who have been sexually active and have a cervix.

SCREENING FOR COLORECTAL CANCER

The U.S. Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults, beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.

COMMUNITY INTERVENTIONS

The following evidence-based community interventions come from the Guide to Community Preventive Services, Centers for Disease Control and Prevention (CDC).

CANCER PREVENTION & CONTROL, CLIENT-ORIENTED SCREENING INTERVENTIONS: CLIENT REMINDERS

Reminders include letters, postcards, or phone calls to alert clients that it is time for their cancer screening.
CANCER PREVENTION & CONTROL, CLIENT-ORIENTED SCREENING
INTERVENTIONS: ONE-ON-ONE EDUCATION

One-on-one education is provided in person or by telephone to encourage individuals to be screened for cancer.

CANCER PREVENTION AND CONTROL, CLIENT-ORIENTED SCREENING
INTERVENTIONS: CLIENT REMINDERS

Small media such as videos, letters, brochures, and newsletters can be used to inform and motivate people to be screened for cancer; they can be tailored to specific persons or targeted to general audiences.

CANCER PREVENTION AND CONTROL, CLIENT-ORIENTED SCREENING
INTERVENTIONS: REDUCING OUT-OF-POCKET COSTS

Reducing out-of-pocket costs to increase cancer screening may include providing vouchers, reimbursing clients, or reducing health insurance costs associated with screening tests.

CANCER PREVENTION AND CONTROL, CLIENT-ORIENTED SCREENING
INTERVENTIONS: REDUCING STRUCTURAL BARRIERS

Reducing structural barriers to increase screening may include increasing hours of operation, providing child care, or addressing language or cultural factors.

CANCER PREVENTION AND CONTROL, CLIENT-ORIENTED SCREENING
INTERVENTIONS: SMALL MEDIA

Small media such as videos, letters, brochures, and newsletters can be used to inform and motivate people to be screened for cancer; they can be tailored to specific persons or targeted to general audiences.

CANCER PREVENTION AND CONTROL, PROVIDER-ORIENTED SCREENING
INTERVENTIONS: PROVIDER ASSESSMENT AND FEEDBACK

These interventions assess how often providers offer or deliver screening services to clients (assessment) and then give providers information about their performance (feedback).
CANCER PREVENTION AND CONTROL, PROVIDER-ORIENTED SCREENING INTERVENTIONS: PROVIDER REMINDER AND RECALL SYSTEMS

Reminders inform health care providers it is time for a client’s cancer screening test (called a “reminder”) or that the client is overdue for screening (called a “recall”).

HEALTH COMMUNICATION & SOCIAL MARKETING: HEALTH COMMUNICATION CAMPAIGNS THAT INCLUDE MASS MEDIA & HEALTH-RELATED PRODUCT DISTRIBUTION

Health communication campaigns can increase the use of health-related products when they use mass media messaging and distribute the products at free or reduced prices.

PREVENTING SKIN CANCER: EDUCATION AND POLICY APPROACHES IN OUTDOOR RECREATION SETTINGS

Interventions in recreational or tourism settings are designed to increase sun-protective knowledge, attitudes, and intentions, and affect behaviors among adults and children.
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<tr>
<th>County or Statewide Program</th>
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<tr>
<td>Colorado/Statewide</td>
<td>Aurora</td>
<td>The Young Women's Breast Cancer Translation Program (YWBCTP) at the Diane O'Connor Thompson Breast Center</td>
<td><a href="mailto:my.healthconnection@uch.edu">mailto:my.healthconnection@uch.edu</a></td>
<td><a href="http://www.uch.edu/conditions/cancer/breast-cancer/ywbc">http://www.uch.edu/conditions/cancer/breast-cancer/ywbc</a> tp/</td>
<td>University of Colorado Hospital, Anschutz Medical Campus, Aurora, Colorado</td>
<td>(720) 848-0300</td>
<td></td>
<td>The Young Women's Breast Cancer Translational Program (YWBCTP) at the Diane O'Connor Thompson Breast Center is one of the few centers in the country that focuses solely on the unique challenges of young women's breast cancer and pregnancy-related breast cancer.</td>
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<tr>
<td>Colorado/Statewide</td>
<td>Aurora</td>
<td>Lung Cancer &amp; Other Thoracic and Related Cancers</td>
<td><a href="mailto:my.healthconnection@uch.edu">mailto:my.healthconnection@uch.edu</a></td>
<td><a href="http://www.uch.edu/conditions/cancer/lung/">http://www.uch.edu/conditions/cancer/lung/</a></td>
<td>University of Colorado Hospital, Anschutz Medical Campus, Aurora, Colorado</td>
<td>(866) 407-6621</td>
<td></td>
<td>At University of Colorado Hospital and the University of Colorado Cancer Center, you'll find the leading lung and thoracic cancer specialists in the Rocky Mountain region. We're also one of only 40 National Cancer Institute-designated Comprehensive Cancer Centers in the United States</td>
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<tr>
<td>Colorado/Statewide</td>
<td>Colorado</td>
<td>Translational Research Program (TRP)</td>
<td>Dr. Toby T. Hecht</td>
<td><a href="http://trp.cancer.gov/">http://trp.cancer.gov/</a></td>
<td>Translational Research Program Division of Cancer Treatment and Diagnosis, National Cancer Institute, 6116 Executive Boulevard, Rockville, MD 20852-8347</td>
<td>301-496-8528</td>
<td></td>
<td>The Translational Research Program (TRP) is the home of the SPOREs — the Specialized Programs of Research Excellence — a cornerstone of NCI’s efforts to promote collaborative, interdisciplinary translational cancer research. SPORE grants involve both basic and clinical/applied scientists and support projects that will result in new and diverse approaches to the prevention, early detection, diagnosis and treatment of human cancers.</td>
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<tr>
<td>Colorado/Statewide</td>
<td>Colorado</td>
<td>Susan G Komen Foundation Denver Affiliate</td>
<td>Michele Ostrander</td>
<td><a href="mailto:michele.ostrander@komendenver.org">mailto:michele.ostrander@komendenver.org</a></td>
<td><a href="http://www.komendenver.org/site/PageServer?pagename=rfcd_homepage">http://www.komendenver.org/site/PageServer?pagename=rfcd_homepage</a></td>
<td>1835 Franklin Street, Denver, CO 80208</td>
<td>303.744.2088</td>
<td>The Komen Denver Affiliate of Susan G Komen for the Cure® is comprised of a committed group of volunteers, Board of Directors and staff members working together to further our mission of ending breast cancer forever.</td>
</tr>
<tr>
<td>Colorado/Statewide</td>
<td>Denver</td>
<td>Medicaid Breast and Cervical Cancer Program</td>
<td>Diane Stayton, Program Coordinator, Colorado Department of Health Care Policy and Financing</td>
<td><a href="mailto:diane.stayton@state.co.us">diane.stayton@state.co.us</a></td>
<td><a href="http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1210324172204">http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1210324172204</a></td>
<td>Department of Health Care Policy and Financing · 1570 Grant Street · Denver, CO 80203-1818</td>
<td>303-866-2385</td>
<td>The Breast and Cervical Cancer Program (BCCP) is a Medicaid program for women who have been diagnosed with breast or cervical cancer at certain screening clinics called Women's Wellness Connection sites (WWC). BCCP also covers breast and cervical conditions that may lead to cancer if not treated.</td>
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<tr>
<td>Colorado/Statewide</td>
<td>Aurora</td>
<td>The University of Colorado Cancer Center Breast Cancer Program</td>
<td><a href="mailto:myle@uch.edu">mailto:myle@uch.edu</a></td>
<td><a href="http://www.uch.edu/conditions/cancer/breast-cancer/">http://www.uch.edu/conditions/cancer/breast-cancer/</a></td>
<td>University of Colorado Hospital, Anschutz Medical Campus, Aurora, Colorado</td>
<td>(720) 848-1030</td>
<td>At our Denver-area campus, you’ll find the only National Cancer Institute-designated Comprehensive Cancer Center in the Rocky Mountain region (one of only 40 in the United States).</td>
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<tr>
<td>Colorado/Statewide</td>
<td>Colorado</td>
<td>University of Colorado Hospital Tomo Therapy Treatment Facility</td>
<td>Becky Alderson</td>
<td><a href="mailto:myhealthconnection@uch.edu">mailto:myhealthconnection@uch.edu</a></td>
<td><a href="http://www.uch.edu/conditions/cancer/tomotherapy-facility/">http://www.uch.edu/conditions/cancer/tomotherapy-facility/</a></td>
<td>10463 Park Meadows Drive, Suite 111, Littleton, Colorado 80124</td>
<td>(720) 848-0102</td>
<td>TomoTherapy® is a new way to deliver radiation treatment for cancer. It delivers a very sophisticated form of intensity-modulated radiotherapy (IMRT), and combines treatment planning, CT image-guided patient positioning, and treatment delivery into one integrated system.</td>
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<td>Colorado/Statewide</td>
<td>Denver</td>
<td>Colorado Cancer Research Program</td>
<td><a href="mailto:ccrcpl@co-cancerresearch.org">ccrcpl@co-cancerresearch.org</a></td>
<td><a href="http://www.co-cancerresearch.org/">http://www.co-cancerresearch.org/</a></td>
<td>2253 South Oneida St. Third Floor, Suite B, Denver, Co 80224</td>
<td>303-777-2663</td>
<td>A nonprofit community-based cancer program established to provide community hospitals and physicians access to a wide range of cancer research trials in order to provide their patients with greater options for the treatment, control, and prevention of cancer.</td>
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<tr>
<td>Colorado/Statewide</td>
<td>Denver</td>
<td>The Colorado Blood Cancer Institute (CBCI)</td>
<td>Email us at: <a href="mailto:cbci@healthoncares.com">cbci@healthoncares.com</a></td>
<td><a href="http://www.bloodcancerinstitute.com/">http://www.bloodcancerinstitute.com/</a></td>
<td>1800 Williams Street, Suite 300, Denver, Colorado 80218</td>
<td>720.754.4800</td>
<td>The Colorado Blood Cancer Institute (CBCI) is a new program established by the expert physicians who have served Rocky Mountain Blood and Marrow Transplant Program patients for more than 15 years. CBCI was developed to provide state-of-the-art treatment for blood cancers such as leukemia, lymphoma and multiple myeloma.</td>
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<tr>
<td>Colorado/Statewide</td>
<td>Denver</td>
<td>Discussion Group for Men Affected by Cancer</td>
<td>Andrea Maikovich-Fong, PhD</td>
<td>Email us at: <a href="mailto:cbci@healthoncares.com">cbci@healthoncares.com</a></td>
<td>Rocky Mountain Children's Hospital - Surgery Room 2D (Intersection of 19th and High Streets, attached to Presbyterian/St. Luke's Hospital)</td>
<td>720-754-4855</td>
<td>Dr. Andrea Maikovich-Fong leads this group for men who have been treated for cancer. All are invited to join this group for discussion, companionship, support, and the sharing of experiences</td>
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<td>Colorado/ Statewide</td>
<td>Colorado</td>
<td>Sun Safe Colorado Program Colorado Department of Health and Environment</td>
<td><a href="mailto:cdph.epsdrequests@state.co.us">mailto:cdph.epsdrequests@state.co.us</a></td>
<td><a href="http://www.sunsafe.colorado.org/">http://www.sunsafe.colorado.org/</a></td>
<td>Colorado Department of Public Health and Environment, 4300 Cherry Creek Drive South, Denver, Colorado 80246-1530</td>
<td>303-692-2520</td>
<td>Sun Safe Colorado (SSC) is a program that was launched by the Comprehensive Cancer Program at the CDPHE, through the Centers for Disease Control and Prevention and is now supported by the Cancer, Cardiovascular Disease, and Pulmonary Disease Grants Program, at the CDPHE. The program provides schools and workplaces with the information and tools they need to educate about skin cancer prevention and create sun safe environments. SSC has provided trainings to schools and has provided mini-grants to schools and school districts to aid them in this process.</td>
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<td>Routt</td>
<td>Steamboat Springs</td>
<td>Services: Planned Parenthood Allison Whitney, Health Center Manager</td>
<td><a href="mailto:allison.whitney@pprm.org">allison.whitney@pprm.org</a></td>
<td><a href="http://www.pprm.org">www.pprm.org</a></td>
<td>1104 B 11th Street Steamboat Springs, CO 80487</td>
<td>970-879-2213</td>
<td>Women’s annual exams, STD testing and treatment, infection diagnoses and treatment, pregnancy testing and options counseling, birth control services, emergency contraception, HPV vaccine, medication abortion, breast checks and mammogram.</td>
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<td>Routt</td>
<td>Steamboat Springs</td>
<td>Adult Health VNA</td>
<td>Stephanie Anderson</td>
<td><a href="mailto:sanderso@nwcovna.org">sanderso@nwcovna.org</a></td>
<td><a href="http://www.nwcovna.org">www.nwcovna.org</a></td>
<td>940 Central Park Drive Suite 101 Steamboat Springs, CO 80487</td>
<td>(970) 879-1632</td>
<td>Programs for Adults &amp; Seniors include:</td>
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<td>Moffat</td>
<td>Craig</td>
<td>Cancer Society</td>
<td>Kelly Smith</td>
<td><a href="mailto:ssmith@bresnan.net">ssmith@bresnan.net</a></td>
<td></td>
<td>745 Russell St Craig, CO 81625</td>
<td>970-824-3735</td>
<td>Cancer Society of Moffat County’s mission is to provide financial</td>
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Communicable Diseases
Yampa Valley Medical Center
COMMUNITY HEALTH NEEDS ASSESSMENT
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COMMUNICABLE DISEASES

OVERVIEW

People in the United States continue to get diseases that are vaccine preventable. Viral hepatitis, influenza, and tuberculosis (TB) remain among the leading causes of illness and death in the United States and account for substantial spending on the related consequences of infection.¹

Acute respiratory infections, including pneumonia and influenza, are the 8th leading cause of death in the United States, accounting for 56,000 deaths annually.² Pneumonia mortality in children fell by 97 percent in the last century, but respiratory infectious diseases continue to be leading causes of pediatric hospitalization and outpatient visits in the United States. On average, influenza leads to more than 200,000 hospitalizations and 36,000 deaths each year. The 2009 H1N1 influenza pandemic caused an estimated 270,000 hospitalizations and 12,270 deaths (1,270 of which were of people younger than age 18) between April 2009 and March 2010.

Infectious disease kills 300 American children per year, despite the availability of vaccines. Pertussis, a vaccine preventable disease, has resurfaced in the United States. In 2010, Colorado had 212 reported pertussis cases among children 6 years of age and younger, representing nearly 40 percent of pertussis cases statewide. Diptheria, Tetanus, and Pertussis (DTaP) vaccine is an effective method to control disease spread and helps protect school-aged children against potential classroom exposure.

HEPATITIS

“Hepatitis” means inflammation of the liver and also refers to a group of viral infections that affect the liver.³ The most common types are Hepatitis A, Hepatitis B, and Hepatitis C. Viral hepatitis is the leading cause of liver cancer and the most common reason for liver transplantation. An estimated 4.4 million Americans are living with chronic hepatitis; most do not know they are infected. About 80,000 new infections occur each year.

- **Hepatitis A** is an acute liver disease caused by the Hepatitis A virus (HAV), lasting from a few weeks to several months. It does not lead to chronic infection. Transmission occurs by ingestion of fecal matter, even in microscopic amounts, from close person-to-person contact or ingestion of contaminated food or drinks. Hepatitis A vaccination is recommended for all children starting at age 1 year, travelers to certain countries, and others at risk.

² Ibid.
- **Hepatitis B** is a liver disease caused by the Hepatitis B virus (HBV). It ranges in severity from a mild illness, lasting a few weeks (acute), to a serious long-term (chronic) illness that can lead to liver disease or liver cancer. Transmission occurs through contact with infectious blood, semen, and other body fluids from having sex with an infected person, sharing contaminated needles to inject drugs, or from an infected mother to her newborn. Hepatitis B vaccination is recommended for all infants, older children and adolescents who were not vaccinated previously, and adults at risk for HBV infection.

- **Hepatitis C** is a liver disease caused by the Hepatitis C virus (HCV). HCV infection sometimes results in an acute illness, but most often becomes a chronic condition that can lead to cirrhosis of the liver and liver cancer. Transmission occurs through contact with the blood of an infected person, primarily through sharing contaminated needles to inject drugs. There is no vaccine for Hepatitis C.

**INFLUENZA**

The flu is a contagious respiratory illness caused by influenza viruses that infect the nose, throat, and lungs. It can cause mild to severe illness, and at times can lead to death. Most experts believe that flu viruses spread mainly by droplets made when people with flu cough, sneeze or talk. These droplets can land in the mouths or noses of people who are nearby. Less often, a person might also get flu by touching a surface or object that has flu virus on it and then touching their own mouth, eyes or possibly their nose.

On February 24, 2010 vaccine experts voted that everyone 6 months and older should get a flu vaccine each year starting with the 2010-2011 influenza season. CDC’s Advisory Committee on Immunization Practices (ACIP) voted for “universal” flu vaccination in the U.S. to expand protection against the flu to more people.

While everyone should get a flu vaccine each flu season, it’s especially important that the following groups get vaccinated either because they are at high risk of having serious flu-related complications or because they live with or care for people at high risk for developing flu-related complications:

- Pregnant women
- Children younger than 5, but especially children younger than 2 years old
- People 50 years of age and older
- People of any age with certain chronic medical conditions
- People who live in nursing homes and other long-term care facilities
- People who live with or care for those at high risk for complications from flu, including:
  - Health care workers
  - Household contacts of persons at high risk for complications from the flu

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4 [http://www.cdc.gov/flu/protect/keyfacts.htm](http://www.cdc.gov/flu/protect/keyfacts.htm)
- Household contacts and out of home caregivers of children less than 6 months of age (these children are too young to be vaccinated)

CDC recommends that people get their seasonal flu vaccine as soon as vaccine becomes available in their community. Vaccination before December is best since this timing ensures that protective antibodies are in place before flu activity is typically at its highest. CDC continues to encourage people to get vaccinated throughout the flu season, which can begin as early as October and last as late as May. Over the course of the flu season, many different influenza viruses can circulate at different times and in different places. As long as flu viruses are still spreading in the community, vaccination can provide protective benefit.

## PNEUMONIA

Pneumonia is an infection in one or both of the lungs. Many small germs, such as bacteria, viruses, and fungi, can cause pneumonia. Pneumonia is not a single disease. It can have more than 30 different causes. Understanding the cause of pneumonia is important because pneumonia treatment depends on its cause.

Approximately one-third of the pneumonia cases in the United States each year are caused by respiratory viruses. These viruses are the most common cause of pneumonia in children younger than 5 years.

The flu virus is the most common cause of viral pneumonia in adults. Other viruses that cause pneumonia include respiratory syncytial virus, rhinovirus, herpes simplex virus, severe acute respiratory syndrome (SARS), and more.

## TUBERCULOSIS

TB disease is caused by a bacterium called Mycobacterium tuberculosis. The bacteria usually attack the lungs, but TB bacteria can attack any part of the body such as the kidney, spine, and brain. If not treated properly, TB disease can be fatal. TB is spread through the air from one person to another. The TB bacteria are put into the air when a person with active TB disease of the lungs or throat coughs, sneezes, speaks, or sings. People nearby may breathe in these bacteria and become infected.

TB bacteria can live in your body without making you sick. This is called latent TB infection (LTBI). In most people who breathe in TB bacteria and become infected, the body is able to fight the bacteria to stop them from growing. People with latent TB infection do not feel sick and do not have any symptoms. People with latent TB infection are not infectious and cannot spread TB bacteria to others. However, if TB bacteria become active in the body and multiply, the person will get sick with TB disease.

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5 http://www.cdc.gov/flu/protect/keyfacts.htm  
6 http://www.lung.org/lung-disease/pneumonia/understanding-pneumonia.html  
7 http://www.cdc.gov/tb/topic/basics/default.htm  
8 Ibid.
There are two tests that can be used to help detect TB infection: a skin test or a special TB blood test.\(^9\) The skin test is used most often. A small needle is used to put some testing material, called tuberculin, under the skin. In 2-3 days, you return to the health care worker who will check to see if there is a reaction to the test. In some cases, a special TB blood test is given to test for TB infection. This blood test measures how a person’s immune system reacts to the germs that cause TB.

**DIPHTHERIA, TETANUS, PERTUSSIS**

In an effort to reduce infectious disease that can be prevented with vaccination, Colorado will increase the percentage of children who are up to date on their DTaP immunizations when they enter kindergarten.\(^10\)

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**CDPHE has chosen DTaP immunizations as a 2016 Infectious Disease Winnable Battle.**

For a child to be up to date when entering kindergarten, the child must have received five DTaP shots or four shots if the fourth is administered on or after the child's fourth birthday.

Each year, the Colorado Immunization Program conducts a survey to assess progress toward meeting school immunization requirements. In Colorado, students are asked to receive the required immunizations, claim an exemption or be in the process of getting immunized. For the 2010-11 school year, the state immunization program determined 92.6 percent of Colorado kindergartners were up to date for DTaP. In Colorado, this means that students have either received the required immunizations, claimed an exemption, or are in the process of getting immunized.

**The Colorado 2016 goal for DTaP immunizations is to increase by 2 percent the number of kindergartners in Colorado who are up to date when they go to school.**

Attaining this goal positions Colorado to achieve the Healthy People 2020 objective that 95 percent of children be vaccinated with four or more doses of DTaP at school entry. Healthy People 2020 includes immunization coverage goals for all ages, but this milestone age group was earmarked with the highest coverage goal, further illustrating the importance of protecting this vulnerable population.

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**OTHER INFECTIOUS DISEASE COLORADO WINNABLE BATTLES**

The Colorado Department of Health has selected the reduction of gonorrhea rates among Colorado’s 15- to 29-year old age group as a 2015 Infectious Disease Winnable Battle.

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\(^10\) [http://www.cdphe.state.co.us/hs/winnableBattles/infectiousDiseasePrevention.html](http://www.cdphe.state.co.us/hs/winnableBattles/infectiousDiseasePrevention.html)
Gonorrhea rates are discussed in the data report for Sexual Health / HIV. The rate of central line-associated bloodstream infections was also chosen as a 2015 Infectious Disease Winnable Battle. Rates are not included in this report as this is not a community-based health indicator.

http://www.cdphe.state.co.us/hs/winnableBattles/infectiousDiseasePrevention.html
HEPATITIS A

Colorado Electronic Disease Reporting System: Cases of Hepatitis A

The incidence rate of Hepatitis A is 0.8 per 100,000 population in Colorado.

Routt County had no reported cases of Hepatitis A.

The Hepatitis A incidence rate in Moffat County is higher than the State and needs significant improvement to reach the HP 2020 goal of 0.3%.

Figure 1: Hepatitis A Incidence

Figure 1: Hepatitis A Incidence

Chart Source: Division of Disease Control and Environmental Epidemiology-Communicable Disease Epidemiology Program (http://www.cdphe.state.co.us/dc/Epidemiology/dc_guide.html). No cases were reported in Summit County. Data is meta-data as calculated by Health Statistics Section of the Colorado Department of Public Health and Education. State data from 2007-2009.
HEPATITIS A TRENDS AND DEMOGRAPHICS

• The rate of reported hepatitis A cases in Colorado has declined dramatically during 2000-2009. It is likely that increased pediatric use of the hepatitis A vaccine is the reason for this decline.13
• In 2000 a total of 212 cases were reported compared with a historic low of 26 cases in 2007.
• During 2005-2009 the average incidence per year was 0.8 cases per 100,000 persons, or an average of 41 reported cases per year in Colorado.
• The largest declines have been among children under 10 years of age, particularly children age 5-9, whose average annual incidence rates declined from 4.1 cases per 100,000 during 2000-2004 to 0.4 cases per 100,000 persons during 2005-2009.
• In recent years (2005-2009), the highest rates of reported illness have been among persons 15-19 years (1.1 per 100,000); persons 20-39 years (1.1 per 100,000) and persons 80 years and older (1.2 per 100,000).
• During 2005-2009 rates of hepatitis A illness were higher among Hispanics than other racial or ethnic groups. The average incidence rate for White non-Hispanic persons was
• 0.7 per 100,000 and the rate for Hispanic persons was 1.1 per 100,000, approximately 55% higher. While this is a substantial disparity, the difference between the two groups has decreased over time.
• During 2004-2009, international travel was the most frequently reported risk factor for hepatitis A infection, with 46.5% of cases reporting international travel during the 2-6 weeks before onset of symptoms.
• Public health efforts to educate travelers about the importance of hepatitis A vaccine might further decrease incidence.
• While persons who handle food are not at increased risk for hepatitis A, even a single case in a food handler can result in a large and costly public health investigation.
• Food Service employers wishing to decrease their risk of a hepatitis A exposure at their establishment could consider hepatitis A vaccination for workers, in addition to continuing to monitor and enforce regulations that pertain to hand hygiene and bare hand contact with ready to eat foods.
• Rapid reporting and case investigation remain very important to limiting potential spread from reported cases to others in the community.

13 http://www.cdphe.state.co.us/dc/hepatitis/hepa/HepAsummary.pdf
HEPATITIS B

Colorado Electronic Disease Reporting System: New Acute and Chronic Cases of Hepatitis B

The incidence rate in Colorado of acute Hepatitis B is 0.8 while the rate for chronic Hepatitis B is 11.4.

Both Moffat and Routt Counties have combined acute and chronic hepatitis B incidence rates that are below the State.

While it is not clear, it is likely that the HP 2020 goal applies to new acute cases of Hepatitis B, in which case all counties are meeting the HP 2020 goal. Moffat did not report any acute cases of Hepatitis B.

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14 Chart Source: Division of Disease Control and Environmental Epidemiology-Communicable Disease Epidemiology Program (http://www.cdphe.state.co.us/dc/Epidemiology/dc_guide.html) Data is meta-data as calculated by Health Statistics Section of the Colorado Department of Public Health and Education. State data is from 2007-2009.
HEPATITIS B DEMOGRAPHICS

- Men had the highest number of reported cases of acute and chronic hepatitis B infection\(^5\).
- For acute cases, persons 30-59 years of age had the highest number of reported cases (40 cases or 75.47%). Person >25 years of age are less likely to be immunized for hepatitis B based on a school-entry requirement that began in 1997. These findings suggest that individuals in these age groups continue to engage in high risk behavior and could benefit from vaccine. For chronic hepatitis B infection persons 20-39 years of age, 287 (51.71%) had the most cases reported. Chronic infections are more likely to be diagnosed among women seeking prenatal care or later in the course of infection when symptoms become more common.
- White non-Hispanic people had the majority of cases reported for acute with 25 (47.10%). The category of Asian/Pacific Islanders had the majority of cases reported for chronic with 208 (37.40%).
- Data in Colorado’s Perinatal Hepatitis B Unit indicates that foreign-born pregnant women are significantly more likely to be reported with hepatitis B infection than pregnant women born in the U.S.

\(^5\) [http://www.cdphe.state.co.us/dc/hepatitis/Hepatitis%20in%20Colorado%202010%20Final.pdf](http://www.cdphe.state.co.us/dc/hepatitis/Hepatitis%20in%20Colorado%202010%20Final.pdf)
Hepatitis C

Men had the highest number of reported cases of acute and chronic hepatitis C infection. The reasons for this are unclear.

White non-Hispanic people had the majority of acute cases reported with (66.70%). The category of Other/Multiple/Unknown had the majority of cases reported for chronic (45.20%).

Acute hepatitis C was reported in 11 counties. Reported chronic cases resided in 59 of the 64 Colorado counties. Outside of Denver, rural and frontier counties (rural areas sparsely populated that are isolated from population centers and services), had the highest rates of reported chronic cases. However, this is based on small numbers of cases reported, and five rural and frontier counties did not report a case.

http://www.cdphe.state.co.us/dc/hepatitis/Hepatitis%20C%20in%20Colorado%202010%20Final.pdf

Note: The Colorado Department of Public Health and Environment did not calculate meta-data for Hepatitis C.

Ibid.

Ibid.

Ibid.
INFLUENZA IMMUNIZATION

**BRFSS Survey Question:** During the past 12 months, have you had a flu shot?

The prevalence rate of adults who had a flu shot in Colorado is higher than the Nation.

Moffat County has a flu shot prevalence rate in adults that is lower than the State, while the Routt County rate is the same as the State.

Both counties have rates that are significantly below the Healthy People 2020 goal.

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**Figure 4: Had a Flu Shot**

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The prevalence of flu shots in adults increases with age. Rates in the age group 35-44 and 45-54 are statistically the same. All other groups have significantly different rates.

Rates of flu shots in White/Non-Hispanic adults are significantly higher than all other groups.

Adults with income of $50,000 and above have a significantly higher rate of flu shots than other income groups.

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22 Ibid.
23 Ibid.
Adults with some college or more have a significantly higher rate of flu shots than other income groups.

Females have a significantly higher rate of flu shots than males.

The prevalence rate of adults who have received flu shots is increasing in Colorado, but significant gains are needed to meet the Healthy People goal of 80%.

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25 Ibid.
INFLUENZA HOSPITALIZATIONS

Hospitalizations due to Influenza vary from year to year. Considerably more infants are hospitalized for influenza than other age groups.

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27 Chart Source: Colorado Department of Public Health, Influenza Surveillance
28 Ibid.
PNEUMONIA VACCINATION

BRFSS Survey Question: Have you ever had a pneumonia vaccination?

The prevalence rate of adults who had a pneumonia vaccination in Colorado is 25.8%.

Both Routt and Moffat Counties have a pneumonia vaccination prevalence rate in adults that is lower than the State.

The HP 2020 Goal of 60% vaccination applies to high risk adults between the ages of 18-64, and is not directly comparable to this data.

Figure 13: Pneumonia Vaccination

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The prevalence of pneumonia vaccination in adults is significantly higher in the youngest and two oldest age groups, than for adults aged 25 to 54.

Hispanic adults have a significantly lower prevalence rate of pneumonia category than all other adults.

Adults with income of $50,000 and above have a significantly lower rate of pneumonia vaccination than other income groups.

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31 Ibid.
32 Ibid.
There are no significant differences between pneumonia vaccination rates based on education groups.

PNEUMONIA IMMUNIZATION TRENDS

A significant increase in the adult prevalence rate of pneumonia vaccination was seen from 2007/2008 to 2009/2010.

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TUBERCULOSIS INCIDENCE RATES

Survey: Tuberculosis in Colorado: 2006-2010 Mean Case Rate by County (Reporting at least one case)

Overall, tuberculosis incidence rates in Colorado are lower than the nation. Neither Moffat or Routt County reported any cases of TB between 2008 and 2010.

![Tuberculosis Incidence Rates](image)

Figure 19: Tuberculosis Incidence Rates

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TUBERCULOSIS TRENDS AND DEMOGRAPHICS

In Colorado, incidence rates of TB are trending downward. In 2010, a total of 11,181 tuberculosis (TB) cases were reported in the United States, for a rate of 3.6 cases per 100,000 population, which was a decline of 3.9% from 2009 and the lowest rate recorded since national reporting began in 1953.\(^{37}\) Despite an average decline in TB rates of 3.8% per year during 2000--2008, a record decline of 11.4% in 2009, and the 2010 decline of 3.9%, the national goal of TB elimination (defined as <0.1 case per 100,000 population) by 2010 was not met.

Although TB cases and rates decreased among foreign-born and U.S.-born persons, foreign-born persons and racial/ethnic minorities were affected disproportionately by TB in the United States. In 2010, the TB rate among foreign-born persons in the United States was 11 times greater than among U.S.-born persons. TB rates among Hispanics, non-Hispanic blacks, and Asians were seven, eight, and 25 times greater, respectively, than among non-Hispanic whites. Among U.S.-born racial and ethnic groups, the greatest racial disparity in TB rates was for non-Hispanic blacks, whose rate was seven times greater than the rate for non-Hispanic whites. Progress toward TB elimination in the United States will require ongoing surveillance and improved TB control and prevention activities to address persistent disparities between U.S.-born and foreign-born persons and between whites and minorities.

\(^{36}\) Chart Source: Colorado Department of Public Health and Environment. Denominators for computing the rate of tuberculosis in Colorado are from the Colorado Division of Local Government, State Demography Office. No TB cases were reported in Archuleta or La Plata.

\(^{37}\) http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6011a2.htm
PERTUSSIS / CHILDHOOD IMMUNIZATION

Colorado Electronic Disease Reporting System: Confirmed or probable case classifications of Pertussis.

Pertussis is commonly known as whooping cough. The number of new cases per 100,000 people is slightly higher in Colorado than the nation.

Both Moffat and Routt Counties have rates that are lower than the State.

HP 2020 goals for pertussis are not comparable to this data.

Figure 21: New Pertussis Cases

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39 Chart Source: Colorado Electronic Disease Reporting System (CEDRS). No cases were reported in Alamosa and Summit Counties. National data source: Office of Surveillance, Epidemiology, and Laboratory Services, Public Health Surveillance Program Office, Centers for Disease Control http://www.cdc.gov/mmwr/PDF/wk/mm5754.pdf.
Infants, especially those who are under-vaccinated, are at increased risk for complicated infections and death from pertussis. Immunity to pertussis is thought to wane approximately 5-10 years after completion of childhood vaccination. A second peak in the number of reported cases is observed among school aged children and adolescents. The contribution of cases in children aged 5-9 years appears to be increasing compared with previous years.

39 Chart Source: Office of Surveillance, Epidemiology, and Laboratory Services, Public Health Surveillance Program Office, Centers for Disease Control http://www.cdc.gov/mmwr/PDF/wk/mm5754.pdf  
*Of 13,278 cases, age was reported unknown for 671 persons.
40 Ibid.
PERTUSSIS TRENDS

Although the incidence of reported pertussis is substantially lower than the peak in 2004, incidence increased slightly during 2007-2008, and continues to remain higher than in the 1990s.

PERTUSSIS IMMUNIZATION

Each year, the Colorado Immunization Program conducts a survey to assess progress toward meeting school immunization requirements. In Colorado, students are asked to receive the required immunizations, claim an exemption or be in the process of getting immunized. According to Colorado data from 2003, of children 7 months to 9 years of age, 60% of pertussis cases occurred in children who were not appropriately immunized for their age.

For the 2010-11 school-year, the state immunization program determined 92.6 percent of Colorado kindergartners were up to date for DTaP.

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41 Office of Surveillance, Epidemiology, and Laboratory Services, Public Health Surveillance Program Office, Centers for Disease Control. Data is per 100,000 population.
42 http://www.cdphe.state.co.us/hs/winnableBattles/infectiousDiseasePrevention.html
In Colorado, this means that students have either received the required immunizations, claimed an exemption, or are in the process of getting immunized.

**The Colorado 2016 goal is to increase by 2 percent the number of kindergartners in Colorado who are up to date with DTaP immunizations when they go to school.**

Child poverty is the single most significant risk factor for under-immunization.\(^{44}\) Income influences immunization rates in a variety of ways, including parental knowledge and attitudes; reliance on publicly-financed health care services; inadequate insurance coverage; lack of childcare; and other health care access barriers. In addition, although national immunization rates for all racial and ethnic groups have improved, racial and ethnic disparities remain. In Colorado, these disparities are most visible among Hispanic children because they are the largest ethnic minority group in the state, and the only group for whom data exist. Because under-immunized children tend to reside in geographic, cultural, or economic pockets of need, the risk associated with a disease outbreak in these communities increases.

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\(^{44}\) Colorado Childhood Immunization Rates: Policy and Practice; Colorado Health Institute Policy Brief
INTERVENTIONS

CLINICAL RECOMMENDATIONS

The following clinical recommendations come from the US Preventive Services Task Force (USPSTF).

SCREENING FOR HEPATITIS B VIRUS INFECTION IN PREGNANCY

The U.S. Preventive Services Task Force (USPSTF) recommends screening for hepatitis B virus (HBV) infection in pregnant women at their first prenatal visit.

COMMUNITY INTERVENTIONS

The following evidence-based community interventions come from the Guide to Community Preventive Services, Centers for Disease Control and Prevention (CDC).

TARGETED VACCINATIONS: MULTIPLE INTERVENTIONS IMPLEMENTED IN COMBINATION

Combinations of specific interventions have proven effective at increasing targeted vaccine coverage,

TARGETED VACCINATIONS: PROVIDER REMINDERS

Provider reminders let providers or other appropriate staff know when individual clients are due for vaccinations, through notations, stickers, or other prompts in clients’ charts, or through computer databases or registries.

UNIVERSALLY RECOMMENDED VACCINATIONS: CLIENT OR FAMILY INCENTIVE REWARDS

Client or family incentive rewards, which may be monetary (e.g., gift cards) or non-monetary (e.g., baby products) are used to motivate people to obtain recommended vaccinations.

UNIVERSALLY RECOMMENDED VACCINATIONS: CLIENT REMINDER AND RECALL SYSTEMS

Client reminder and recall interventions involve reminding members of a target population that vaccinations are due (reminders) or late (recall).
UNIVERSALLY RECOMMENDED VACCINATIONS: HEALTH CARE SYSTEM-BASED INTERVENTIONS IMPLEMENTED IN COMBINATION

Interventions to increase client demand for vaccinations, when combined with interventions that improve access (e.g., home visits) and/or with interventions that target providers or systems (e.g., provider reminders), are recommended for improving vaccination rates.

UNIVERSALLY RECOMMENDED VACCINATIONS: HOME VISITS TO INCREASE VACCINATION RATES

Home visits intended to increase vaccination rates:

- Provide vaccinations to clients in their homes, or
- Promote recommended vaccinations with referral to available immunization services.
Home visits may be conducted by either vaccination providers, such as nurses, or other providers, such as social workers. Visits generally include an assessment of client vaccination status and a brief discussion of the importance of the indicated immunizations.

UNIVERSALLY RECOMMENDED VACCINATIONS: PROVIDER ASSESSMENT AND FEEDBACK

Provider assessment and feedback involves retrospectively evaluating the performance of providers in delivering one or more vaccinations to a client population and giving them feedback on their performance.

UNIVERSALLY RECOMMENDED VACCINATIONS: REDUCING CLIENT OUT-OF-POCKET COSTS

Reducing out-of-pocket costs to families for vaccinations or administration of vaccinations can be implemented by paying for vaccinations or administration, providing insurance coverage, or reducing copayments for vaccinations at the point-of-service.

UNIVERSALLY RECOMMENDED VACCINATIONS: STANDING ORDERS WHEN USED ALONE

Standing orders authorize nurses, pharmacists, and other healthcare personnel to administer vaccinations without the need for examination or direct order from the attending provider.
UNIVERSALLY RECOMMENDED VACCINATIONS: VACCINATION PROGRAMS IN WIC SETTINGS

Coordinated vaccination interventions in WIC settings are recommended based on strong evidence of effectiveness in increasing vaccination coverage in children.

UNIVERSALLY RECOMMENDED VACCINATIONS: VACCINATION REQUIREMENTS FOR CHILD CARE, SCHOOL AND COLLEGE ATTENDANCE

Vaccination requirements are laws or policies requiring vaccinations or other documentation of immunity as a condition of child care, school, and college attendance. Their purpose is to reduce the incidence of vaccine-preventable disease and associated morbidity and mortality by increasing vaccination rates.

UNIVERSALLY RECOMMENDED VACCINES: PROVIDER REMINDERS

Provider reminder interventions inform those who administer vaccinations that individual clients are due for specific vaccinations.

WORKSITE HEALTH PROMOTION: INTERVENTIONS TO PROMOTE SEASONAL INFLUENZA VACCINATIONS AMONG HEALTHCARE WORKERS

Interventions to increase uptake of flu vaccines in healthcare workers (HCW) involve making vaccines available to workers and announcing this availability using things such as newsletters, e-mails, or paycheck inserts.

WORKSITE HEALTH PROMOTION: INTERVENTIONS TO PROMOTE SEASONAL INFLUENZA VACCINATIONS AMONG NON-HEALTHCARE WORKERS

Interventions to promote influenza vaccination among workers can include making vaccines available to workers and announcing this availability in work settings, using things such as newsletters, e-mails, or paycheck inserts.

CONSUMER INFORMATION

The following consumer resources are from the Quick Guide to Healthy Living at healthfinder.gov.

PROTECT YOURSELF FROM SEASONAL FLU

Get a seasonal flu shot every year.
GET A PNEUMONIA SHOT

Get the pneumonia shot at age 65 to protect yourself from the most common type of bacterial pneumonia.

GET ADULT BOOSTER SHOTS

The shots we get as children can weaken over time. That’s why it’s important to get your adult shots.

GET YOUR CHILD’S SHOTS ON SCHEDULE

Shots (also called vaccinations or immunizations) work best when they are given at certain ages.

GET YOUR PRE-TEEN’S SHOTS ON SCHEDULE

All kids need the Tdap and MCV4 shots at age 11 or 12. Doctors recommend girls also get the HPV vaccine.

CHILDHOOD IMMUNIZATIONS

A two-pronged approach will be used to drive the 2 percent increase in DTaP coverage rates among Colorado kindergartners45. The first step is to better educate parents and providers on the importance of immunizations. Colorado recently developed www.ImmunizeForGood.com, a parent-focused website that has received national recognition. To ensure health care providers are equally educated on the benefits of immunization, the Colorado Immunization Program also has launched a new provider education series in 2011. The educational webinars will continue in 2012. In the second approach, the immunization program will expand access and utilization of the Colorado Immunization Information System (CIIS) in child care facilities, head start programs, WIC programs and elementary schools. This will allow staff at these facilities to review immunization records online and quickly identify any children who need additional vaccinations to be fully vaccinated.

45 http://www.cdphe.state.co.us/hs/winnableBattles/infectiousDiseasePrevention.html
## LOCAL RESOURCES

<table>
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<tr>
<th>County</th>
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<th>Contact Person</th>
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<th>Programs</th>
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</thead>
<tbody>
<tr>
<td>Colorado</td>
<td></td>
<td>CDPHE: Communicable Disease Program</td>
<td>Lisa Miller</td>
<td>*</td>
<td><a href="http://www.cdphe.state.co.us/dc/epidemiology/dc_guide.html">http://www.cdphe.state.co.us/dc/epidemiology/dc_guide.html</a></td>
<td>4300 Cherry Creek Drive South A5 Denver, CO 80246</td>
<td>(303)-692-2628</td>
<td>Walk in clinic every Wednesday from 1-6:45 PM, serves low income families</td>
</tr>
<tr>
<td>Colorado</td>
<td></td>
<td>Colorado Children’s Immunization Coalition</td>
<td>Erin Suelmann-Noonan</td>
<td><a href="mailto:erin.suelmann@childrenscolorado.org">erin.suelmann@childrenscolorado.org</a></td>
<td><a href="http://www.childrensimmunization.org/">http://www.childrensimmunization.org/</a></td>
<td>13123 East 16th Avenue, Box 281 Aurora, CO 80045</td>
<td>(720)-777-5340</td>
<td>An immunization information system is an important tool to increase and sustain high immunization coverage by consolidating immunization records of children from multiple providers, allowing providers to generate reminder and recall notices, and providing official school forms. The Centers for Disease Control and Prevention has guidelines for immunization information system functionality. These guidelines were used to develop the Colorado Immunization Coalition.</td>
</tr>
<tr>
<td>Colorado</td>
<td></td>
<td>Colorado Influenza and Pneumococcal Alert Coalition</td>
<td>Erica Bloom</td>
<td><a href="mailto:erica.bloom@state.co.us">erica.bloom@state.co.us</a></td>
<td><a href="http://immunizecolorado.com/">http://immunizecolorado.com/</a></td>
<td>303-692-2789</td>
<td>A statewide partnership that promotes vaccination of adults against life-threatening diseases such as influenza, pneumonia, and many others</td>
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</tr>
<tr>
<td>County</td>
<td>City</td>
<td>Provider</td>
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</tr>
<tr>
<td>Colorado</td>
<td></td>
<td>Colorado Immunization Program</td>
<td>Margaret Huffman</td>
<td><a href="mailto:cdphedcdimmunization@cdphe.state.co.us">cdphedcdimmunization@cdphe.state.co.us</a></td>
<td><a href="http://www.cdphe.state.co.us/dc/immunization/index.html">http://www.cdphe.state.co.us/dc/immunization/index.html</a></td>
<td>4300 Cherry Creek Drive South Denver, CO 80246</td>
<td>(303)-692-2650</td>
<td>The Immunization Program works to decrease preventable illness through the use of vaccines.</td>
</tr>
<tr>
<td>Colorado</td>
<td></td>
<td>Children's Hospital of Colorado Infectious Disease Program</td>
<td>*</td>
<td>*</td>
<td><a href="http://www.childrenscolorado.org/conditions/immune/index.aspx">http://www.childrenscolorado.org/conditions/immune/index.aspx</a></td>
<td>13123 East 16th Ave. Aurora, CO 80045</td>
<td>(720) 777-6981</td>
<td>Infectious Disease Program for Children across Colorado</td>
</tr>
<tr>
<td>Colorado</td>
<td></td>
<td>Colorado Department of Public Health Immunizations</td>
<td>*</td>
<td>*</td>
<td><a href="http://www.cdphe.state.co.us/dc/immunization/">http://www.cdphe.state.co.us/dc/immunization/</a></td>
<td>4300 Cherry Creek Drive South Denver, CO 80246</td>
<td>(303)-692-2650</td>
<td>The Immunization Program works to decrease preventable illness through the use of vaccines.</td>
</tr>
<tr>
<td>Grand County</td>
<td>Hot Sulphur Springs</td>
<td>Hot Sulphur Spring Communci cable Disease Control</td>
<td>Brene Belew-Ladue, Public Health Director</td>
<td><a href="mailto:bbelew@co.grand.us">bbelew@co.grand.us</a></td>
<td>co.grand.co.us.org</td>
<td>150 Moffat Ave. Hot Sulphur Springs, Co 80451</td>
<td>970-725-3288</td>
<td>Provides services related to communicable disease control such as reporting, education, investigation, referral, and control. Prevention of infectious diseases. Tuberculosis screening and control.</td>
</tr>
<tr>
<td>County</td>
<td>City</td>
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<tr>
<td>Routt and Jackson County</td>
<td>Steamboat Springs</td>
<td>Flu Clinic VNA</td>
<td><a href="mailto:info@nwcovna.org">info@nwcovna.org</a></td>
<td><a href="http://www.nwcovna.org/flu_shots.php">www.nwcovna.org/flu_shots.php</a></td>
<td>940 Central Park Drive Suite 101 Steamboat Springs, CO 80487</td>
<td>(970) 879-1632</td>
<td>Drop-In Flu Clinic Schedule 2011 • Adult Flu Shot Injections: $22 • Adult FluMist: $25 • Children’s Flu Shots/Intra Nasal Flu Mist: $14.00 or less Medicare, Medicaid and CHP+ accepted. Must present card at clinic. Children Under 18 must be accompanied by a parent or guardian. For specific days and locations refer to website</td>
<td></td>
</tr>
<tr>
<td>Moffat</td>
<td>Steamboat Springs</td>
<td>Flu Clinic VNA</td>
<td><a href="http://www.nwcovna.org/flu_shots.php">www.nwcovna.org/flu_shots.php</a></td>
<td>745 Russell Street Craig, CO 81625</td>
<td>970-824-8233</td>
<td>Drop-In Flu Clinic Schedule 2011 Adult Flu Shot Injections: $22 • Adult FluMist: $25 • Children’s Flu Shots/Intra Nasal Flu Mist: $14.00 or less Medicare, Medicaid and CHP+ accepted. Must present card at clinic. Children Under 18 must be accompanied by a parent or guardian. Visit Website for specific locations</td>
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</tr>
<tr>
<td>Jackson</td>
<td>Walden</td>
<td>Family Medicine Center</td>
<td>Frances Jenkins, Admin</td>
<td><a href="mailto:npmedclinic@centurytel.net">npmedclinic@centurytel.net</a></td>
<td><a href="http://www.mpmc.org">www.mpmc.org</a></td>
<td>350 McKinley St</td>
<td>970-723-4255</td>
<td>X-ray, Lab draws / QuickLab (open lab), pulmonary function testing, treatments for illnesses, vaccinations, Well Woman. NO emergency services Flight for Life transports patients to the hospital in Fort Collins, Laramie WY., and Steamboat Springs.</td>
</tr>
<tr>
<td>Grand County</td>
<td>Kremmling</td>
<td>Family Medicine Center</td>
<td>Bill Widner, CEO</td>
<td><a href="http://www.mpmc.org">www.mpmc.org</a></td>
<td><a href="http://www.mpmc.org">www.mpmc.org</a></td>
<td>214 South 4th Street</td>
<td>970-724-3442</td>
<td>Out-Patient Family practice. Services include physicals, treatments, vaccinations, Well Woman, allergy and pediatrics</td>
</tr>
<tr>
<td>Grand County</td>
<td>Granby</td>
<td>Family Medicine Center</td>
<td>Bill Widner, CEO</td>
<td><a href="http://www.mpmc.org">www.mpmc.org</a></td>
<td><a href="http://www.mpmc.org">www.mpmc.org</a></td>
<td>1000 Granby Park Drive</td>
<td>970-724-3442</td>
<td>Out-Patient Family practice. Services include physicals, treatments, vaccinations, Well Woman and pediatrics</td>
</tr>
<tr>
<td>County</td>
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<td>Provider</td>
<td>Contact Person</td>
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<tr>
<td>Grand County</td>
<td>Hot Sulphur Springs</td>
<td>Grand County Public Health</td>
<td>Brene Belew-LaDue Public Health Director</td>
<td><a href="mailto:bbelew@co.grand.us">bbelew@co.grand.us</a></td>
<td>co.grand.co.us.org</td>
<td>150 Moffat Ave. Hot Sulphur Springs, CO 80451</td>
<td>970-725-3288</td>
<td>Public Health Nursing service providing Public Health and Home Health services in Grand County.</td>
</tr>
<tr>
<td>Grand County</td>
<td>Hot Sulphur Springs</td>
<td>Communicable Disease Control</td>
<td>Brene Belew-LaDue Public Health Director</td>
<td><a href="mailto:bbelew@co.grand.us">bbelew@co.grand.us</a></td>
<td>co.grand.co.us.org</td>
<td>150 Moffat Ave. Hot Sulphur Springs, CO 80451</td>
<td>970-725-3288</td>
<td>Provides services related to communicable disease control such as reporting, education, investigation, referral, and control. Prevention of infectious diseases. Tuberculosis screening and control.</td>
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Heart Disease and Cerebrovascular Disease
Yampa Valley Medical Center
COMMUNITY HEALTH NEEDS ASSESSMENT
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HEART DISEASE AND CEREBROVASCULAR DISEASE

OVERVIEW

In 2006, heart disease was the leading cause of death in Colorado, accounting for 21% of all deaths. Heart disease was also the leading cause of death in the United States, representing about 25% of all deaths. Heart disease includes a variety of diseases that affect the heart, including coronary artery disease, angina, heart attacks, cardiomyopathy (heart muscle disease), ischemic heart disease, heart failure, valvular disease, and others. Major risk factors for heart disease are aging, smoking, diets high in fat and salt, hypertension, diabetes, sedentary lifestyle, obesity and stress. Treatment for heart disease depends on the underlying cause, but typically involves lifestyle changes, medication, surgery and/or other procedures.

Cerebrovascular disease is a group of brain injuries, including strokes and transient ischemic attacks (TIA) which are due to disease of the blood vessels that supply the brain. Embolisms and aneurysms are some of the more common causes of strokes and TIAs. Strokes are the third leading cause of death in Colorado and the United States, and the principal cause of serious, long term disability in this country. Most strokes occur in people over 65 years old and are higher in African-Americans than in whites. The leading risk factor for strokes is hypertension; other risk factors include smoking, diabetes, and obesity.

Treatment of heart disease and strokes is expensive. Colorado’s estimated annual treatment costs in 2003 for cardiovascular diseases are the following:

- Hypertension: $.34 billion
- Heart disease: $.59 billion
- Stroke: $.14 billion

Estimated Colorado Medicaid treatment costs for cardiovascular diseases in 2007 are the following:

- Heart disease: $41 million
- Hypertension: $132 million
- Stroke: $87 million
- Congestive heart failure: $17.8 million

---

1 Colorado Department of Health and Environment, ahttp://www.cdphe.state.co.us/pp/cvd/statistics.html
5 http://www.mayoclinic.com/health/heart-disease/DS0120/DSECTION=risk-factors
6 http://www.strokecenter.org/patients/about-stroke/stroke-statistics/
7 Milken Institute, An Unhealthy America: The Economic Impact of Chronic Disease, October 2007.
8 Centers for Disease Control and Prevention and RTI International Chronic Disease Cost Calculator
HYPERTENSION

HYPERTENSION RATES

**BRFSS Survey Question:** Have you ever been told by a doctor, nurse, or other health professional that you have high blood pressure?

The hypertension rate in Routt County is close to the state average and much lower than the HP 2020 target of 26.9%. Moffat County’s rate is higher than the state.

![Figure 1 Hypertension Rates](chart.png)

---

HYPERTENSION DEMOGRAPHICS

Hypertension rates are generally higher among males, and also increase with age.

Figure 2 Hypertension by Gender

Hypertension rates are highest among those of Black race, followed by those of White race and then Hispanics.

Figure 3 Hypertension by Age

Figure 4 Hypertension by Race/Ethnicity

---


11 Ibid.

12 Ibid.
High hypertension rates were most significant among those making less than $25,000 a year. Those with high income levels generally had the lowest hypertension rates. Differences among education levels were not statistically significant.

![Hypertension by Income](image)

*Figure 5 Hypertension by Income*

Divorced/separated/widowed persons also have significantly higher rates, while those who have never married had the lowest rates.

![Hypertension by Marital Status](image)

*Figure 6 Hypertension by Marital Status*

---


14 Ibid.
HIGH CHOLESTEROL

CHECKED CHOLESTEROL IN PAST FIVE YEARS

BRFSS Survey Question: Have you had your blood cholesterol checked in the past 5 years?

People in Routt and Moffat Counties check their cholesterol levels more often than the state average but are still lower than the HP 2020 goal.

Figure 7 Cholesterol Checked in Past 5 Years

---

DEMOGRAPHICS OF THOSE MOST LIKELY TO CHECK THEIR CHOLESTEROL LEVELS

Those who are most likely to check their cholesterol levels are female, and the likelihood of checking cholesterol increases significantly with age.

Coloradans of White and Black race were significantly more likely than Hispanics to check their cholesterol levels.

---

17 Ibid.
18 Ibid.
People are significantly more likely to check their cholesterol levels the higher their education and income levels.

![Graph 1: Checked Cholesterol by Income](image1)

People who have never married were the least likely to check their cholesterol.

![Graph 2: Checked Cholesterol by Education](image2)

![Graph 3: Checked Cholesterol by Marital Status](image3)

---

20 Ibid.
21 Ibid.
HIGH CHOLESTEROL RATES

BRFSS Survey Question:  Have you ever been told by a doctor, nurse, or other health professional that your blood cholesterol is high? (Among those who have ever had it checked.)

Routt County’s high cholesterol rate is lower than the state average, while Moffat County has a higher rate.

![High Cholesterol Among Those Tested](chart)

Figure 14 High Cholesterol Among Those Tested\(^{22}\)

HIGH CHOLESTEROL DEMOGRAPHICS

Males are significantly more likely than females to have high cholesterol levels. Cholesterol increases significantly with age, starting at 35 years old.

Cholesterol levels are significantly more likely to be high for those with incomes less than $25,000, while the levels are significantly lower for those making $50,000 and above. Differences among education levels were not significant.

---

24 Ibid.
25 Ibid.
Cholesterol levels were significantly higher for those who are divorced/separated/widowed, than people who are married or part of a couple, and even less for those who have never married.

![High Cholesterol by Marital Status](chart.png)

**Figure 18 High Cholesterol by Marital Status**

---


---

Heart disease generally includes heart attacks, heart failure, myocarditis and all other forms of heart disease. The death rate due to heart disease is highest in Routt County, which is slightly lower than the state average. Moffat County has a lower death rate than the state but still exceeds the HP 2020 goal.

Figure 19 Heart Disease Death Rates

---

The death rates due to heart disease are decreasing in Colorado for all race and ethnic groups. However, among those groups, people of Black race experience the highest mortality rates from heart disease. Asians have the lowest rates followed by American Indians.

**Trends in Heart Disease by Race/Ethnicity, Colorado, 1990-2003**

![Graph showing trends in heart disease by race/ethnicity, Colorado, 1990-2003.](figure.png)

---

CEREBROVASCULAR DISEASE DEATH RATES

Deaths due to cerebrovascular disease are usually caused by strokes. Moffat County’s rate is the same as the HP 2020 goal of 33.8 deaths per 100,000 population, while Routt County’s rate is worse than both the HP goal and Colorado average.

![Cerebrovascular Disease Deaths](chart.png)

Figure 21 Cerebrovascular Disease Death Rates

---

People of Black race experience higher death rates due to stroke than other ethnic groups. Part of the reason is the higher hypertension rates among this demographic group, which if reduced, would greatly reduce their death rates due to stroke. American Indians have the lowest death rates while people of White race have the steadiest rate.


![Figure 22 Trends in Stroke by Race/Ethnicity, Colorado 1990-2003](http://www.cdphe.state.co.us/pp/cvd/HealthDisparities2005.pdf)
Many risk factors for heart disease and stroke are non-modifiable, such as aging, family history, and gender. The risk factors that are modifiable are listed in the chart below. The chart also shows disparities by race and ethnicity.

Risk Factors for Heart Disease and Cerebrovascular Disease by Race/Ethnicity

One of the most significant risk factors is inadequate nutrition. People's risk for ischemic strokes would be reduced by 30% if they ate five servings of fruits and vegetables a day. Other risk factors are as follows:

- “High blood pressure is a major risk for heart attack and the most important risk factor for stroke.
- High blood cholesterol, high total cholesterol, high LDL cholesterol, high triglyceride levels, and low levels of HDL cholesterol increase risk of heart disease and stroke.
- Tobacco smoking increases risk of cardiovascular disease. Breathing second-hand smoke is an additional risk.
- Adults with diabetes are two to four times more likely to have a heart attack or suffer a stroke than adults who do not have diabetes.
- Adults who are obese are twice as likely to have high blood pressure. Obesity is also associated with elevated triglycerides and decreased HDL cholesterol.
- Physical inactivity increases the risk of heart disease and stroke by 50 percent.”

---

INTERVENTIONS

Colorado Program to Reduce Risk of Cardiovascular Disease and Strokes

“The Cardiovascular Disease and Stroke Prevention Program, administered through the Chronic Disease Section of the Colorado Department of Public Health and Environment, is designed to reduce premature morbidity and mortality from cardiovascular disease and stroke and to promote healthy lifestyles for all Coloradans.

The Cardiovascular Health Coalition developed a 10-year strategic plan that helps to guide the efforts of the program. Current efforts focus on prevention, detection and management of high blood pressure and high cholesterol. In addition, the coalition educates health care professionals on the management of these risk factors while informing the public about the signs and symptoms of heart attack and stroke. Future efforts by the Coalition and its task forces will direct special efforts toward:

- Collaborating with healthcare agencies, businesses, community organizations to promote cardiovascular health
- Promoting policy changes which enhance cardiovascular health
- Reducing heart attack and stroke in women
- Training healthcare providers on current guidelines for heart attack and stroke treatment
- Morbidity, mortality, and cardiovascular disease risk factor data are reviewed on an ongoing basis.”

National Programs That Reduce the Risk of Heart Disease, Stroke & Diabetes

“Interventions that reduce obesity, blood pressure, and cholesterol and increase physical activity and healthy eating have been proven effective in reducing risks for cardiovascular disease as well as diabetes and stroke.

In Pawtucket, Rhode Island, the Pawtucket Heart Health Program conducted an intervention to educate 71,000 people about heart disease through a mass media campaign and community programs. Five years into the intervention, the risks for cardiovascular disease and coronary heart disease had decreased by 16 percent among members of the randomly selected intervention population.34

The Stanford Five-City Project used a mass media campaign and community programs to target a population of 122,800 people. At five years, risk for coronary heart disease...
disease had decreased by 16 percent, cardiovascular disease mortality risk had decreased by 15 percent, prevalence of smoking was down 13 percent, blood pressure was down 4 percent, resting pulse rates were down 3 percent, and cholesterol was down 2 percent among members of the randomly selected intervention population.\(^\text{35}\)

Researchers at Ohio State University recruited 60 women in their forties for a 12-week walking program that took place on the college’s campus. At 3 months, the intervention group saw a 1 percent decrease in body mass index (BMI), a 3.4 percent decrease in hypertension, a 3 percent decrease in cholesterol, and a 5.5 percent decrease in glucose.\(^\text{36}\)

**Shape Up Somerville**, a comprehensive effort to prevent obesity in high-risk first through third grade students in Somerville, Massachusetts, included improved nutrition in schools, a school health curriculum, an after-school curriculum, parent and community outreach, collaboration with community restaurants, school nurse education, and a safe routes to school program. After one year, on average the program reduced one pound of weight gain over 8 months for an 8 year old child. On a population level, this reduction in weight gain would translate into large numbers of children moving out of the overweight category and reducing their risk for chronic disease later in life.\(^\text{37}\)

A physical activity intervention targeting low-income adults in Oslo, Norway, provided individual counseling, walking groups, increased accessible areas for safe recreation, and information through leaflets and mass media. After 3 years, compared to the control group, the intervention group had an 8-9 percent increase in physical activity, 14 percent fewer individuals gained weight, 3 percent more quit smoking, and significant decrease in blood pressure rates were reported.\(^\text{38}\)

**WISEWOMAN**, a CDC-funded lifestyle intervention program, provides low-income uninsured women aged 40 to 64 with chronic disease risk factor screenings, lifestyle interventions, and referral services in an effort to prevent coronary heart disease and improve health. Over the course of a year, WISEWOMAN participants improved their 10-year risk of coronary heart disease by 8.7%, and there were significant reductions in the percent of participants who smoked (11.7%), had high blood pressure (15.8%), or had high cholesterol (13.1%).\(^\text{39}\)

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**Hartslag Limburg** is an integrative, community-based cardiovascular disease prevention program that promotes a healthy lifestyle. The 5-year follow-up for a cohort of over 2,400 participants who were compared with a control group found that Hartslag Limburg succeeded in reducing – and in some cases, preventing – age- and time-related increase in BMI, waist circumference, blood pressure, and, in women, non-fasting glucose concentration.40

The **Rockford Coronary Health Improvement Project (CHIP)** was a community-based lifestyle intervention program aimed at reducing coronary risk, especially in a high risk group. The intervention included a 40-hour educational curriculum delivered over a 30-day period with clinical and nutritional assessments before and after the educational component, in which participants were instructed to optimize their diet, quit smoking, and exercise daily (walking 30 minutes per day). At the end of the 30-day intervention period, stratified analyses of total cholesterol, LDL, triglycerides, blood glucose, blood pressure and weight showed highly significant reductions with the greatest improvements among those at highest risk.41

A community-oriented, **coronary heart disease prevention program** conducted in six regions of former West Germany included activities that emphasized healthy nutrition and increased physical activity, in addition to the reduction of smoking, hypertension, and hypercholesterolemia. Over a seven year period, the intervention saw a net reduction in the mean values of systolic (-2.0%) and diastolic (-2.0%) blood pressure, total serum cholesterol (-1.8%), as well as the percentage of smokers (-6.7%), compared with the nationwide trend.42

A study that followed **Diabetes Prevention Program** participants randomized to an intensive lifestyle intervention found that weight loss was the dominant predictor of reduced diabetes incidence. Participants experienced a 16 percent reduction in their diabetes risk for every kilogram of weight that they lost after a 3.2 year mean follow-up period.43

**EPODE**, a multisectoral, 5-year plan to **improve nutrition among 5 to 12 year old youths** in 10 French towns, involved parents and families, medical providers, school nurses, teachers, towns, businesses, and media campaigns in the intervention. In the targeted towns, obesity rates have remained consistent while they have doubled in control areas, making youths who experienced the intervention less likely to develop obesity.

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obesity-related health conditions in the future. Mothers in the intervention towns have reported weight loss as well.”


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<th>Website</th>
<th>Address</th>
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<th>Programs</th>
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</thead>
<tbody>
<tr>
<td>Colorado/ Statewide</td>
<td>Colorado</td>
<td>Colorado Foundation for Physical Fitness-Shape Up Colorado</td>
<td>President - Clayton Ellis</td>
<td><a href="mailto:ceellisifiedpe@gmail.com">ceellisifiedpe@gmail.com</a></td>
<td><a href="http://www.coloradofitness.org/?page_id=3">http://www.coloradofitness.org/?page_id=3</a></td>
<td>*</td>
<td>*</td>
<td>Community outreach program to encourage individuals to incorporate physical activity into everyday living to increase healthful lifestyles and habits</td>
</tr>
<tr>
<td>Colorado/ Statewide</td>
<td>Colorado</td>
<td>9 Health Fair</td>
<td>Becky Aragon</td>
<td>*</td>
<td><a href="http://www.9healthfair.org/default.aspx">http://www.9healthfair.org/default.aspx</a></td>
<td>1139 Delaware Street</td>
<td>(303) 698-4455</td>
<td>Statewide Health Fairs that encourage the public to partake in weight loss programs and develop healthy eating habits</td>
</tr>
<tr>
<td>Colorado/ Statewide</td>
<td>Colorado</td>
<td>Elevate Your Health Colorado</td>
<td>*</td>
<td>*</td>
<td><a href="http://www.elevateyourhealthco.com/node/534">http://www.elevateyourhealthco.com/node/534</a></td>
<td>*</td>
<td>*</td>
<td>Kaiser Permanente Program that offers the public advice via the web on weight loss and maintaining and developing a healthy lifestyle</td>
</tr>
<tr>
<td>Colorado/ Statewide</td>
<td>Colorado</td>
<td>Cardiovascular and Stroke Prevention Program</td>
<td>*</td>
<td><a href="mailto:cdphe.psdrequests@state.co.us">cdphe.psdrequests@state.co.us</a></td>
<td><a href="http://www.colorado.gov/cs/Satellite/CDPHE-PSD/CBON/1251621451112">http://www.colorado.gov/cs/Satellite/CDPHE-PSD/CBON/1251621451112</a></td>
<td>PSD-CD-A5 4300 Cherry Creek Drive South Denver, CO 80246-1530</td>
<td>(303) 692-2562</td>
<td>Prevention program based on community projects, awareness, education and referral</td>
</tr>
<tr>
<td>Colorado/ Statewide</td>
<td>Colorado</td>
<td>Colorado Prevention Center</td>
<td>Marilyn Greenwalt</td>
<td><a href="mailto:Marilyn.Greenwalt@cpemed.org">Marilyn.Greenwalt@cpemed.org</a></td>
<td><a href="http://www.cpcmed.org">http://www.cpcmed.org</a></td>
<td>13199 E. Montview Blvd.</td>
<td>(303) 860-9900</td>
<td>Interactive cardiovascular risk assessment kiosks, community programs, awareness, education</td>
</tr>
<tr>
<td>Colorado/ Statewide</td>
<td>Colorado</td>
<td>CDC National Heart Disease and Stroke Prevention Program Colorado Capacity Building</td>
<td>*</td>
<td><a href="mailto:cdcinfo@cdc.gov">cdcinfo@cdc.gov</a></td>
<td><a href="http://www.cdc.gov/ndhsp/programs/nhdp_program/co.htm">http://www.cdc.gov/ndhsp/programs/nhdp_program/co.htm</a></td>
<td>CDC/NCCDPHP/DHDS P 4770 Buford Hwy, NE Mail Stop F-72 Atlanta, GA 30341-3717</td>
<td>800-CDC-INFO</td>
<td>CDC National Initiative regarding heart health and stroke prevention focusing on education and reduction in case numbers</td>
</tr>
</tbody>
</table>

Yampa Valley Medical Center | Heart Disease and Cerebrovascular Disease | 21
<table>
<thead>
<tr>
<th>County</th>
<th>City</th>
<th>Provider</th>
<th>Contact Person</th>
<th>Email</th>
<th>Website</th>
<th>Address</th>
<th>Phone Number</th>
<th>Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorado/Statewide</td>
<td>Colorado</td>
<td>Colorado Connections for Healthy Kids</td>
<td>Carol Muller</td>
<td><a href="mailto:cmuller@actionforhealthykids.org">cmuller@actionforhealthykids.org</a></td>
<td><a href="http://take.actionforhealthykids.org/site/Clubs?club_id=1104&amp;pg=main">http://take.actionforhealthykids.org/site/Clubs?club_id=1104&amp;pg=main</a></td>
<td>*</td>
<td>*</td>
<td>Statewide initiative in support of Coordinated School Health Programs. Through this coordination of programs, resources, messages and training school staff, students, families and community resources we will work together for healthy students, healthy living, and better learners</td>
</tr>
<tr>
<td>Colorado/Statewide</td>
<td>Colorado</td>
<td>Action For Healthy Kids Colorado</td>
<td>Carol Muller</td>
<td><a href="mailto:cmuller@actionforhealthykids.org">cmuller@actionforhealthykids.org</a></td>
<td><a href="http://take.actionforhealthykids.org/site/Clubs?club_id=1104&amp;pg=main">http://take.actionforhealthykids.org/site/Clubs?club_id=1104&amp;pg=main</a></td>
<td>*</td>
<td>(1-800) 416-5136</td>
<td>Build awareness and encourage positive role modeling among administrators, teachers, food service workers, develop and implement policies that are consistent with dietary guidelines, provide age appropriate education to children and offer opportunities for youth to explore nutrition and physical activity topics</td>
</tr>
<tr>
<td>Colorado/Statewide</td>
<td>Colorado</td>
<td>Live Well Colorado</td>
<td>Maren C. Stewart</td>
<td>*</td>
<td><a href="http://www.livewellcolorado.org">www.livewellcolorado.org</a></td>
<td>1490 Lafayette Street #404 Denver, CO 80218</td>
<td>(720) 353-4120</td>
<td>LiveWell Colorado is a nonprofit organization committed to reducing obesity in Colorado by promoting healthy eating and active living. In addition to educating and inspiring people to make healthy choices.</td>
</tr>
<tr>
<td>Colorado/Statewide</td>
<td>Colorado</td>
<td>Heart Disease Information-American Heart Association</td>
<td>Kathryn Gash</td>
<td>*</td>
<td><a href="http://www.heart.org">www.heart.org</a></td>
<td>1280 S Parker Rd. Denver, Co 80231</td>
<td>303-369-5433</td>
<td>Information regarding heart related issues can be found at <a href="http://www.heart.org/swahealthfairkit">www.heart.org/swahealthfairkit</a>. All information can be found on this website.</td>
</tr>
<tr>
<td>Moffat</td>
<td>Craig</td>
<td>Northwest Colorado Visiting Nurse Association</td>
<td>Stephanie Anderson</td>
<td><a href="mailto:sanderso@nwcovna.org">sanderso@nwcovna.org</a></td>
<td><a href="http://www.nwcova.org">www.nwcova.org</a></td>
<td>745 Russel Street Craig, CO 81625</td>
<td>970-824-2548</td>
<td>Our local Community Health Centers provide medical services for people of all ages, all income levels, and all insurance status on a sliding fee scale based on income. As the only federally qualified Community Health</td>
</tr>
<tr>
<td>County</td>
<td>City</td>
<td>Provider</td>
<td>Contact Person</td>
<td>Email</td>
<td>Website</td>
<td>Address</td>
<td>Phone Number</td>
<td>Programs</td>
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<td>----------------------------------------------</td>
<td>----------------------------------------------</td>
<td>--------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Moffat</td>
<td>Craig</td>
<td>Craig Youth Soccer -</td>
<td>Lashanna Cox</td>
<td><a href="mailto:coxnailman1@gmail.com">coxnailman1@gmail.com</a></td>
<td>craigyouthsoccer.com</td>
<td>PO BOX 548 CRAIG, CO 81626</td>
<td>970-629-0082</td>
<td>Craig Youth Soccer is a program of the Colorado State Youth Soccer Association. It provides soccer for the youth of the community while building partnerships that promote positive attitudes and healthy habits.</td>
</tr>
<tr>
<td>Routt</td>
<td>Steamboat Springs</td>
<td>First Impressions of Routt County</td>
<td>Stephanie Martin, Program Director</td>
<td><a href="mailto:firstimpressions@co.routt.co.us">firstimpressions@co.routt.co.us</a></td>
<td><a href="http://www.firstimpressionsofrouttcounty.org">www.firstimpressionsofrouttcounty.org</a></td>
<td>135 6th Street Steamboat Springs, CO 80477</td>
<td>970-870-5270</td>
<td>First Impressions of Routt County works to ensure that young children will be provided adequate resources and quality programs to promote healthy development and school readiness. Our focus is on building an early childhood system which integrates early childhood care and education, health, mental health and family support services. The First Impressions Early Childhood Council strengthens the community's collaborative web of resources where children and families experience dignity and a sense of belonging.</td>
</tr>
<tr>
<td>Routt</td>
<td>Hayden</td>
<td>Totally Kids Inc.</td>
<td>Amy J. Williams, President</td>
<td><a href="mailto:amywilliams@mybrokers.com">amywilliams@mybrokers.com</a></td>
<td>*</td>
<td>Hayden Valley Elementary HAYDEN, CO 81639</td>
<td>970-276-2532</td>
<td>Provides youth services in the Hayden community including an after school program, summer day camp, youth sports, swimming lessons and dance lessons.</td>
</tr>
<tr>
<td>Routt</td>
<td>Steamboat Springs</td>
<td>Wellness Program -</td>
<td>Mrs. Lisa Bankard, Wellness &amp; Community Education Director</td>
<td><a href="mailto:lisa.bankard@yvmc.org">lisa.bankard@yvmc.org</a></td>
<td><a href="http://www.yvmc.org">www.yvmc.org</a></td>
<td>1024 Central Park Drive Steamboat Springs, CO 80487</td>
<td>970-871-2500</td>
<td>Yampa Valley Medical Center. The Wellness Program provides free and low cost health and fitness programs for the community throughout the year. The Wellness Program offers a broad spectrum of health promotion services and health...</td>
</tr>
<tr>
<td>County</td>
<td>City</td>
<td>Provider</td>
<td>Contact Person</td>
<td>Email</td>
<td>Website</td>
<td>Address</td>
<td>Phone Number</td>
<td>Programs</td>
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<td>---------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Grand County</td>
<td>Hot Sulphur</td>
<td>Grand County Rural Health Network -</td>
<td>Jen Fanning</td>
<td><a href="mailto:jfanning@co.grand.co.us">jfanning@co.grand.co.us</a></td>
<td><a href="http://www.gcruralhealth.com">www.gcruralhealth.com</a></td>
<td>416 Byers Ave Hot Sulphur Springs, CO 80451</td>
<td>970-725-3477</td>
<td>screenings for employers and businesses and coordinates a large community health fair annually.</td>
</tr>
<tr>
<td>Moffat</td>
<td>Craig</td>
<td>Northwest Colorado Community Health Center</td>
<td>Ms. Gisela Garrison, Clinic Director</td>
<td><a href="http://www.nwco.org">www.nwco.org</a></td>
<td>745 Russell St Craig, CO 81625</td>
<td>970-824-8233</td>
<td>NCCHC Moffat County Care Clinic provides basic health care, urgent care, wellness exams and diabetes screening and treatment. Care is provided to uninsured people regardless of immigrant status. Moffat County Care Clinic currently serves all of Moffat County as well as Hayden, Baggs, and Meeker. Referrals will be made to other providers if the care needed is not within the clinic’s scope.</td>
<td></td>
</tr>
</tbody>
</table>

See Resource Inventory for Obesity, Nutrition and Physical Activity for other relevant resources.
Injury
Yampa Valley Medical Center
COMMUNITY HEALTH NEEDS ASSESSMENT

Center for Health Administration
University of Colorado Denver
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INJURY

OVERVIEW

“Injuries and violence are widespread in society. Both unintentional injuries and those caused by acts of violence are among the top 15 killers for Americans of all ages. Many people accept them as “accidents,” “acts of fate,” or as “part of life.” However, most events resulting in injury, disability, or death are predictable and preventable.”1 The goal of Healthy People 2020 is to reduce injury and violence through recognition of risk factors and prevention.

Injuries are the leading cause of death for young people, ages 1 to 44, and a significant cause of disability for people of all ages.2 The effects of injuries and violence extend to relatives, friends, employers, and taxpayers.

Motor vehicle crashes are one of the leading causes of injury and death due to injury in Colorado. Every year, more than 300 people die in motor vehicle crashes while almost 2,500 are hospitalized for injuries sustained in these accidents. The total costs associated with these injuries are more than $103 million every year.3

Many injuries are the result of individual choices regarding risk taking behavior and alcohol consumption. Others are the result of external factors, such as car accidents, drowning, fires, and falls. Access to health care, such as emergency care, can reduce the impact of injuries, thus reducing related mortality rates and disability. Improving one's social and cultural environment through a variety of strategies such as conflict resolution programs, parenting skills development, elder maltreatment reduction, etc., can also have a positive impact on reducing injuries and violence.4

---

2 Ibid.
3 Colorado Winnable Battles, Colorado Department of Health and Environment.
4 Ibid.
ADULT SEATBELT USE

Seat belt use was approximately 83% in 2010. The Colorado Winnable Battle Goal is 90% for 2016. Seatbelt use is viewed as the most effective way to reduce injuries and fatalities in car crashes. Increasing the seatbelt use to 90% is estimated to save $16.4 million annually in reduced hospitalization costs.  

Figure 1 Seat Belt Use Among Adults

---

5 Colorado Winnable Battles, Colorado Department of Health and Environment.
6 Chart Source: Colorado Winnable Battles, Colorado Department of Health and Environment.
**BRFSS Survey Question:** How often do you use seatbelts when you drive or ride in a car? (excludes those who never drive or ride in a car.)

Moffat County’s seatbelt use is lower than the state average, while Routt County is close to the state rate. The Healthy People 2020 goal is 92.4% of the population using seat belts.

---

**Figure 2: Seatbelt Use**

Yampa Valley Medical Center

<table>
<thead>
<tr>
<th></th>
<th>Average 2005-2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routt</td>
<td>84.9%</td>
</tr>
<tr>
<td>Moffat</td>
<td>75.2%</td>
</tr>
<tr>
<td>State</td>
<td>83.3%</td>
</tr>
<tr>
<td>Nation</td>
<td>84.0%</td>
</tr>
<tr>
<td>HP2020</td>
<td>92.4%</td>
</tr>
</tbody>
</table>

**Figure 2 Seatbelt Use**

---

The following demographic section shows that those most likely to use seatbelts are female.

Significant differences are seen between the young age group, age 18-34 years, and those 45 years and up, with the older group more likely to wear seat belts.

---

**Figure 3 Seat Belt Use by Gender**

**Figure 4 Seat Belt Use by Age**

---


9 Ibid.
Residents with incomes over $50,000 were more likely to use seat belts compared to all other income groups.

Those with some college or more were significantly more likely to use seatbelts compared to high school graduates.

People in a married/coupled relationship were significantly more likely to wear seat belts compared to those who have never married or were divorced/separated/widowed.

---

11 Ibid.
12 Ibid.
YOUTH SEAT BELT USE

YRBS Survey Question: Percentage of students who never or rarely wore a seat belt when riding in a car driven by someone else.

In 2009, the rate for high school students who rarely or never wore a seat belt was better in the state than the nation. No discernible trends were noted between high school years. Data for other years were incompatible with 2009 data.

![Rarely or Never Wore a Seat Belt Among Youth Colorado](image)

Figure 8 Rarely or Never Wore a Seat Belt

---

Both Routt and Moffat Counties have motor vehicle death rates that are at least double the state rate. Counties with death rates higher than the state tend to be in more rural areas than along the Front Range.

![Motor Vehicle Deaths Chart]

**Figure 9 Motor Vehicle Deaths**

---

“Deaths and injuries from motor vehicle crashes disproportionately affect younger (ages 15-24) and older (ages 65+) adults.”¹⁵ The main reasons for these crashes among young drivers are inexperience and risk taking. In addition, lack of seatbelt use is an underlying cause of death and injury.¹⁶ The Colorado Winnable Battles target for year 2016 is to reduce the teen motor vehicle death rate to 10.5 per 100,000 teens. Fortunately, the trend is decreasing for motor vehicle deaths among Colorado teens.

Figure 10 Motor Vehicle Death Rates for Colorado Teens¹⁷

¹⁵ Colorado Winnable Battles, Colorado Department of Public Health and Environment.
¹⁶ Ibid.
¹⁷ Ibid
TRENDS IN BEHAVIORS THAT CONTRIBUTE TO UNINTENTIONAL INJURY AMONG YOUTH

This current section shows a mix of behaviors that tend to lead to injury among young people. Most charts show a positive trend of declining risky behaviors that frequently lead to injury. This data was compiled from a national database since state data was collected and/or analyzed differently from year to year, making trend analysis difficult.

![Rarely or Never Wore Seat Belt](image)

![Rarely or Never Wore Bicycle Helmet](image)

---

19 Ibid.
The chart below shows the percent of youth who rode with a driver who had been drinking alcohol one or more times (in a car or other vehicle during the last 30 days before the survey.)

![Chart Rode with Drive Who Had Been Drinking](image)

**Figure 13 Rode with Drive Who Had Been Drinking**

The following chart shows the percentage of youth who drove when drinking alcohol one or more times (in a car or other vehicle during the last 30 days before the survey).

![Chart Drove When Drinking Alcohol](image)

**Figure 14 Drove When Drinking Alcohol**

---


21 Ibid.
For the older adult population, 65 years and older, falls are the leading cause of injury death and the most common cause for hospitalization due to injuries. About 400 older Coloradans die every year from fall related injuries, and more than 10,000 older adults are hospitalized every year due to injuries sustained from falls.

Falls at home among the elderly can have significant consequences. Of those who were hospitalized after falls, only 28% were discharged to home. Most were discharged to short-term care or a skilled nursing facility. Participating in programs to reduce falls helps to reduce hospitalization costs and improve quality of life among the elderly.22

High risk groups include those with chronic health conditions such as arthritis and stroke, female gender, Hispanic ethnicity, and advanced age. Individual factors include:

- “Mobility problems due to muscle weakness
- Chronic health conditions
- Vision changes and loss
- Home hazards (clutter, poor lighting etc.)
- Inactivity
- Medication side effects and/or interaction”23

Other factors that increase the probability of falls include a lack of access to adequate medical care, recreational facilities, and transportation. Social isolation and ill-fitting assistive devices are additional factors that can increase the risk of falling among the elderly. 24

---

22 Colorado Winnable Battles, Colorado Department of Health and Environment.
23 Ibid.
24 Ibid.
Routt and Moffat Counties have fall-related hospitalizations among the elderly that are lower than the state average.

Figure 15 Fall-Related Hospitalizations Among Older Adults (age 65+)
Yampa Valley Medical Center

---

25 Colorado Winnable Battles. Colorado Department of Health and Environment. Rate per 100,000.
DOMESTIC VIOLENCE

In Colorado, the most common domestic violence incident reported was simple assault, followed by aggravated assault in 2010. Most assaults occur in the home/residence/apartment by a boyfriend/girlfriend, followed by a marital partner. Many assaults result in minor injury from personal weapons. Trends over the years are not available in Colorado as new sources contribute information each year, thus making comparisons inaccurate.

**Figure 16 Incident Based Domestic Violence Report**

<table>
<thead>
<tr>
<th>Incident</th>
<th>Number of Reported Victims, 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homicide</td>
<td>1000</td>
</tr>
<tr>
<td>Robbery</td>
<td>100</td>
</tr>
<tr>
<td>Forcible Sex Offenses</td>
<td>200</td>
</tr>
<tr>
<td>Intimidation</td>
<td>300</td>
</tr>
<tr>
<td>Kidnapping</td>
<td>400</td>
</tr>
<tr>
<td>Aggravated Assault</td>
<td>5000</td>
</tr>
<tr>
<td>Simple Assault</td>
<td>8000</td>
</tr>
</tbody>
</table>

**Figure 17 Domestic Violence by Relationship Type**

<table>
<thead>
<tr>
<th>Relationship Type</th>
<th>Number of Reported Victims, 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Same Sex Relationship</td>
<td>100</td>
</tr>
<tr>
<td>Ex-Spouse</td>
<td>200</td>
</tr>
<tr>
<td>Common Law Spouse</td>
<td>300</td>
</tr>
<tr>
<td>Spouse</td>
<td>4000</td>
</tr>
<tr>
<td>Boyfriend/Girlfriend</td>
<td>5000</td>
</tr>
</tbody>
</table>

---

INTERVENTIONS

SEATBELT LAWS AND GRADUATED DRIVERS LICENSING LAWS

“The Colorado Department of Public Health and Environment’s Injury, Suicide and Violence Prevention Unit has a five-year grant from the Centers for Disease Control and Prevention to promote evidence-based policy strategies proven to save lives, reduce injury and reduce public costs. In order to be in line with national best practices, Colorado should consider the following:

1. Implementing a primary enforcement seatbelt law that covers all seating positions and all ages.
2. Strengthening and simplifying the existing graduated drivers licensing (GDL) law to help young drivers gain experience under lower-risk conditions:
   • Increase the minimum age to receive a learner’s permit from 15 to 16.
   • Increase the minimum age to receive an intermediate license from 16 to 17.
   • Expand the restricted driving hours for an intermediate license to 10 p.m. through 5 a.m.”

FALL PREVENTION INTERVENTIONS

“Falls are not an inevitable consequence of aging. There are effective, community-based fall prevention interventions that reduce fall risk factors.

The most effective strategy is exercise that includes balance, gait and strength training. Community-wide programs to prevent falls should combine exercise with the other strategies, including older adult and caregiver education, medication management, vision exams and correction, and home safety assessment and modification. For individuals at high risk, clinical assessment by health care providers combined with individual risk reduction and patient follow-up are needed.

The Colorado Department of Public Health and Environment (CDPHE) was one of three state health departments recently to receive a $1.25 million grant from the Centers for Disease Control and Prevention to pilot a program aimed at integrating evidence-based fall prevention strategies and exercise interventions with community and clinical care practices. As part of this five-year project, CDPHE and its partners will pilot the Tai-Chi Moving for Better Balance, Stepping On, and Otago Exercise programs in Adams and Arapahoe counties. Additionally, CDPHE will work with primary care physicians to implement a new fall prevention tool for clinicians called, STEADI (Stopping Elderly Accidents, Deaths and Injuries).”

28 Ibid.
29 Colorado Winnable Battles, Colorado Department of Public Health and Environment.
30 Ibid.
The Centers for Disease Control and Prevention (CDC) has collected the following evidence-based community interventions relating to the prevention of injury.

**“EARLY CHILDHOOD HOME VISITATION TO PREVENT VIOLENCE**

Home visitation to prevent violence includes programs in which trained personnel visit parents and children at home to provide some combination of information, support, or training about child health, development, and care.

**HEALTH COMMUNICATION & SOCIAL MARKETING: HEALTH COMMUNICATION CAMPAIGNS THAT INCLUDE MASS MEDIA & HEALTH-RELATED PRODUCT DISTRIBUTION**

Health communication campaigns can increase the use of health-related products when they use mass media messaging and distribute the products at free or reduced prices.

**REDUCING ALCOHOL-IMPAIRED DRIVING: 0.08% BLOOD ALCOHOL CONCENTRATION (BAC) LAWS**

These laws state that it is illegal for a driver’s blood alcohol concentration to exceed 0.08%.

**REDUCING ALCOHOL-IMPAIRED DRIVING: INTERVENTION TRAINING PROGRAMS FOR SERVERS OF ALCOHOLIC BEVERAGES**

These programs provide education and training to servers of alcoholic beverages with the goal of altering their serving practices to prevent customer intoxication and alcohol-impaired driving.

**REDUCING ALCOHOL-IMPAIRED DRIVING: LOWER BAC LAWS FOR YOUNG OR INEXPERIENCED DRIVERS**

Lower blood alcohol concentration (BAC) laws establish a lower illegal BAC for young or inexperienced drivers than for older or more experienced drivers.

**REDUCING ALCOHOL-IMPAIRED DRIVING: MAINTAINING CURRENT MINIMUM LEGAL DRINKING AGE (MLDA) LAWS**

MLDA laws specify an age below which the purchase or public consumption of alcoholic beverages is illegal.

**REDUCING ALCOHOL-IMPAIRED DRIVING: MASS MEDIA CAMPAIGNS**

Mass media campaigns intended to reduce alcohol-impaired driving are designed to persuade individuals either to avoid drinking and driving or to prevent others from doing so.
**REDUCING ALCOHOL-IMPAIRED DRIVING: MULTICOMPONENT INTERVENTIONS WITH COMMUNITY MOBILIZATION**

Multicomponent interventions to reduce alcohol-impaired driving can include any or all of a number of components, such as sobriety checkpoints, training in responsible beverage service, education and awareness-raising efforts, and limiting access to alcohol.

**REDUCING ALCOHOL-IMPAIRED DRIVING: SOBRIETY CHECKPOINTS**

At sobriety checkpoints, law enforcement officers use a system to stop drivers to assess their level of alcohol impairment.

**SCHOOL-BASED PROGRAMS TO REDUCE VIOLENCE**

Universal school-based programs to reduce violence are designed to teach all students in a given school or grade about the problem of violence and its prevention or about one or more of the following topics or skills intended to reduce aggressive or violent behavior: emotional self-awareness, emotional control, self-esteem, positive social skills, social problem solving, conflict resolution, or team work.

**THERAPEUTIC FOSTER CARE TO REDUCE VIOLENCE**

In therapeutic foster care programs, youth who cannot live at home because of behavioral or emotional problems are placed with foster parents who are specially trained to provide a structured environment for learning social and emotional skills.

**USE OF CHILD SAFETY SEATS: DISTRIBUTION AND EDUCATION PROGRAMS**

Child safety seat distribution and education programs provide an educational component and child safety seats through a loan, low-cost rental or giveaway of an approved safety seat.

**USE OF CHILD SAFETY SEATS: INCENTIVE AND EDUCATION PROGRAMS**

Incentive and education programs reward parents for correctly using child safety seats or directly reward children for correctly using safety seats.

**USE OF CHILD SAFETY SEATS: LAWS MANDATING USE**

Child safety seat laws require children riding in motor vehicles to be restrained in federally approved infant or child safety seats.

**USE OF SAFETY BELTS: ENHANCED ENFORCEMENT PROGRAMS**

Enhanced enforcement programs provide increased rather than routine enforcement of safety belt laws at specific locations and times, and they always include a publicity component.
USE OF SAFETY BELTS: LAWS MANDATING USE
Safety belt laws mandate the use of safety belts by motor vehicle occupants.

USE OF SAFETY BELTS: PRIMARY (VS. SECONDARY) ENFORCEMENT LAWS
Primary safety belt laws allow police to stop motorists solely for being unbelted, whereas secondary safety belt laws permit police to ticket unbelted motorists only if they are stopped for other reasons such as speeding.

WORKSITE HEALTH PROMOTION: ASSESSMENT OF HEALTH RISKS WITH FEEDBACK TO CHANGE EMPLOYEES’ HEALTH
This intervention includes an assessment of personal health habits and risk factors; an estimation or assessment of risk of death and other adverse health outcomes; and provision of feedback in the form of educational messages and counseling.31

<table>
<thead>
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<th>County</th>
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<th>Contact Person</th>
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<th>Website</th>
<th>Address</th>
<th>Phone Number</th>
<th>Programs for Reducing Injury</th>
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<tbody>
<tr>
<td>Archuleta, La Plata,</td>
<td>Denver</td>
<td>CDHS: Prevention and Reduction of Under 18 Alcohol, Tobacco and Other Drug Use</td>
<td>Deb Hutson, Program Manager</td>
<td><a href="mailto:deb.hutson@state.co.us">deb.hutson@state.co.us</a></td>
<td><a href="http://www.colorado.gov/cs/Satellite/CDHS-BehavioralHealth/CPHON/1251581449373">http://www.colorado.gov/cs/Satellite/CDHS-BehavioralHealth/CPHON/1251581449373</a></td>
<td>*</td>
<td>(303) 866-7494</td>
<td>The program is designed to reduce the current alcohol, tobacco and other drug use rate, prevent early initiation of substance use, promote healthy behavior, and support positive choices in school and communities by youth under age 18 at the local level. Through 2015.</td>
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<tr>
<td>Plata, Garfield, Douglas, Adams, Boulder, Pueblo, Arapahoe, Jefferson</td>
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<tr>
<td>Colorado State-wide</td>
<td>Denver</td>
<td>Colorado Nonprofit Development Center</td>
<td>*</td>
<td><a href="mailto:info@cndc.org">info@cndc.org</a></td>
<td><a href="http://www.cndc.org/current_project.html">http://www.cndc.org/current_project.html</a></td>
<td>4130 TEJON STREET, SUITE A, DENVER, CO 80211</td>
<td>720.855.0501</td>
<td>Projects of the Colorado Nonprofit Development Center operate across the state, addressing a wide variety of issues, all in their own unique way. Please see website for Projects related to Prevention.</td>
</tr>
<tr>
<td>Colorado State-wide</td>
<td>Greenwood Village</td>
<td>American Medical Response Team</td>
<td>Douglas Moore</td>
<td><a href="mailto:Doug.moore@emsc.net">Doug.moore@emsc.net</a></td>
<td><a href="http://www.amr.net/Contact-Us.aspx">http://www.amr.net/Contact-Us.aspx</a></td>
<td>6200 S. Syracuse Way Suite 200 Greenwood Village, CO 80111</td>
<td>303-495-1200</td>
<td>Provides ground and air ambulance service along with para-transit service to supplement federal and military responses to disasters, acts of terrorism and other public health emergencies.</td>
</tr>
<tr>
<td>Colorado State-wide</td>
<td>Denver</td>
<td>Brain Injury Alliance Colorado</td>
<td>Liz Gerdeman Community Outreach Director</td>
<td><a href="mailto:Liz@biacolorado.org">Liz@biacolorado.org</a></td>
<td><a href="http://biacolorado.org/">http://biacolorado.org/</a></td>
<td>4200 W Conejos Place Suite 524 Denver, CO 80204</td>
<td>303.355.9969</td>
<td>BIAC actively advocates for the prevention of brain injuries, and raises awareness in the community by working with other prevention groups and legislators toward governmental change. We also provide information, resources and support to individuals with brain injuries and their families though all phases of their recovery and their return to daily activity.</td>
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<td>County</td>
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<tr>
<td>Colorado</td>
<td>State-wide</td>
<td>CDPHE: Child, Adolescent and School Health Unit</td>
<td>*</td>
<td><a href="mailto:cdphe.pscash@state.co.us">cdphe.pscash@state.co.us</a></td>
<td><a href="http://www.cdphe.state.co.us/pp/injuryprevention/">http://www.cdphe.state.co.us/pp/injuryprevention/</a></td>
<td>4300 Cherry Creek Drive South PSD-CASH-A4 Denver, CO 80246</td>
<td>303-692-2941</td>
<td>The Child, Adolescent and School Health Unit leads efforts to improve the health and well-being of all Colorado children and adolescents through health promotion, public health prevention programs, and access to health care.</td>
</tr>
<tr>
<td>Colorado</td>
<td>State-wide</td>
<td>Colorado Anti-Violence Program</td>
<td>*</td>
<td><a href="mailto:info@coavp.org">info@coavp.org</a></td>
<td><a href="http://www.coavp.org/">http://www.coavp.org/</a></td>
<td>PO Box 181085 Denver, CO 80218</td>
<td>303.839.5204</td>
<td>The Colorado Anti-Violence Program has been dedicated to eliminating violence within and against the lesbian, gay, bisexual, transgender and queer (LGBTQ) communities in Colorado, and providing the highest quality services to survivors.</td>
</tr>
<tr>
<td>Colorado</td>
<td>State-wide</td>
<td>Colorado Cease Fire</td>
<td>*</td>
<td><a href="mailto:info@coloradoceasefire.org">info@coloradoceasefire.org</a></td>
<td><a href="http://www.coloradoceasefire.org/">http://www.coloradoceasefire.org/</a></td>
<td>PO Box 7501 Denver, CO 80207</td>
<td>303.380.6711</td>
<td>Reduce gun violence by establishing awareness campaigns.</td>
</tr>
<tr>
<td>Colorado</td>
<td>State-wide</td>
<td>Colorado Department of Transportation Safety Education and Enforcement Program</td>
<td>Donald Hunt, Executive Director</td>
<td>*</td>
<td><a href="http://www.colorado.dot.info/programs/alcohol-and-impaired-driving">http://www.colorado.dot.info/programs/alcohol-and-impaired-driving</a></td>
<td>4201 E. Arkansas Ave., EP 770 Denver, CO 80222</td>
<td>303-757-9383</td>
<td>CDOT’s Office of Transportation Safety and Public Relations Office oversee programs and public awareness campaigns in an effort to fight impaired driving. CDOT has launched a new anti-drugged driving campaign to educate motorists about the dangers of driving under the influence of medications, medical marijuana, and illegal drugs.</td>
</tr>
<tr>
<td>Colorado</td>
<td>State-wide</td>
<td>Colorado State University: Colorado Injury Control Resource Center</td>
<td>Lorann Stallones, Director</td>
<td><a href="mailto:lorann@colorado.state.edu">lorann@colorado.state.edu</a></td>
<td><a href="http://psy.psych.colorado.state.edu/CICRC/">http://psy.psych.colorado.state.edu/CICRC/</a></td>
<td>Sage Hal 1879 Campus Delivery Fort Collins, CO 80523-1879</td>
<td>970-491-2680</td>
<td>Colorado Injury Control Research Center (CICRC) is dedicated to providing leadership within the Rocky Mountain Region in reducing the occurrence, severity and adverse consequences of injuries and violence through developing and applying evidence based approaches that bridge research with practice including both policy and programs. The CICRC emphasizes building community based partnerships,</td>
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<td>County</td>
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<tr>
<td>Colorado</td>
<td>Denver</td>
<td>CDPHE: Injury, Suicide &amp; Violence Prevention Program</td>
<td>Jarrod Hindman</td>
<td><a href="mailto:Jarrod.hindman@state.co.us">Jarrod.hindman@state.co.us</a></td>
<td><a href="http://www.cdphe.state.co.us/pp/injuryprevention/">http://www.cdphe.state.co.us/pp/injuryprevention/</a></td>
<td>4300 Cherry Creek Drive South PSD-IP-A4 Denver, CO 80246-1530</td>
<td>(303) 692-2590</td>
<td>The focus of the Injury, Suicide and Violence Prevention Unit of the Colorado Department of Public Health and Environment is reducing intentional and unintentional injuries in Colorado. Focus on Motor Vehicle Safety, Unintentional Poisoning, Bicycle &amp; Pedestrian Safety, Recreation Safety, Teen Dating Violence Prevention, TBI Prevention, Older Adult Fall Prevention.</td>
</tr>
<tr>
<td>Colorado</td>
<td>Denver</td>
<td>St. Anthony North Hospital Trauma &amp; Injury Prevention: Jungle Mobile</td>
<td>*</td>
<td><a href="mailto:Junglemobile@childrenscolorado.org">Junglemobile@childrenscolorado.org</a></td>
<td><a href="http://www.stanthonynorth.org/body.cfm?id=79">http://www.stanthonynorth.org/body.cfm?id=79</a></td>
<td>13123 E. 16th Avenue, B911 Aurora, CO 80045</td>
<td>720-777-4809</td>
<td>This program provides effective injury prevention education to young children ages 3-10 throughout the rural areas of Colorado. Bike/Helmet Safety Child Passenger/Seat Belt Emergency Activation/Dialing 911 Fall Prevention Fire Safety Pedestrian Safety Poison Prevention Water Safety Farm Safety ATV Safety</td>
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<td>Colorado</td>
<td>Denver</td>
<td>Children's Hospital: Safe Kids Colorado</td>
<td></td>
<td>*</td>
<td><a href="mailto:safekids@childrenscolorado.org">safekids@childrenscolorado.org</a></td>
<td>13123 East 16th Ave. • Aurora, CO 80045</td>
<td>(720) 777-4807</td>
<td>Safe Kids Colorado, led by</td>
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<td>State-wide</td>
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<td><a href="http://www.childrenscolorado.org/wellness/safety/safekids/index.aspx">http://www.childrenscolorado.org/wellness/safety/safekids/index.aspx</a></td>
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<td>Children’s Hospital Colorado, is a</td>
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<td>Colorado children ages 14 and</td>
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<td>Colorado</td>
<td>Denver</td>
<td>Colorado Department of Education: School Health Injury Program</td>
<td>Amy Dillon</td>
<td><a href="mailto:dillon_a@cde.state.co.us">dillon_a@cde.state.co.us</a></td>
<td><a href="http://www.cde.state.co.us/HealthAndWellness/HealthSchools.htm">http://www.cde.state.co.us/HealthAndWellness/HealthSchools.htm</a></td>
<td>201 E Colfax Avenue Room 300 Denver, CO 80203</td>
<td>(303) 866-6903</td>
<td>School health services</td>
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<tr>
<td>Colorado</td>
<td>Denver</td>
<td>State Highway Safety Showcase, Denver Latino Occupant Protection</td>
<td>Gabriela Vidal</td>
<td>gabiри<a href="mailto:ela.vidal@dot.state.co.us">ela.vidal@dot.state.co.us</a></td>
<td><a href="http://www.ghsa.org/html/resources/showcase/co.1.html">http://www.ghsa.org/html/resources/showcase/co.1.html</a></td>
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<td>solutions and activities to reduce</td>
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<td>deaths/ injuries within the Hispanic</td>
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<td>media campaigns and child-seat</td>
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<td>passenger safety and seat-belt usage</td>
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<td>in the Denver Metro area.</td>
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<tr>
<td>Colorado</td>
<td>Denver</td>
<td>Car Seats Colorado</td>
<td>Heather Cobler</td>
<td><a href="mailto:heather.cobler@cdps.state.co.us">heather.cobler@cdps.state.co.us</a></td>
<td><a href="http://www.coloradodot.info/programs/seatbelts-carseats/carseats">http://www.coloradodot.info/programs/seatbelts-carseats/carseats</a></td>
<td>Headquarters Office 4201 E Arkansas Ave Denver CO 80222</td>
<td>303-239-4537</td>
<td>Motor vehicle injuries represent the</td>
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<td>State-wide</td>
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<td>children age 3–14 years old in the</td>
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<td>Many of these deaths can be</td>
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<td>prevented. Placing children in age-</td>
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<td>and size-appropriate car seats and</td>
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<td>booster seats reduces serious and</td>
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<td>fatal injuries by more than half.</td>
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Yampa Valley Medical Center | Injury | 23
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<th>County</th>
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<th>Provider</th>
<th>Contact Person</th>
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<th>Programs for Reducing Injury</th>
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<tbody>
<tr>
<td>Denver and 9 surrounding</td>
<td>Denver</td>
<td>Rape Assistance and Awareness Program</td>
<td>Tara Roesener</td>
<td><a href="mailto:troesener@raap.org">troesener@raap.org</a></td>
<td><a href="http://www.raap.org/">http://www.raap.org/</a></td>
<td>PO Box 18951 Denver, CO 80218</td>
<td>303.329.9964</td>
<td>website to find fit station</td>
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<tr>
<td>counties</td>
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<tr>
<td>Rocky Mountain Region</td>
<td>Denver</td>
<td>Rocky Mountain Poison and Drug Center</td>
<td>Richard Dart</td>
<td><a href="mailto:Richard.Dart@rmpdc.org">Richard.Dart@rmpdc.org</a></td>
<td><a href="http://www.rmpdc.org/">http://www.rmpdc.org/</a></td>
<td>777 Bannock St. Mail code 0180 Denver, CO 80204</td>
<td>303.739.1100</td>
<td>Education, research, safety programs, intervention which reduces toxicity, injury and disease by providing caring expertise to all.</td>
</tr>
<tr>
<td>County</td>
<td>City</td>
<td>Provider</td>
<td>Contact Person</td>
<td>Email</td>
<td>Website</td>
<td>Address</td>
<td>Phone Number</td>
<td>Domestic Violence Programs</td>
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<tr>
<td>Colorado; Statewide</td>
<td>Colorado</td>
<td>Colorado Coalition Against Domestic Violence</td>
<td><a href="mailto:nolson@ccadv.org">nolson@ccadv.org</a></td>
<td><a href="http://www.ccadv.org">http://www.ccadv.org</a></td>
<td>1120 Lincoln Street, Suite 900 Denver, CO 80203</td>
<td>303.831.9632</td>
<td>Networking, support, counseling, advocacy, outreach, education and referral</td>
<td></td>
</tr>
<tr>
<td>Colorado; Statewide</td>
<td>Colorado</td>
<td>Colorado Coalition Against Sexual Assault</td>
<td>Erin Jemison, Executive Director</td>
<td><a href="mailto:info@ccasa.org">info@ccasa.org</a></td>
<td><a href="http://www.ccasa.org/">http://www.ccasa.org/</a></td>
<td>1120 Lincoln Street, Suite 700 • Denver, CO 80203</td>
<td>303.839.9999</td>
<td>Network of organizations and individuals working together against sexual violence in Colorado. Provide information and referral, special projects, advocacy and education on sex assault issues to the general public and professionals</td>
</tr>
<tr>
<td>Colorado; Statewide</td>
<td>Colorado</td>
<td>Colorado Organization for Victim Assistance</td>
<td>Nancy Lewis, Executive Director</td>
<td><a href="mailto:Info@ColoradoCrimeVictims.org">Info@ColoradoCrimeVictims.org</a></td>
<td><a href="http://www.coloradocrimevictims.org/">http://www.coloradocrimevictims.org/</a></td>
<td>90 Galapago Street Denver, Colorado 80223</td>
<td>303.861.1160</td>
<td>COVA is a nonprofit statewide membership organization, with over 800 members throughout Colorado. Colorado Organization for Victim Assistance (COVA) is committed to fairness and healing for crime victims, their families and communities through leadership, education, and advocacy.</td>
</tr>
<tr>
<td>Colorado; Statewide</td>
<td>Colorado</td>
<td>The Domestic Violence Program</td>
<td>Ruth M. Glenn, DVP Director</td>
<td><a href="http://www.colorado.gov/cdhs/dvp">http://www.colorado.gov/cdhs/dvp</a></td>
<td>1575 Sherman Street 3rd Floor Denver, CO 80203</td>
<td>(303) 866-2855</td>
<td>The mission of the DVP is to serve as the state governmental authority on domestic violence issues by providing leadership, guidance, and awareness within government agencies as well as ensuring grant funded programs deliver optimal services to victims, ultimately promoting a Colorado free of domestic violence. DVP currently funds 44 domestic violence crisis centers across the State. All DVP-funded crisis centers provide confidential services 24 hours a day, 7 days a week via crisis lines.</td>
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<td>County</td>
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<td>Provider</td>
<td>Contact Person</td>
<td>Email</td>
<td>Website</td>
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<td>Domestic Violence Programs</td>
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<tr>
<td>Glenwood Springs, Eagle, El</td>
<td>Glenwood Springs, Eagle, El Jebel, Carbondale, Rifle, Craig, Edgewater, Avon, Vail, Leadville &amp; Steamboat</td>
<td>Alpine Springs Counseling</td>
<td>Dr. Stark, Director</td>
<td><a href="mailto:leslie@rof.net">leslie@rof.net</a></td>
<td><a href="http://www.alpine">http://www.alpine</a> springscounseling.com/</td>
<td>1432 Grand Ave. Glenwood Springs, CO 81601</td>
<td>(970) 945-7858</td>
<td>Domestic Violence Men Offenders program (English and Spanish) and Domestic Violence Women Offenders program (English) are currently offered. The programs are Level based upon an evaluation. These groups have as their goal to stop abusive behavior.</td>
</tr>
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Diabetes mellitus (DM) occurs when the body cannot produce or respond to insulin appropriately. Insulin is a hormone needed by the body to absorb and use glucose as a fuel for the body’s cells. Without a properly functioning insulin signaling system, blood glucose levels become elevated and other metabolic abnormalities occur.

The three most common types of DM are:

- **Type 1 diabetes**, which results when the body loses its ability to produce insulin. Type 1 diabetes is an autoimmune disease and, at this time, is not preventable. Type 1 diabetes is typically diagnosed in people younger than 30 years of age and accounts for fewer than 10 percent of all diagnosed cases of diabetes.
- **Type 2 diabetes**, which results from a combination of resistance to the action of insulin and insufficient insulin production. Type 2 accounts for about 90 to 95 percent of all diagnosed cases of diabetes. Until recently, type 2 diabetes typically occurred in people older than 30 years of age. With increases in overweight children, youth and adolescents, the rate of type 2 diabetes in children and adolescents has increased to 0.2 percent.
- **Gestational diabetes** is a common complication of pregnancy. Gestational diabetes can lead to perinatal complications in mother and child and substantially increases the likelihood of cesarean section. Gestational diabetes is also a risk factor for subsequent development of type 2 diabetes after pregnancy.

DM affects an estimated 23.6 million people in the United States and is the 7th leading cause of death. The estimated total financial cost of DM in the United States in 2007 was $174 billion, which includes the costs of medical care, disability, and premature death. The rate of DM continues to rise in the United States, and throughout the world. Diabetes can lead to serious complications and premature death. Complications include:

- Heart disease and stroke
- Hypertension
- Blindness and eye problems
- Kidney disease
- Nervous system disease

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2. Ibid.
5. Ibid.
• Amputations
• Dental disease
• Complications of pregnancy

Effective therapy can prevent or delay diabetic complications.\textsuperscript{6} Lifestyle change has been proven effective in preventing or delaying the onset of type 2 diabetes in high-risk individuals. Based on this, new public health approaches are emerging that may deserve monitoring at the national level. For example, the Diabetes Prevention Program demonstrated that lifestyle intervention had its greatest impact in older adults and was effective in all racial and ethnic groups.

Four “transition points” in the natural history of diabetes health care provide opportunities to reduce the health and economic burden of DM:

• Primary prevention: movement from no diabetes to diabetes
• Testing and early diagnosis: movement from unrecognized to recognized diabetes
• Access to care for all persons with diabetes: movement from no diabetes care to access to appropriate diabetes care
• Improved quality of care: movement from inadequate to adequate care

There are social determinants that affect diabetes:

• People from minority populations are more frequently affected by type 2 diabetes. Minority groups constitute 25 percent of all adult patients with diabetes in the United States and represent the majority of children and adolescents with type 2 diabetes.
• African Americans, Hispanic/Latino Americans, American Indians, and some Asian Americans and Native Hawaiians and other Pacific Islanders are at particularly high risk for the development of type 2 diabetes.
• Diabetes prevalence rates among American Indians are 2 to 5 times those of whites. On average, African American adults are 1.7 times as likely and Mexican Americans and Puerto Ricans are twice as likely to have the disease as non-Hispanic whites of similar age.

Diabetes was not selected as one of the ten Winnable Battles by the Colorado Department of Public Health and Environment. According to CDPHE, “obesity increases a person’s risk for several serious illnesses: heart disease, type 2 diabetes, high blood pressure, high cholesterol, stroke and some types of cancer.” Therefore, by naming obesity as a top ten winnable battle, rates of type 2 diabetes will be impacted by strategies to reduce obesity. CDPHE’s Diabetes Prevention and Control Program has identified the reduction of complications resulting from diabetes as an important outcome for the state. Goals for 2013 have been identified for diabetes preventive care practices and will be discussed in this report.

\textsuperscript{6} http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=8
The overall incidence rate for type 1 diabetes in Colorado children and youth ages 0-17 was 23.9 per 100,000 people during 2002-2004. The incidence rates were higher in White/Non-Hispanics compared to White/Hispanics, while there are no strong differences in the incidence rates between females and males. The incidence of type 1 diabetes is on the rise in Colorado as well as across the nation. County-level data is not available.

---

GESTATIONAL DIABETES

PRAMS: During your most recent pregnancy, were you told by a doctor, nurse or other health care worker that you had gestational diabetes (diabetes that started during this pregnancy)?

![Gestational Diabetes - Colorado](image)

In Colorado, the percentage of women who had diabetes during pregnancy fluctuated between 5% and 10% during 2000-2006.\textsuperscript{10} From 2004 forward the PRAMS question related to diabetes during pregnancy was changed to differentiate between pre-existing and gestational diabetes. The highest percentage was 8.9% of mothers who gave birth in 2006 and reported having gestational diabetes during pregnancy. This estimate for 2006 and subsequent years did not include women with pre-existing diabetes. It is difficult to determine an overall trend from this data.

The following are social determinants of diabetes as indicated by data from 2004-2006\textsuperscript{11}:

- More than 11% of the Hispanic women have gestational diabetes
- Almost 11% of women 35 and older have gestational diabetes
- 10.8% of women with fewer than 12 years of education have gestational diabetes
- 10.2% of women who were at or below 185% of federal poverty level have gestational diabetes

\textsuperscript{9} Chart Source: Pregnancy Risk Assessment Monitoring System, Colorado Department of Public Health and Environment.
\textsuperscript{11} Ibid.
BRFSS Survey Question: Have you ever been told by a doctor that you have diabetes? (excludes gestational diabetes)

The prevalence rate of Diabetes in Colorado is lower than the Nation.
Moffat County has a diabetes prevalence rate that is above the State, but below the nation. The Routt county diabetes rate is well below the State. There is not a Healthy People 2020 goal that is comparable to this measure.

![Figure 3 Told by Doctor Have Diabetes](image)

*Figure 3 Told by Doctor Have Diabetes*¹²

---

DEMOGRAPHICS OF DIABETES

The prevalence of diabetes increases with age. Beginning with the age group 35-44, each older age group has a significantly higher prevalence rate.

Black and Hispanic adults have significantly higher prevalence rates of diabetes than White/Non-Hispanic adults.

Prevalence of diabetes increases as income decreases. Each income group has a statistically different rate.

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14 Ibid.
15 Ibid.
Adults with some college or more had significantly lower prevalence rates of diabetes than adults with a high school education or less.

![Figure 7 Diabetes by Education](image)

### DIABETES TRENDS

![Figure 8: Percent of Adults with Diabetes, Colorado and the United States](image)

When comparing the trends in diabetes prevalence overall, Colorado has lower prevalence rates than the nation, but rates are increasing at a similar pace.

---


All people with diabetes need education to manage the disease. The Colorado Diabetes Prevention and Control Program has identified 2013 goals for preventive practices including self-monitoring of blood glucose (SMBG), Hemoglobin A1C testing, foot exams, eye exams, Diabetes Self-management Education (DSME), and cholesterol checks.

Figure 9: Preventive Care Practices Performed by Adults with Diabetes

Figure 10: Baseline and Target BRFSS Measures for Diabetes

---

19 Ibid.
DIABETES SELF-MANAGEMENT EDUCATION (DSME)

In 2009, in an effort to address the increased need for better education and access among individuals with diabetes to quality diabetes self-management education, the Colorado Diabetes Prevention and Control program undertook a comprehensive statewide needs assessment for Diabetes Self-Management Education (DSME). DSME improves clinical outcomes through encouraging preventive care and self-management of diabetes.20

Diabetes self-management is extremely important in reducing the risk for complications associated with diabetes. These techniques first need to be learned through diabetes self-management education, which is an integral part of the treatment plan. People with diabetes and their physicians are responsible for maintaining these preventive health practices to ensure the best health possible.

Health Statistic Regions 1, 6, 7, 8, 14 and 20 were identified as having the greatest need for DSME based on secondary and tertiary prevention indicators, including prevalence of diabetes among adults, estimated counts of adults with diabetes, diabetes mortality rates, prevalence of diabetes self-management education and prevalence of preventive care practices for persons with diabetes. The prevalence of diabetes was considered the most important factor, followed by the prevalence of persons with diabetes who had received DSME.

None of the counties in Yampa Valley Medical Center Primary Service Areas were identified as focus regions.

<table>
<thead>
<tr>
<th>Region</th>
<th>Counties</th>
<th>Diabetes Prevalence (%)²¹ 2005-2007</th>
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<tr>
<td>Region 1 – Northeast</td>
<td>Morgan, Logan, Sedgwick, Phillips, Yuma, Washington</td>
<td>7.5</td>
</tr>
<tr>
<td>Region 6 – Southeast</td>
<td>Crowley, Kiowa, Otero, Bent, Prowers, Huerfano, Las Animas, Baca</td>
<td>10.2*</td>
</tr>
<tr>
<td>Region 7 – Pueblo</td>
<td>Pueblo</td>
<td>8.7*</td>
</tr>
<tr>
<td>Region 8 – San Luis Valley</td>
<td>Saaguache, Mineral, Rio Grande, Alamosa, Conejors, Costilla</td>
<td>6.4</td>
</tr>
<tr>
<td>Region 14 – Adams County</td>
<td>Adams</td>
<td>7.5*</td>
</tr>
<tr>
<td>Region 20 – Denver County</td>
<td>Denver</td>
<td>5.4</td>
</tr>
</tbody>
</table>

* Denotes regional diabetes prevalence significantly higher than statewide prevalence of 5.1 percent (2005-2007)

Figure 11: Colorado Counties in Diabetes Focus Regions²¹

DIABETES MORTALITY RATES

Survey: Death Certificates with Diabetes as Underlying Cause of Death

Diabetes causes a variety of serious health complications that can cause or contribute to death. Diabetes is underreported on death certificates; therefore, the number and rate of diabetes related deaths presented are lower than the true number and rate.

Routt and Moffat Counties have diabetes death rates below the State.

Figure 12: Diabetes Death Rates

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22 Chart Source: Certificate of Death, Colorado Department of Public Health and Environment. Light blue bars indicate weak data. Rates are per 100,000 population and are adjusted using the direct method applied to 10-year age groups. Population figures are 2007-based estimates from the Demography Section, Colorado Department of Local Affairs. County-specific data are for deaths reported as occurring for residents of those counties. National Rate: Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2010 on CDC WONDER Online Database, released 2012. Data are from the Multiple Cause of Death Files, 1999-2010, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10.html on Feb 5, 2013 5:11:23 PM.
INTERVENTIONS

COLORADO DIABETES PREVENTION AND CONTROL STRATEGIC PLAN

GOAL: Prevent, detect and delay diabetes in Coloradans through effective health systems and community interventions.

Strategy 1: Identify people at risk of developing type 2 diabetes.

Action steps

- Based upon known risk factors for type 2 diabetes, identify priority populations who are at high risk for developing type 2 diabetes.
- Promote early identification of people with diabetes.
- Conduct risk assessments for type 2 diabetes and ensure appropriate diagnostic testing is ordered.
- Reduce incidence of gestational and type 2 diabetes by promoting healthy weight and active lifestyles in women of childbearing age.
- Educate health-care providers about the high conversion rate of women with gestational diabetes mellitus to type 2 diabetes, and refer to the Colorado Clinical Guidelines Collaborative Gestational Diabetes Mellitus clinical guidelines for actions to reduce risk.
- Convey message to women on the importance of achieving prepregnancy weight within 6 to 12 months after delivery.

Strategy 2: Communicate diabetes risk factors and prevention using model public health programs directed to all population segments, with priority given to disparately affected groups.

Action steps

- Use assessment tools to raise the public’s awareness of the risk of developing type 2 diabetes.
- Partner with communication specialists, stakeholders and other state and national organizations in conducting diabetes prevention campaigns utilizing already developed materials.
- Promote programs such as the National Diabetes Education Program’s Small Steps, Big Rewards: Prevent Type 2 Diabetes Healthcare Provider Toolkit by distributing materials to diabetes partners and stakeholders.

Empower the general public, including children, youth and adults, through education on how to reduce their risk for developing type 2 diabetes.

Work with community organizations including faith-based organizations, schools, senior centers, community health centers, professional organizations and fraternal societies to raise risk awareness, especially in diverse, at-risk populations such as older adults, African-Americans, Hispanic/Latino, Native Americans and the uninsured.

**Strategy 3: Implement effective interventions that support healthy lifestyles and early detection of diabetes.**

**Action steps**

- Identify and encourage the implementation of evidence-based programs to increase physical activity, improve nutrition and promote weight loss.

- Partner with the Colorado Physical Activity and Nutrition Program and Coordinated School Health in promoting healthy communities and schools, increasing public awareness of healthy weight, good nutrition and physical activity.

- Partner with the Colorado Physical Activity and Nutrition Program to encourage Colorado employers to implement diabetes-prevention programs such as CDC’s Diabetes at Work.

- Train health-care providers to follow the Colorado Clinical Guidelines Collaborative clinical guidelines for obesity.

- Ensure diabetes prevention programs are available and accessible to high-risk populations in all areas of Colorado.

- Partner with all payers to reimburse for diabetes prevention and detection services.

- Build capacity of communities throughout Colorado to offer evidence-based diabetes primary prevention programs for persons with prediabetes.

**GOAL: Reduce the impact of diabetes on Coloradans by decreasing diabetes-related complications and deaths.**

**Strategy 1: Promote quality and consistent management of diabetes.**

**Action steps**

- Promote the use of the Colorado Clinical Guidelines Collaborative evidence-based diabetes guidelines to health-care professionals throughout Colorado.

- Form a Medical Expert Advisory Group to communicate issues of concern that impact the diabetes community, such as diabetes drug recalls, new technologies, changes in lab values, etc.

- Partner with professional associations and health benefit plans to promote the use of the Colorado Clinical Guidelines Collaborative diabetes and gestational diabetes guidelines and to ensure providers have the appropriate tools and resources to implement the guidelines.
- Improve professional education (such as nursing and dental schools, medical education) related to the care of people with diabetes and prediabetes by including diabetes-specific content and expanding the required clinical competencies.

- Promote awareness and distribution of the Colorado *Guiding Principles for the Management of Students with Diabetes* for the safe and appropriate care of children with diabetes in schools.

- Design strategies and incentives to help more bilingual/bicultural health-care professionals pursue Certified Diabetes Educator credentials and other provider recognitions (e.g., National Committee for Quality Assurance Provider Recognition), especially in underserved areas serving diverse populations.

- Partner with academic institutions (colleges of medicine, nursing, podiatry, optometry, dentistry, nutrition, social work and public health), medical professional associations, and peer review groups to promote improved care and services for people with diabetes.

- Partner with health system projects (e.g. Improving Performance in Practice) that promote data collection and analysis, practice redesign and quality improvement in caring for people with diabetes (and other chronic diseases).

**Strategy 2: Promote a team-based approach to diabetes management.**

**Action steps**

- Promote the use of the Improving Chronic Illness Care’s Chronic Care Model (see Appendix C) as a quality improvement tool for health-care practices.

- Support and promote evidence-based self-management education programs.

- Promote and train the use of community health workers and promotoras to reinforce and support diabetes education.

- Facilitate the creation of diabetes care teams that include diabetes educators, navigators, promotoras and community health workers.

- Include academic institutions and research institutions such as the Rocky Mountain Prevention Research Center in the development and evaluation of community programs.

**Strategy 3: Identify and address gaps in diabetes care.**

**Action steps**

- Identify diabetes care needs and work with the diabetes network to develop statewide efforts to address those needs.

- Raise awareness of the strong link between diabetes and stress and depression for both men and women with diabetes.

- Support the use of Electronic Health Records or diabetes registries by the provider community.

- Support community health centers in their efforts to improve diabetes care through participation in the Bureau of Primary Health Care’s Health Disparities Collaborative.
Collaborate with managed care plans, Medicaid, and Medicare to measure and improve diabetes care for their constituents.

Provide training and educational opportunities for healthcare professionals that promote diabetes standards of care.

**Strategy 4: Improve health outcomes for those with diabetes.**

**Action steps**

- Promote the measurement of quality indicators for diabetes care.
- Support providing feedback to health-care providers on performance.
- Promote diabetes self-management skills including self-monitoring of blood glucose; regular dilated eye, foot and oral health exams; stress management plans; and the use of a diabetes self-management contract.

**Strategy 5: Improve access to diabetes services and education for those who are underserved.**

**Action steps**

- Ensure diabetes educational messages are culturally relevant and appropriate for different literacy levels.
- Support the provision of diabetes services in community settings rather than in just clinical settings.
- Foster sensitivity to the differing needs and appropriate interventions for specific populations including men, women, children, diverse populations and rural communities.

**GOAL: Develop and integrate a surveillance and evaluation system that informs and supports: local level decision-making; state resource allocation; practice-based research; and local, state and national policy development.**

**Strategy 1: Improve diabetes-related surveillance efforts**

**Action Steps**

- Based on existing diabetes surveillance resources as outlined by CDC and prior work of the Colorado DPCP, determine indicators of diabetes prevention and control that are sufficiently valid and sensitive to change. Present these indicators annually in a brief statewide report available through the DPCP website and linked to the CDPHE health statistics portal.
- Collaborate with SEARCH for Diabetes in Youth, a research project of UCD, Preventive Medicine and Biometrics to make county and state level incidence data on diabetes in children available through the DPCP website and linked to the CDPHE health statistics portal.
Partner with other CDPHE programs and state agencies to develop a long term plan for coordinated and integrated local level surveillance that can be used a) for local planning and evaluation, as well as b) state level planning and resource allocation. Assure that key measures, related to diabetes prevention and control, are valid and useful for planning and evaluation.

Develop a mechanism to populate CDC’s map of local programs in order to promote access to programs and services. Develop reports that describe local and state program capacity in order to inform diabetes prevention and control priorities.

**Strategy 2. Enhance evaluation of diabetes-related initiatives**

**Action Steps**

- Work with partners at the CDPHE, PHAC, RMPRC and CSPHI to provide training and technical assistance on program planning and evaluation for state and local partners, as needed.

- Partner with the Interagency Prevention Leadership Council, RMPRC and CSPHI to promote the development of practice-based evidence through stronger evaluations of diabetes prevention programs. Link with the service to science program to build capacity and support dissemination of effective community programs.
  

**Strategy 3. Support translation of diabetes research into practice**

**Action Steps**

- Work with Colorado’s academic and research centers to disseminate the results of their diabetes research to health care professionals and other community stakeholders.

- Partner with UCD SOM Department of Family Medicine to support and promote Primary Care Practice Based Research and continuous quality improvement in diabetes prevention and control.

- As part of the long term surveillance plan (referenced in strategy 1 above), work with the RMPRC along with academic and practice partners to establish surveillance measures that are population-based, and that are used to for practice-based public health research and continuous quality improvement studies in public health.

**Abbreviations:**

CDC—Centers for Disease Control  
CDPHE—Colorado Department of Public Health and Environment  
CSPHI – Colorado School of Public Health Initiative  
DPCP—Diabetes Prevention and Control Program  
PHAC – Public Health Alliance of Colorado  
RMPRC – Rocky Mountain Prevention Research Center  
UCD SOM—University of California Davis School of Medicine
GOAL: Identify opportunities for change through network activities that support diabetes prevention and control.

Strategy 1: Build and mobilize a statewide diabetes network to coordinate and conduct activities that support diabetes prevention and control.

Action Steps:

- Identify local and state diabetes partners to build a diabetes network.
- Conduct training for members on effective networking utilizing the Health Policy Guide from the Center for Health Improvement.
- Through the statewide diabetes network raise public awareness about issues related to diabetes prevention and control.
- Develop fact sheets highlighting the human and economic costs of diabetes in Colorado, including the costs and benefits of good diabetes management.
- Coordinate with other diabetes-related public policy initiatives.
- Engage health professionals and organizations to publicly support diabetes care issues.

Strategy 2: Educate policy makers, community leaders, and funding sources about the importance of public policies and programs that support diabetes prevention and control.

Action Steps:

- Use the Colorado Diabetes Strategic Plan as a communication tool.
- Ensure health care providers have access to the tools they need to treat diabetes to best evidence standards or guidelines.
- Identify diabetes experts to conduct policy analysis and assessment.
- Tailor “talking points” to the specific audience.
- Develop an agenda annually with identified opportunities for change.

Strategy 3: Develop and sustain diabetes community coalitions throughout Colorado.

Action Steps

- Work with community organizations and programs to improve health promotion activities as part of their efforts to achieve Healthy People 2010 objectives.
- Partner with community-based diabetes programs, diabetes centers, community groups, faith-based organizations, senior centers, schools and providers, especially those serving diverse, at-risk populations.
- Engage underserved populations to become diabetes system partners.
Evaluation Plan

The intent of evaluation is to support the state plan as it evolves and to allow for the flexibility to respond to emerging issues and contextual circumstances. All activities outlined in this plan will be evaluated to identify areas that require modification and to assess program impact.

Process Evaluation
This component of evaluation focuses on the ongoing tracking of progress made toward completing activities designed to bring about changes directly linked to the program’s goals.

The process evaluation will determine
 the extent to which the plan is being implemented as intended;
 the degree to which goals and strategies are progressing towards completion over the course of the four-year plan, including assessing the strengths, weaknesses and lessons learned during the implementation of the plan;
 how the program appropriately focuses diabetes health efforts, especially toward priority populations.

Outcome Evaluation
The outcome evaluation determines whether or not changes are occurring and the impact of the changes in the state. Outcomes include changes in diabetes risk factors such as hypertension, physical inactivity and excess body weight.

The outcome evaluation will
 determine changes in behavior, services and policies that have occurred as a result of the plan;
 assess the inroads in addressing health disparities;
 determine if educational intervention increases public awareness of diabetes;
 track the changes occurring in the state population’s diabetes burden and risk factors over time (as measured primarily through vital statistics, hospital discharge data and the Behavioral Risk Factor Surveillance System).

Surveillance
Using existing data systems, such as the Behavioral Risk Factor Surveillance Survey, Child Health Survey, Pregnancy Risk Assessment Monitoring System, HEDIS® data, vital statistics and hospital discharge data, the Diabetes Prevention and Control Program has the capacity to track changes. The program will continue to use the existing data systems to continue its surveillance of diabetes and related risk factors.

US PREVENTIVE SERVICES TASK FORCE CLINICAL RECOMMENDATIONS
SCREENING FOR LIPID DISORDERS IN ADULTS

The U.S. Preventive Services Task Force (USPSTF) recommends screening men aged 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease. The U.S. Preventive Services Task Force (USPSTF) recommends screening women aged 20

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24 http://www.uspreventiveservicestaskforce.org/
to 45 for lipid disorders if they are at increased risk for coronary heart disease. The U.S. Preventive Services Task Force (USPSTF) strongly recommends screening men aged 35 and older for lipid disorders. The U.S. Preventive Services Task Force (USPSTF) strongly recommends screening women aged 45 and older for lipid disorders if they are at increased risk for coronary heart disease.

### CDC RECOMMENDATIONS

#### COMMUNITY INTERVENTIONS

The following evidence-based community interventions come from the Guide to Community Preventive Services, Centers for Disease Control and Prevention (CDC).

#### BEHAVIORAL AND SOCIAL APPROACHES TO INCREASE PHYSICAL ACTIVITY: INDIVIDUALLY-ADAPTED HEALTH BEHAVIOR CHANGE PROGRAMS

Individually-adapted health behavior change programs to increase physical activity teach behavioral skills to help participants incorporate physical activity into their daily routines.

#### BEHAVIORAL AND SOCIAL APPROACHES TO INCREASE PHYSICAL ACTIVITY: SOCIAL SUPPORT INTERVENTIONS IN COMMUNITY SETTINGS

Social support interventions focus on changing physical activity behavior through building, strengthening, and maintaining social networks that provide supportive relationships for behavior change (e.g., setting up a buddy system, making contracts with others to complete specified levels of physical activity, or setting up walking groups or other groups to provide friendship and support).

#### CAMPAIGNS AND INFORMATIONAL APPROACHES TO INCREASE PHYSICAL ACTIVITY: COMMUNITY-WIDE CAMPAIGNS

Community-wide campaigns to increase physical activity involve many community sectors; include highly visible, broad-based, component strategies; and may also address other cardiovascular disease risk factors.

#### DIABETES PREVENTION AND CONTROL: CASE MANAGEMENT INTERVENTIONS TO IMPROVE GLYCEMIC CONTROL

Case management involves planning, coordinating, and providing health care for all people affected by a disease, such as diabetes.

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DIABETES PREVENTION AND CONTROL: DISEASE MANAGEMENT PROGRAMS

Disease management is an organized, proactive, multicomponent approach to healthcare delivery for people with a specific disease, such as diabetes.

DIABETES PREVENTION AND CONTROL: SELF-MANAGEMENT EDUCATION

Diabetes self-management education (DSME) is the process of teaching people to manage their diabetes. It can be provided in a variety of community settings.

ENVIRONMENTAL AND POLICY APPROACHES TO INCREASE PHYSICAL ACTIVITY: STREET-SCALE URBAN DESIGN AND LAND USE POLICIES

Street-scale urban design and land use policies involve the efforts of urban planners, architects, engineers, developers, and public health professionals to change the physical environment of small geographic areas, generally limited to a few blocks, in ways that support physical activity.

HEALTH COMMUNICATION & SOCIAL MARKETING: HEALTH COMMUNICATION CAMPAIGNS THAT INCLUDE MASS MEDIA & HEALTH-RELATED PRODUCT DISTRIBUTION

Health communication campaigns can increase the use of health-related products when they use mass media messaging and distribute the products at free or reduced prices.

OBESITY PREVENTION AND CONTROL, INTERVENTIONS IN COMMUNITY SETTINGS: WORKSITE PROGRAMS

Worksite nutrition and physical activity programs are designed to improve health-related behaviors and health outcomes.
<table>
<thead>
<tr>
<th>County or State-wide</th>
<th>City</th>
<th>Provider</th>
<th>Contact Person</th>
<th>Phone Number/ Email</th>
<th>Website</th>
<th>Address</th>
<th>Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorado, State-wide</td>
<td>Denver</td>
<td>American Diabetes Association, Colorado</td>
<td>Sue Glass, Executive Director</td>
<td>720.855.1102</td>
<td><a href="http://www.diabetes.org/in-my-community/local-offices/denver-colorado/">http://www.diabetes.org/in-my-community/local-offices/denver-colorado/</a></td>
<td>2480 W 26th Avenue, Suite 120B Denver, CO 80211</td>
<td>The American Diabetes Association's Denver office is so committed to educating the public about how to stop diabetes and support those living with the disease.</td>
</tr>
<tr>
<td>Colorado, State-wide</td>
<td>Denver</td>
<td>American Diabetes Association, Camp Colorado</td>
<td>Emily Fay</td>
<td>720.855.1102x7015</td>
<td><a href="mailto:emfay@diabetes.org">emfay@diabetes.org</a></td>
<td>2450 S Downing Street Denver, CO 80210</td>
<td>The mission of the American Diabetes Association Camp Colorado is to foster independence, self-confidence and awareness of a healthy lifestyle through education, nutrition, exercise, emotional well-being and glucose control in children.</td>
</tr>
<tr>
<td>Colorado, State-wide</td>
<td>Denver</td>
<td>CDPH: Colorado Diabetes Prevention and Control</td>
<td>*</td>
<td>303-692-2577</td>
<td><a href="mailto:cdphe.pdsrequests@state.co.us">cdphe.pdsrequests@state.co.us</a></td>
<td>Prevention Services Division PSD-DPCP-A5 4300 Cherry Creek Drive South Denver, CO 80246-1530</td>
<td>A program by the Colorado Department of Public Health that has resources for prevention and control of diabetes.</td>
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This link provides a comprehensive list of clinics that provide AADE accredited diabetes programming.
<table>
<thead>
<tr>
<th>County or State-wide</th>
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<th>Provider</th>
<th>Contact Person</th>
<th>Phone Number/ Email</th>
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<th>Programs</th>
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<td>Colorado, State-wide</td>
<td>Rocky Mountain area</td>
<td>Juvenile Diabetes Research Foundation, Rocky Mountain Chapter</td>
<td>James Buckles Executive Director</td>
<td>303.770.2873</td>
<td><a href="http://www.jdrfrockymountain.org/">http://www.jdrfrockymountain.org/</a></td>
<td>8055 East Tufts Ave. Ste.770 Denver, CO 80237</td>
<td>Research, education, community programs focused on juvenile diabetes</td>
</tr>
<tr>
<td>Colorado, State-wide</td>
<td></td>
<td>Defeat Diabetes</td>
<td>*</td>
<td>*</td>
<td><a href="http://www.defeatdiabetes.org">www.defeatdiabetes.org</a></td>
<td>*</td>
<td>Referral and education website to assist people in finding Self Management Programs in the US.</td>
</tr>
<tr>
<td>Routt</td>
<td>Steamboat Springs</td>
<td>Diabetes Education Program - Yampa Valley Medical Center</td>
<td>Ms. Jane K. Dickison, Program Director</td>
<td><a href="mailto:jane.dickinson@yvmc.org">jane.dickinson@yvmc.org</a> 970-871-2352</td>
<td><a href="http://www.yvmc.org/diabetes">http://www.yvmc.org/diabetes</a></td>
<td>1024 Central Park Drive Steamboat Springs, CO 80487</td>
<td>The Diabetes Education Program provides diabetes self-management education that is consistent, comprehensive, current and easy to understand. All individuals in the Yampa Valley whose lives are affected by diabetes are served. The Diabetes Education Program publishes a quarterly newsletter which includes diabetes related articles and information about upcoming events.</td>
</tr>
<tr>
<td>Routt</td>
<td>Steamboat Springs</td>
<td>Adult Health (Routt County) - Northwest Colorado Visiting Nurse Association Inc. (VNA)</td>
<td>Stephanie Anderson</td>
<td><a href="mailto:sanderso@nwcovna.org">sanderso@nwcovna.org</a> (970) 879-1632</td>
<td><a href="http://www.nwcovna.org">www.nwcovna.org</a></td>
<td>940 Central Park Drive Suite 101 Steamboat Springs, CO 80487</td>
<td>Programs for Adults &amp; Seniors include:  -Women's Health Clinic 970-879-3738 -Adult Immunizations -Travel Immunizations -Senior Wellness Services -Communicable Disease Control -Cancer Awareness and Screening -cardiovascular and Diabetic screening -medical eligibility and enrolment -Tobacco Prevention and Education Services -Adult Day services -Hospice and palliative care services -Emergency Preparedness</td>
</tr>
<tr>
<td>County or State-wide</td>
<td>City</td>
<td>Provider</td>
<td>Contact Person</td>
<td>Phone Number/Email</td>
<td>Website</td>
<td>Address</td>
<td>Programs</td>
</tr>
<tr>
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<td>----------------</td>
<td>-------------------</td>
<td>-----------------------------------------</td>
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<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Rio Blanco County</td>
<td>Rangely</td>
<td>Rangely Family Medicine - Rangely District Hospital</td>
<td>Nick Gooshe, CEO</td>
<td>970-675-4219</td>
<td><a href="http://www.hospitalsoup.com/rangely/">www.hospitalsoup.com/rangely/</a></td>
<td>511 S White Ave Rangely, CO 81648</td>
<td>Rangely Family Medicine Clinic is the primary care provider of the Rangely area. It is the initial entry to receive medical evaluation and general care. Intake for citizens with minor emergency medical needs and testing, minor illness, and injuries. The clinic has the ability to refer to specialists as needed. The clinic conducts the areas general wellness physicals, employer, employee physicals, children's school physicals. It provides education for diabetes control and smoking cessation. Respiratory testing, breathing therapy, Audiology and mammogram testing are also available. The clinic receives visits once a month from a general surgeon, cardiologist, orthopedic surgeon and sports medicine physician.</td>
</tr>
<tr>
<td>Rio Blanco County</td>
<td>Meeker</td>
<td>Diabetes Support Group - Diabetes Support Group</td>
<td>Vicki Johnnson</td>
<td>970-878-4554</td>
<td>Methodist Church at 8th &amp; Park St. Meeker, Co 81641</td>
<td>Diabetes support group and informative presentations on diabetes issues. Held the 2nd Wednesday of every month at 7:00pm.</td>
<td></td>
</tr>
<tr>
<td>Moffat</td>
<td>Craig</td>
<td>TMH Diabetic Program - The Memorial Hospital - TMH</td>
<td>Amy Knights, Diabetes Educator</td>
<td><a href="mailto:amy.knights@tmhcraig.org">amy.knights@tmhcraig.org</a></td>
<td>970-826-3247</td>
<td>111 W Victory Way - Centennial Mall Craig, CO 81625</td>
<td>The Diabetic Program is a program of The Memorial Hospital. Its mission is to take a leadership role in the community to strengthen and integrate interrelated systems that support and aide our customers, to care for themselves as much as possible within the scope of each customer’s capabilities and limitations.</td>
</tr>
<tr>
<td>County or State-wide</td>
<td>City</td>
<td>Provider</td>
<td>Contact Person</td>
<td>Phone Number/ Email</td>
<td>Website</td>
<td>Address</td>
<td>Programs</td>
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<td>---------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Moffat</td>
<td>Craig</td>
<td>Northwest Colorado Community Health Center</td>
<td>Ms. Gisela Garrison, Clinic Director</td>
<td>970-824-8233</td>
<td><a href="http://www.nwcovna.org">www.nwcovna.org</a></td>
<td>745 Russell St</td>
<td>Moffat County Care Clinic provides basic health care, urgent care, wellness exams and diabetes screening and treatment. Care is provided to uninsured people regardless of immigrant status. Moffat County Care Clinic currently serves all of Moffat County as well as Hayden, Baggs, and Meeker. Referrals will be made to other providers if the care needed is not within the clinic’s scope.</td>
</tr>
</tbody>
</table>
Mental Health
Yampa Valley Medical Center
COMMUNITY HEALTH NEEDS ASSESSMENT

Center for Health Administration
University of Colorado Denver
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MENTAL HEALTH

OVERVIEW

Successful mental function leads to a productive life, meaningful relationships, positive contributions to society, and the ability to navigate changing circumstances. Mental disorders are frequently characterized by altered thinking and moods, and/or behaviors that lead to reduced functioning and/or emotional distress.1

Mental disorders are the leading causes of disability in the United States. Twenty five percent of all years that are lost to disability or premature death are due to mental disorders.2

Suicide is the eleventh leading cause of death in the United States, and is responsible for approximately 30,000 deaths a year.3 4 “Colorado consistently ranks in the top 10 states in terms of suicide rate. More Coloradans die by suicide than from illnesses such as diabetes, pneumonia or breast cancer. Suicide is the second-leading cause of death for youth (ages 10-14) in Colorado. In addition, nearly one out of every 13 Colorado youth report attempting suicide in the past year.”5

Most people in Colorado who died by suicide were suffering from depression at the time of death. Depression is a treatable mental health illness, and interventions to treat depression can in turn reduce suicide rates.6

In 2008, 7% of all adults in Colorado reported suffering from depression.6

Mental health and physical health are interrelated. If a person is feeling depressed, he/she is less likely to engage in physical activities that promote good health. In turn, if a person’s mobility is restricted due to illness or disease, he/she can be prone to feelings of hopelessness or despair, thus inhibiting their participation in recovery.7

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3 Centers for Disease Control and Prevention (CDC), National Center for Injury Prevention and Control (NCIP). Web-based injury statistics query and reporting system (WISQARS) [Internet]. Atlanta: CDC; 2010.
6 Ibid.
The development of mental, emotional and behavioral (MEB) disorders can be quite complex and involve a variety of factors. Prevention and treatment usually requires approaches that are varied and involve addressing many contributing factors.

Mental health research has made great strides in 1) identifying risk factors that contribute to the development of mental illness, and 2) determining protective factors that protect people from developing mental disorders. A few of research’s most significant findings focus on youth and include the following:

- Mental, emotional and behavioral (MEB) disorders are fairly common and usually begin early in life.
- Prevention is most effective in young people.
- School based interventions that focus on improving emotional and behavioral status can positively affect academic performance.\(^8\)

Even though an estimated 60% of all people with a mental disorder do not receive treatment, the use of mental health services is higher now than in the previous decade due to more primary care physicians providing psychiatric services. In fact, people who seek treatment for mental health disorders were more likely to receive it from primary care physicians/nurses or other general medical doctors (23%) than mental health specialists, such as psychologists, social workers or counselors (16%) or psychiatrists (12%). Spiritual advisors and self-help groups treat another 10% each. People with the greatest unmet need for mental health treatment were those with low incomes or no insurance, the elderly and racial/ethnic minorities.\(^9\)

---

MENTAL HEALTH NOT GOOD IN LAST 30 DAYS

**BRFSS Survey Question:** For how many days during the past thirty days was your mental health not good?

**SHORT TERM**

Counties reporting higher rates for poor mental health in the short term tend to have higher education and income levels, as well as higher housing costs. On the other hand, these same counties do not report many long-term mental health issues, as shown in Figure 2 on the following page. Perhaps the ability to access helpful resources enables this group to successfully navigate short-term crises and prevent them from becoming long-term problems.

For people reporting poor mental health for the short-term, or 1-7 days in the past 30 days, Routt County had rates exceeding the state average, while Moffat County was less than the state average.

---

**Figure 1 Mental Health Not Good for 1-7 Days in Last Month**

<table>
<thead>
<tr>
<th></th>
<th>Average 2003-2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>State</td>
<td>22.4</td>
</tr>
<tr>
<td>Moffat</td>
<td>16.9</td>
</tr>
<tr>
<td>Routt</td>
<td>23.6</td>
</tr>
</tbody>
</table>

---

LONG TERM

People reporting negative mental health status on a longer term basis, or 8 or more days in the past month, were more likely to come from counties that had higher unemployment, higher poverty levels and lower median household incomes. Education levels were low in these counties, too. Many of these counties also had a larger percentage of people claiming Hispanic or Latino heritage.

Moffat County residents reported a higher average rate of long term mental distress compared to those in Routt County, with Routt County’s rate better than the state average.

Figure 2: Mental Health Not Good for 8 or More Days in Last Month

**Figure 2.** Mental Health Not Good for 8 or More Days in Last Month

DEMOGRAPHIC DESCRIPTION

Females report poor mental health more frequently than males. People who have never married report negative mental health status in the short term more frequently than other groups, while being married or part of a couple seems to contribute to a more positive longer term mental health status. Differences among those of different races and ethnicity were not statistically significant.

Figure 3 Mental Health Not Good by Gender

Figure 4 Mental Health Not Good by Marital Status

---


13 Ibid.
One of the most consistent predictors of mental health status is age. The most significant data in the accompanying chart is that only a small percentage of people age 65 and older report negative mental health in the long term. Further, only a small percentage of people age 55 and older have negative mental health in the short term. In other words, most older people report good mental health for both short and long term.

---

Figure 5 Mental Health Not Good by Age

Higher education levels lead to improvements in long term mental health status, but were not significant for the short term. Income levels under $25,000 were significant for poor mental health in the short term, while no income differences were significant for long term mental health.

Figure 6 Mental Health Not Good by Education

Figure 7 Mental Health Not Good by Income

---

16 Ibid.
DEPRESSION

“Depression is the most common mental disorder....Depression is more than just sadness. People with depression may experience a lack of interest and pleasure in daily activities, significant weight loss or gain, insomnia or excessive sleeping, lack of energy, inability to concentrate, feelings of worthlessness or excessive guilt and recurrent thoughts of death or suicide.... Depression is a real illness and carries with it a high cost in terms of relationship problems, family suffering, and lost work productivity.”

Depression can also lead to suicide. In fact, half of those who die by suicide in the nation were experiencing major depression prior to their death. The suicide rate for people with major depression is eight times the rate of the general population.

The 2008 depression rate in Colorado among adults was 7% of the population. The Colorado Winnable Battles goal for 2016 is 5% of the adult population.

Fortunately, depression can be treated successfully with psychotherapy, coping and cognitive-behavioral techniques, and medication. Exercise has also been proven to be a cost-effective and successful method for treating depression. An interesting side note is that even though reducing social isolation helps treat depression, spending too much time talking about problems with friends can actually make depression worse.

19 American Psychological Association.
20 Ibid.
21 Ibid.
DEMOGRAPHIC CHARACTERISTICS OF COLORADO RESIDENTS WITH DEPRESSION

Depression rates for those below 150% Federal Poverty Level are higher at 12.8% compared to the general population at 7%.

**Depression Rates by Federal Poverty Level, 2008**

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Lower Limit</th>
<th>Upper Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;150% FPL</td>
<td>12.8</td>
<td>9.1</td>
</tr>
<tr>
<td>=150% FPL</td>
<td>5.4</td>
<td>4.5</td>
</tr>
<tr>
<td>All</td>
<td>7.0</td>
<td>6.0</td>
</tr>
</tbody>
</table>

**Figure 8 Depression Rates by Federal Poverty Level, 2008**

Whites have a significantly lower rate of depression compared to Hispanics. Seniors over 65 years of age also have a significantly lower rate of depression at 3.4% compared to the adult population at 7%. (Depression rates are not significantly different 1) between genders, 2) among different races and ethnic groups, or 3) across Colorado regions.)

**Depression Rates by Race/Ethnicity 2008**

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Lower Limit</th>
<th>Upper Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>White, Non-Hispanic</td>
<td>5.9</td>
<td>4.9</td>
</tr>
<tr>
<td>Black, Non-Hispanic</td>
<td>9.9</td>
<td>3.2</td>
</tr>
<tr>
<td>Hispanic</td>
<td>10.7</td>
<td>7.1</td>
</tr>
<tr>
<td>Other</td>
<td>14.6</td>
<td>5.4</td>
</tr>
<tr>
<td>All</td>
<td>7.0</td>
<td>6.0</td>
</tr>
</tbody>
</table>

**Figure 9 Depression Rates by Race/Ethnicity**

---

23 Ibid.
MENTAL HEALTH STATUS OF YOUTH

The National Institute of Mental Health (NIMH) states that half of all lifetime cases of mental illness begin by age 14, and three quarters of all cases start by age 24. Anxiety disorders typically begin by late childhood, mood disorders by late adolescence, and substance abuse problems by the early twenties. Females are more likely to experience anxiety and mood disorders, while males experience more substance abuse problems.24

Despite the availability of successful treatments, there are often long delays — sometimes decades — between the initial onset of symptoms and when people seek and receive treatment. Research indicates that untreated mental disorders in youth can lead to more severe, more difficult to treat illnesses in adulthood, and to the development of secondary mental illnesses.25

FELT SAD OR HELPLESS

YRBS Survey Question: During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?

About 25% of all Colorado high school students felt so sad or hopeless every day for two or more weeks in a row during the past year (for 2005 and 2009) that they stopped doing some usual activities.26 Differences among high school grades were not significant.

CONSIDERED SUICIDE

YRBS Survey Question: During the past 12 months, did you ever seriously consider attempting suicide?

Almost 14% of high school students in Colorado seriously considered suicide one or more times in the past twelve months for both 2005 and 2009.27 Differences among high school grades were not significant.

25 Ibid.
27 Ibid.
**ATTEMPTED SUICIDE**

YRBS Survey Question: *During the past 12 months, how many times did you actually attempt suicide?*

Almost 8% of all high school students attempted suicide in the past 12 months in 2009. The Colorado Winnable Battles Goal is 5% of high school students attempting suicide in the past 12 months. No significant differences were noted among the high school grades.

Among Colorado teenagers who died by suicide, almost half of them experienced a personal crisis within two weeks prior to death. The crises typically involved conflicts in intimate relationships, disciplinary problems, and other life stressors. These teens were more likely to abuse substances, be aggressive in relationships, demonstrate antisocial behavior, and be depressed.²⁸

---

COLORADO SUICIDE RATE COMPARED TO OTHER STATES

Colorado’s suicide rate is significantly higher at 16.5 per 100,000 persons than the national average of 11 deaths per 100,000 persons. In the chart below, Colorado ranked sixth in the nation for suicide deaths when examining the average rates for 2001-2005. The highest rates for suicide are concentrated in the western states and are not unique to Colorado.31

![Suicide Rates: Highest Ten States and Lowest Five States](chart)

---

32 Colorado Office of Suicide Prevention, Colorado Department of Health and Environment.
Suicide mortality rates are higher in Colorado than in the nation for people 18 years and older. Both Moffat and Routt Counties have rates higher than the HP 2020 goal and state rate. (Moffat County had weak data.)
RISK FACTORS FOR SUICIDE

Within Colorado, three factors are strongly associated with higher suicide rates:

- higher levels of unemployment,
- higher proportions of people living in social isolation, and
- a lower percentage of Hispanic populations, whose cultural norms are more apt to discourage suicide.34

In Colorado, suicide risk is strongly correlated with depression, other mental disorders and substance abuse. Other facts are as follows.

- Among 20-24 year olds, 45% of suicides showed evidence of a problem with an intimate partner prior to death.
- Approximately 70% of young and middle-aged people were depressed prior to committing suicide.
- Most men ages 25-54 had a problem with alcohol and had not sought professional help prior to suicide.35

SOCIODEMOGRAPHIC VARIABLES FOR SUICIDE

Suicide is frequently associated with a mix of sociodemographic variables, which include cultural, situational, and social factors. The table below lists these factors, as well as at risk subpopulations.36

<table>
<thead>
<tr>
<th>Sociodemographic Variables for Suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
</tr>
<tr>
<td>Age</td>
</tr>
<tr>
<td>Social status</td>
</tr>
<tr>
<td>Educational status</td>
</tr>
<tr>
<td>Marital status</td>
</tr>
<tr>
<td>Residential status</td>
</tr>
<tr>
<td>Employment status</td>
</tr>
<tr>
<td>Economic status</td>
</tr>
<tr>
<td>Profession</td>
</tr>
<tr>
<td>Special subpopulations</td>
</tr>
</tbody>
</table>

35 Ibid.
Other demographic variables listed by the Colorado Department of Health and Environment include White/non-Hispanic race, military veterans, and individuals who are lesbian, gay, bisexual or transgendered. Contributing factors for suicide among older people are physical problems, isolation, and friends and family members dying. Veterans struggling with post-traumatic stress disorder, traumatic brain injuries and/or substance abuse are at risk for suicide. Sexual minority youth and adults are at a higher risk of suicide than heterosexuals. In one youth survey, 44% of sexual minority respondents reported attempting suicide compared to 13.5% among their heterosexual peers.37

### PSYCHOLOGICAL AND BIOLOGICAL INFLUENCES ON SUICIDE RATES

Psychological and biological influences on suicide rates are listed below.38

<table>
<thead>
<tr>
<th>Psychological and Biological Influences on Suicide Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family history</strong></td>
</tr>
<tr>
<td><strong>Mental disorders</strong></td>
</tr>
<tr>
<td><strong>Contact with psychiatric services</strong></td>
</tr>
<tr>
<td><strong>Psychiatric symptoms</strong></td>
</tr>
<tr>
<td><strong>Suicidal behavior</strong></td>
</tr>
<tr>
<td><strong>Physical health</strong></td>
</tr>
<tr>
<td><strong>Availability of suicide methods</strong></td>
</tr>
</tbody>
</table>

Suicide can be prevented with appropriate interventions that include: recognizing signs of depression, treating depression with medications, and fostering supportive social relationships.39

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38 Longvist.
39 Ibid.
RELATIONSHIP BETWEEN SUBSTANCE ABUSE AND MENTAL ILLNESS

Many people with serious substance abuse issues also struggle with underlying mental illness. The most common serious mental disorders associated with chronic substance abuse include “schizophrenia, bipolar disorder, manic depression, attention deficit hyperactivity disorder (ADHD), generalized anxiety disorder, obsessive-compulsive disorder, post-traumatic stress disorder, panic disorder and antisocial personality disorder.”40 Some people take drugs to alleviate symptoms of mental disorders (self-medicating), while others develop mental illness as a result of drugs (ecstasy leads to depression and anxiety). Further, chronic drug abuse during adolescence can interfere with learning normal socialization behaviors and cognitive development, and ultimately lead to serious mental disorders.41

MENTAL HEALTH PROFESSIONAL SHORTAGE AREAS

Mental Health Professional Shortage Areas (HPSA) in Yampa Valley Medical Center’s market of interest includes Summit County. All other counties in Yampa Valley Medical Center’s area of interest are not designated as Mental HPSAs. However, even in these areas, people without health insurance, with low incomes, or language barriers can have difficulty accessing mental health care.42

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41 Ibid.
INTERVENTIONS

“Statewide organizations, networks and advocacy groups have actively promoted suicide prevention in Colorado. Mental Health America of Colorado has provided technical assistance to communities that are developing suicide prevention programs and initially sponsored the Suicide Prevention Coalition of Colorado. The Pueblo Suicide Prevention Center provides statewide suicide prevention, intervention and postvention services in response to calls to the 1-800-273-TALK and 1-800-SUICIDE national hotlines. Foundations and federal agencies also have provided vital funding and technical assistance for suicide prevention efforts in Colorado. For example:

• The Western Colorado Suicide Prevention Foundation, based in Grand Junction, has funded a range of suicide prevention programs and activities in six Western Slope counties.

• Colorado is one of 17 states that has been awarded funding from the Centers for Disease Control and Prevention to develop the National Violent Death Reporting System, which provides a clearer picture of suicide death characteristics and trends (e.g., methods used, locale and precipitating events or circumstances).

• With the support of three-year grants from the federal Substance Abuse and Mental Health Services Administration (SAMHSA), Denver’s Regis University and Trinidad State Junior College in southern Colorado are working to enhance services for students with mental health or substance abuse problems that place them at risk of suicide.

• Colorado is one of more than 30 states receiving funding from SAMHSA to implement suicide prevention programs to youth statewide.

• The Colorado Trust’s $4.1 million Preventing Suicide in Colorado initiative has supported a variety of activities in 31 of the state’s 64 counties over the past six years – from community suicide prevention training; to partnership and capacity building; to outreach, counseling and therapy programs.

Colorado enters its second decade of suicide prevention efforts with a major asset: a growing infrastructure of collaborative, community-based suicide prevention programs and services. A sampling of the numerous suicide prevention efforts within Colorado are listed below. Though not a full listing, the following programs provide examples of the types of strategies recommended by stakeholders in the process of developing this plan as important to suicide prevention efforts in the next decade.
A focus on subpopulations at high risk for suicide: Civilians for Veterans
Campaign Colorado former First Lady Jeannie Ritter headed a campaign aimed at expanding access to mental health services for military veterans living in rural areas of the state. The Civilians for Veterans campaign, launched in July 2008 with a $50,000 grant from the Firefly Fund, is a collaborative effort of several mental health groups, the Colorado Behavioral Healthcare Council and the U.S. Department of Veterans Affairs. The campaign will raise money to support the extension of existing VA services into rural areas, focusing initially on the San Luis Valley, Montrose County, La Junta and Lamar.

A focus on culturally-competent suicide prevention: Voz y Corazón Latina teens are at higher risk of suicide attempt than other teens. Important efforts have been made to address this suicide behavior using a culturally-competent approach. This program, established under the auspices of the Mental Health Center of Denver, was designed by Latina leaders and teens to help Latina teens develop healthy identities through suicide prevention trainings. A key component of the program is regularly scheduled mentoring and art groups that result in an annual Art Gallery of works illustrating creative expression of the lives, emotions and hopes of the Latina teenagers.

A focus on integration of primary health and mental health care: Northern Colorado Health Alliance (NCHA) NCHA, which serves low-income residents in Weld County, is an example of integrated physical and mental health care. This partnership of a behavioral health center, primary care clinics and a hospital system is structured so that an individual who enters the project from any “door” can easily access the services of other partner providers. Fundamental to integrated care is co-location of physical and mental services as well as staff trained to work collaboratively across health sectors. A medical chart system that includes information and treatment for both physical and mental health care practitioners is under development.

A focus on cross-system suicide prevention: Project Safety Net. Project Safety Net, coordinated by the Office of Suicide Prevention at the Colorado Department of Public Health and Environment, is a three-year initiative launched in October 2006 that involves five counties, the University of Colorado at Boulder and the Suicide Prevention Coalition of Colorado (SPCC). The goal is to build a safety net for adolescents and young adults who are at a heightened risk for suicidal behavior.

In the five counties (El Paso, Larimer, Mesa, Pueblo and Weld), adults working with adolescents ages 15-18 in the juvenile justice and child welfare systems, and the adolescents’ parents or caregivers, are receiving suicide intervention and referral skills training. At the University of Colorado, similar training is offered to faculty, athletic department staff, resident advisors, Greek system representatives and others who work with students.

Project partners are working together to create and disseminate cross-system referral protocols for care and treatment of suicidal individuals and reach out to potential suicide interveners through campus and community awareness campaigns.

A focus on community-based comprehensive efforts: Reaching Everyone Preventing Suicide (REPS) Suicide prevention stakeholders in Moffat and Routt counties joined forces in April 2004 to create Reaching Everyone Preventing Suicide. As one project among a number of community based comprehensive projects that received
support from The Colorado Trust’s Preventing Suicide in Colorado initiative, this comprehensive program includes education and training of residents in the Yampa Valley and screening, risk assessment, referral to mental health services, emergency and ongoing treatment for individuals at-risk of suicide and their families. Postvention services to families and friends of individuals who have completed suicide are also provided as a component of the comprehensive effort toward suicide prevention.

**A focus on increased mental health treatment: Second Wind Fund**  
The Second Wind Fund was established by Green Mountain Presbyterian Church following the suicide deaths of four Jefferson County high school students during the 2001-02 school year. Its goal is to decrease the incidence of teen suicide by removing financial and social barriers to treatment for at-risk youth. Over the past several years, the Second Wind Fund has raised more than $600,000 through its annual Walk/Run/Ride event, which drew nearly 3,000 participants in 2008. The money is used to subsidize professional therapy (up to 20 sessions) for economically disadvantaged high school students who are identified as at least moderately at risk for suicide. Referrals are initiated by school counselors or administrators, with the involvement and consent of a student’s parents. Since 2003, the program has served more than 1,200 students in Adams, Arapahoe, Boulder, Denver, Douglas, Jefferson and Park counties. Students can choose from a list of 60 state-licensed therapists who have experience with teens at risk for suicide, and who have agreed to see Second Wind clients at a reduced hourly rate.

**A focus on education of Colorado’s media: Suicide Prevention Coalition of Colorado’s Annual Media Award**  
In 2008, the Suicide Prevention Coalition of Colorado honored Denver television station KUSA-Channel 9 for its commitment to promoting mental health and preventing suicide. Over the past two years, KUSA has broadcast dozens of pieces focusing on salient issues in the field, ranging from the suicide risk among combat veterans, the elderly and other vulnerable populations, to the connection between incarceration and mental health. The Suicide Prevention Coalition of Colorado also cited KUSA for promoting National Depression Screening Day, sponsoring a suicide prevention helpline, and offering free mental health screenings as part of its 9Health Fair program, which reaches more than 87,000 Coloradans in 165 communities each year. In spring 2008, KUSA co-sponsored and provided coverage of Mirrors and Metaphors: Reflections on Suicide, Mental Health and Healing, a month-long art exhibit at Access Gallery in west Denver.

**Promising and evidence-based strategies**

Colorado suicide prevention stakeholders now have the benefit of a national registry of strategies with evidence or promise of effectiveness. These programs are classified as evidence-based (either effective or promising) by the Suicide Prevention Resource Center and the American Foundation of Suicide Prevention, and include: community-based, emergency-room, primary care, school-based health clinics and service delivery programs.
Information about these programs may be accessed at www.sprc.org/bpr/ebpp.asp#list."43

The American Foundation for Suicide Prevention is working in partnerships with other entities to find new and improved methods to prevent suicide. One of its key goals is to disseminate information about best practices to interested community groups throughout the country. The most current projects listed on its web-site are the following.

• “The Interactive Screening Program, which has developed and pilot-tested an interactive, web-based method of reaching out to students at risk of suicide, and encouraging them to get help.

• The Physician Depression and Suicide Prevention Project, which works with a range of other groups and professional organizations to address the disproportionately high rates of suicide among physicians and physicians in training.

• The International Project on National Suicide Prevention Strategies, which is bringing together experts from around the world to examine and evaluate individual countries' strategies for suicide prevention, and to encourage replication of evidence-based projects and approaches.

• The Media Project, which encourages responsible reporting of suicide by news media.

• The Hungarian Suicide Prevention Project, which has provided training about identifying and treating patient depression to physicians and other clinicians in a region of Hungary with an extremely high suicide rate.

• The Suicide Data Bank, which has collaborated with therapists who lost a patient to suicide, to improve recognition of suicide risk and treatment of seriously suicidal individuals.

• The LGBT Depression and Suicide Prevention Project, an initiative aimed at reducing suicide among lesbian, gay, bisexual and transgender populations.

• The Billboard Campaign looks to educate Americans about the serious nature of depression, and to urge those clinically depressed to see their doctor.”44

A Systematic Review (of) Suicide Prevention Strategies in the Journal of the American Medical Association noted two of the most effective methods in reducing suicide rates: 1) physician education in depression recognition and treatment, and 2) restricting access to lethal means and devices.45 These conclusions reinforce the need to support primary care providers in their efforts to screen and treat those at risk for suicide.

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Other resources include the following programs and organizations:
- Substance Abuse and Mental Health Services: http://www.samhsa.gov/prevention/
- Office of Suicide Prevention, http://www.cdphe.state.co.us/pp/suicide/

RESOURCE INVENTORY

See Resource Inventory at the end of Substance Abuse for a combined Substance Abuse/Mental Health Resource Inventory.
Obesity, Nutrition, and Physical Activity
Yampa Valley Medical Center
COMMUNITY HEALTH NEEDS ASSESSMENT
Center for Health Administration
University of Colorado Denver
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OVERWEIGHT AND OBESEITY

OVERVIEW

Overweight and obesity are both labels for ranges of weight that are greater than what is generally considered healthy for a given height. The terms also identify ranges of weight that have been shown to increase the likelihood of certain diseases and other health problems.

For adults, overweight and obesity ranges are determined by using weight and height to calculate a number called the "body mass index" (BMI). BMI is used because, for most people, it correlates with their amount of body fat. BMI is calculated as weight in kilograms divided by height in meters squared.

An adult who has a BMI between 25 and 29.9 is considered overweight. An adult who has a BMI of 30 or higher is considered obese.

It is important to remember that although BMI correlates with the amount of body fat, BMI does not directly measure body fat. As a result, some people, such as athletes, may have a BMI that identifies them as overweight even though they do not have excess body fat.

For children and teens, BMI ranges above a normal weight have different labels. Additionally, BMI ranges for children and teens are defined so that they take into account normal differences in body fat between boys and girls and differences in body fat at various ages.

<table>
<thead>
<tr>
<th>BMI Category</th>
<th>BMI Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight</td>
<td>Less than 5th percentile</td>
</tr>
<tr>
<td>Healthy Weight</td>
<td>5th through 84th percentile</td>
</tr>
<tr>
<td>Overweight</td>
<td>85th through 94th percentile</td>
</tr>
<tr>
<td>Obese</td>
<td>95th percentile or greater</td>
</tr>
</tbody>
</table>

There are two major surveys conducted in the United States that report adult obesity prevalence: the National Health and Nutrition Examination Survey (NHANES) and the Behavioral Risk Factor Surveillance System (BRFSS). The Centers for Disease Control oversees both surveys. NHANES reports national data only, and uses direct measurements of height and weight to calculate obesity. In other words, a survey worker actually visits the home and measures the respondent’s height and weight. BRFSS reports national data and state data. Each state then chooses whether or not to collect enough data to report results on a county level basis. Height and weight measurements are self-reported in the BRFSS survey.

1 Centers for Disease Control, http://www.cdc.gov/obesity/defining.html
Obesity prevalence rates reported by the NHANES survey and BRFSS survey are not comparable due to the differences in data collection.\(^2\) It has been found that when survey participants are asked to report their own height and weight, they often give inaccurate estimates. Care must be taken not to compare data between the two surveys. The NHANES survey was used by the CDC to set the Healthy People 2020 Obesity goals. Colorado data is not comparable to Healthy People 2020 obesity goals.

### CAUSES

Overweight or obesity is caused by consuming more calories than are expended. The United States has seen two general behavioral trends that have had an effect on overweight and obesity within the population: 1) a shift in diet toward energy-dense foods high in fat and sugars but low in vitamins and micronutrients, and 2) decreased physical activity due, in part, to changes in both workplace behaviors and modes of transportation.\(^3\) Compounding these behavioral trends of unhealthy dietary habits and sedentary lifestyles are other environmental, cultural and socioeconomic factors. For example, processed convenience foods have high amounts of sugar, fat and salt, and are easily accessible and inexpensive. Also, Americans spend most of their time engaged in behaviors that expend very little energy.\(^4\)

Because weight is influenced by energy (calories) consumed and expended, interventions to improve weight can support changes in diet or physical activity.\(^5\) They can help change individuals' knowledge and skills, reduce exposure to foods low in nutritional value and high in calories, or increase opportunities for physical activity. Interventions can help prevent unhealthy weight gain or facilitate weight loss among obese people. They can be delivered in multiple settings, including health care settings, worksites, or schools.

### CO-EXISTING CHRONIC CONDITIONS

Research has shown that as weight increases to reach the levels referred to as "overweight" and "obesity," the risks for the following conditions also increases.\(^6\)

- Coronary heart disease
- Type 2 diabetes
- Cancers (endometrial, breast, and colon)
- Hypertension (high blood pressure)
- Dyslipidemia (for example, high total cholesterol or high levels of triglycerides)

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\(^{1}\) National Institutes of Health, [http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1557888/](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1557888/)


\(^{3}\) Ibid.


• Stroke
• Liver and Gallbladder disease
• Sleep apnea and respiratory problems
• Osteoarthritis (a degeneration of cartilage and its underlying bone within a joint)
• Gynecological problems (abnormal menses, infertility)

**ECONOMIC COSTS OF OBESITY**

In Colorado, medical spending attributable to obesity was estimated at $874 million dollars in 2003, with $139 million in Medicare costs and $158 million in Medicaid costs. These estimates for Colorado likely underestimate the true costs of overweight and obesity because they do not include the indirect costs of obesity or the direct or indirect costs of overweight.

**SOCIAL DETERMINANTS OF OBESITY**

Certain groups at high-risk for obesity have been identified by the Colorado Department of Public Health:

- Adults ages 45–64 years
- Non-Hispanic blacks
- Hispanics
- Adults who are non-high school graduates
- Southeast Colorado residents

**OBESITY GOALS**

Reducing obesity has been identified as one of Colorado’s greatest opportunities for ensuring the health of citizens and has been selected as a top ten “Winnable Battle” by the Colorado Department of Public Health and Environment. In January, 2012, CDPHE released three obesity goals for 2016:

- Decrease the percentage of Colorado high school students who are overweight or obese to 17 percent.
- Decrease the percentage of Colorado children aged 2-14 years who are overweight or obese to 20 percent.

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8 Ibid.
9 [http://www.cdphe.state.co.us/hs/winnableBattles/obesity.html](http://www.cdphe.state.co.us/hs/winnableBattles/obesity.html)
• Decrease the percentage of Colorado adults who are overweight or obese to 50 percent.

The most recent review of overweight and obesity conducted by the Colorado Department of Public Health is a report titled, *The Weight of the State: 2009 Report on Overweight and Obesity in Colorado*[^10], which served as a model for this report.

ADULT OVERWEIGHT AND OBESITY

**BRFSS Survey Question:** Based on body mass index, are you overweight or obese?

Routt County has a combined overweight and obesity prevalence rate that is lower than the State and is meeting the 2016 Colorado Winnable Battle Goal. Moffat County has an overweight and obesity prevalence rate higher than both the State and the Colorado Winnable Battle Goal.

**Figure 1: Overweight and Obese Adults**

![Overweight and Obese Adults Chart](chart.png)

**Figure 1: Overweight and Obese Adults**

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ADULT OVERWEIGHT AND OBESITY DEMOGRAPHICS

Demographic factors impacting obesity follow the same general patterns in Colorado as the Nation overall.\(^\text{12}\) Obesity prevalence is approximately the same in females and males overall. Males have a significantly greater prevalence of overweight than females. An analysis of 2008 obesity rates demonstrated a significantly lower prevalence of obesity in adult females than adult males within the income group of $50,000 or more.\(^\text{13}\)

![Overweight and Obese Adults by Gender]\(^\text{14}\)

Adults aged 18-24 have significantly lower overweight prevalence than all other age groups. Adults aged 24-34 have significantly higher overweight prevalence than the younger age group, but significantly lower than older age groups. There is no significant difference in overweight prevalence in adults 35 and over. Adults aged 45-64 have a significantly higher prevalence of obesity than other age groups. 18-24 year olds have a significantly lower prevalence of obesity than all other age groups.

![Overweight and Obese Adults by Age]\(^\text{15}\)


\(^{13}\) Ibid.

\(^{14}\) Chart Source: Behavioral Risk Factor Surveillance System, Colorado Department of Public Health and Environment.

\(^{15}\) Ibid.
There were no significant differences in overweight adults by racial/ethnic groups. Non-Hispanic White adults had a significantly lower obesity prevalence compared with non-Hispanic Black or Hispanic adults. The “other” race category combined several races such as Asian, Pacific Islander, American Indian and Alaskan Native. Obesity prevalence for the “other” race did not differ significantly from other groups.

Colorado adults with at least some college education had a significantly lower prevalence of obesity than adults with lower levels of education. There were no significant differences in overweight by education.

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Overall, the prevalence of overweight and the prevalence of obesity did not vary significantly between income groups in 2009/2010.

Figure 6: Overweight and Obese Adults by Income

A recent analysis completed by the Colorado Department of Public Health shows a higher percentage of overweight and obese adults are below 150% of the federal poverty level. However, these differences are not statistically significant.

CDPHE has completed further demographic analysis that has identified the following groups at high risk for obesity:

- Adults ages 45–64 years (39 percent overweight, 22.8 percent obese)
- Non-Hispanic blacks (36.8 percent overweight, 26.6 percent obese)
- Hispanics (40.8 percent overweight, 25.5 percent obese)
- Adults who are non-high school graduates (37.9 percent overweight, 22.1 percent obese)
- Southeast Colorado residents (26 percent overweight, 27 percent obese)

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Colorado is the only state with obesity prevalence rates under 20% as of 2010.\textsuperscript{21} Compared to the 2007-2009 obesity prevalence rate of 19.1%, Colorado saw a significant increase to 19.8% for the combined years of 2008-2010. During the same time period, sixteen states saw a significant increase in obesity. No state experienced a significant decrease in obesity.

While Colorado has a lower prevalence of obese adults than the nation, rates continue to increase at a similar pace to the rest of the country. From 1995 through 2008, obesity in Colorado increased 89%.\textsuperscript{23} The prevalence of overweight has remained steady in both the Nation and State.

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{obesity_map.png}
\caption{Obese Adults by State\textsuperscript{24}}
\end{figure}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{obesity_trends.png}
\caption{Adult Overweight and Obese Trends\textsuperscript{24}}
\end{figure}

\textsuperscript{21} \textit{F as in Fat: How Obesity Threatens America’s Future} 2011, Trust for America’s Health and Robert Wood Johnson Foundation (Data Source: Behavioral Risk Factor Surveillance System, 2008-2010 Combined Data)
\textsuperscript{22} Ibid.
\textsuperscript{23} Colorado Physical Activity and Nutrition Program, \textit{The Weight of the State: 2009 Report on Overweight and Obesity} (Denver: Colorado Department of Public Health and Environment, 2009.)
\textsuperscript{24} Chart Source: Behavioral Risk Factor Surveillance System, Colorado Department of Public Health and Environment. For State and County data, two years of data are combined. National data averages single years, 2004, 2006, 2008, 2010 as reported by CDC BRFSS.
YOUTH OVERWEIGHT AND OBESITY

**YRBS Survey: Percentage of students who were obese (i.e., at or above the 95th percentile for body mass index, by age and sex)**

There were no significant differences in the prevalence of overweight or obesity between grades in Colorado high-school students. Males and females had a similar prevalence of both overweight and obesity. Colorado does not report county or health statistic region data for youths.

![Figure 10: Overweight and Obese Youths](image)

**YOUTH OBESITY TRENDS**

The prevalence of obesity among adolescents has increased similar to the prevalence in the adult population. Colorado data is reported differently from year to year during this time period and cannot be compared.

![Figure 11: Youth Obese Trends](image)

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27 Chart Source: Youth Risk Behavior Surveillance System, Centers for Disease Control.
The prevalence of overweight and obesity among children in the United States has increased similar to the prevalence in the adult population.\textsuperscript{29}

According to CDPHE\textsuperscript{30}, overweight and obesity trends from 2004 to 2008 have remained stable for children ages 2-14, but “it is not possible to determine if childhood obesity trends follow national trends. In other words, the obesity prevalence might or might not have increased since the 1980s or 1990s.” This is due to a lack of historical data.

HSR 11 has overweight and obesity prevalence rates slightly below the state, but above the Colorado 2016 goal of 20%. Routt and Moffat County data is not available.

\textsuperscript{28} Chart Source: CDPHE, Colorado Child Health Survey, Combined Years 2007-2009.
\textsuperscript{29} Colorado Physical Activity and Nutrition Program, The Weight of the State: 2009 Report on Overweight and Obesity (Denver: Colorado Department of Public Health and Environment, 2009.)
\textsuperscript{30} Ibid
CHILDHOOD OVERWEIGHT AND OBESITY DEMOGRAPHICS

Overweight and Obese Children by Parent Reported Race/Ethnicity
Colorado 2006-2008

In 2008, approximately the same percentage of children in each age group was overweight and obese. The prevalence of obesity among non-Hispanic White children was significantly lower than the prevalence for non-Hispanic Black children during the combined years 2006-2008. Asian children also had lower obesity prevalence than Hispanic children. The obesity prevalence for children who were non-Hispanic Black, Hispanic or other race/ethnicity was not significantly different. The prevalence of overweight across race/ethnicity groups was not significantly different.

Overweight and Obese Children by Federal Poverty Level
Colorado 2008-2010

A more recent CDPHE analysis examined rates by federal poverty levels. Children living at less than 150% of the federal poverty level have significantly higher rates of overweight and obesity.

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32 http://www.chd.dphe.state.co.us/Winnables/winnables_results.aspx?winID=7&Year=&subWinID=21&race_code=18  Colorado Child Health Survey, CPHHE
The key to achieving and maintaining a healthy weight isn't about short-term dietary changes. It's about a lifestyle that includes healthy eating, regular physical activity, and balancing the number of calories consumed with the number of calories the body uses.\(^{33}\)

A healthy lifestyle involves many choices. Among them, choosing a balanced diet or eating plan. According to the Dietary Guidelines for Americans, a healthy eating plan:\(^{34}\)

- Emphasizes fruits, vegetables, whole grains, and fat-free or low-fat milk and milk products
- Includes lean meats, poultry, fish, beans, eggs, and nuts
- Is low in saturated fats, trans fats, cholesterol, salt (sodium), and added sugars
- Stays within your daily calorie needs

Good nutrition is important to the growth and development of children. A healthful diet also helps Americans reduce their risks for many health conditions, including:\(^{35}\)

- Overweight and obesity
- Malnutrition
- Iron-deficiency anemia
- Heart disease
- High blood pressure
- Dyslipidemia (poor lipid profiles)
- Type 2 diabetes
- Osteoporosis
- Oral disease
- Constipation
- Diverticular disease
- Some cancers

Demographic characteristics of those with a more healthful diet vary with the nutrient or food studied. However, most Americans need to improve some aspect of their diet.\(^{36,37}\)

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Social factors thought to influence diet include:38

- Knowledge and attitudes
- Skills
- Social support
- Societal and cultural norms
- Food and agricultural policies
- Food assistance programs
- Economic price systems

The Centers for Disease Control has historically recommended five servings of fruit and vegetables per day, and data on fruit and vegetable consumption is reported relevant to these recommendations. Recently, however, the CDC has moved toward individualized fruit and vegetable recommendations based on age, gender, and level of physical activity.39
ADULT FRUIT AND VEGETABLE CONSUMPTION

BRFSS Survey Question: What is your average frequency of fruit and vegetable consumption per day?

The prevalence of adults eating the recommended amount of fruits and vegetables is slightly higher in Colorado than the Nation.

Adults in Routt County consume more fruits and vegetables than Colorado overall; however, they still fall well short of the Healthy People 2010 goal of 75%. The HP 2010 goal has been adopted by Colorado as the state goal.40

Healthy People 2020 Fruit and Vegetable Goals are not comparable to this data.

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40 http://www.cdphe.state.co.us/pp/COPAN/5-a-day/5ADAYCoalition.html

Yampa Valley Medical Center | Obesity, Nutrition, Physical Activity
ADULT FRUIT AND VEGETABLE CONSUMPTION DEMOGRAPHICS

Significantly more adult females eat the recommended amount of fruit and vegetables per day than males.

Although it appears that more older Americans meet the daily consumption recommendations of fruit and vegetables, there are no significant differences between age groups.

Figure 16: Adult Fruit and Vegetable Consumption by Gender

Figure 17: Adult Fruit and Vegetable Consumption by Age

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44 Ibid.
Significantly more Non-Hispanic White adults eat the recommended amount of fruit and vegetables than other race/ethnicity groups. There were no significant differences between the other race/ethnicity groups.

Adults with income $50,000 and above, as well as adults with some college education or more, met the fruit and vegetable consumption recommendation more often than adults with less income or less education.

Figure 18: Adult Fruit and Vegetable Consumption by Race/Ethnicity

ADULT FRUIT AND VEGETABLE CONSUMPTION TRENDS

Figure 19: Adult Fruit and Vegetable Consumption by State

According to the Centers for Disease Control, both State and National rates of fruit and vegetable consumption fell far short of Healthy People 2010 targets as of 2009 and

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42 http://www.fruitsandveggiesmatter.gov/health_professionals/statereport.html#Behavioral
consumption trends have remained relatively flat.\textsuperscript{46} Considerable variability occurred between states, which may be related to differences in population demographics, access, availability, and affordability of produce.

The average consumption of fruit and vegetables in Colorado increased from 3.7 to 3.9 daily servings from 1994 to 2000. During the same time period, the percentage of Coloradans who, on average, ate 5 or more servings of fruit and vegetables each day, increased from 21.6\% to 23.4\%.\textsuperscript{47}

The Colorado Department of Public Health and Environment has set goals for fruit and vegetable consumption in Colorado equal to the national Healthy People 2010 objectives.

- Goal 1: Increase the percentage of Coloradans ages 2 and older who eat 2 or more daily servings of fruits to 75\% by 2010.
- Goal 2: Increase the percentage of Coloradans ages 2 and older who eat 3 or more daily servings of vegetables to 50\% by 2010.

\textbf{YOUTH FRUIT AND VEGETABLE CONSUMPTION}

\textit{YRBS Survey: Percentage of Students Who ate Fruits and Vegetables Five or More Times per Day During the Past Seven Days}

The prevalence of Colorado high-school students eating the recommended amount of fruit and vegetables per day in 2009 was 24.4\%. High-school aged males consumed significantly more fruit and vegetables per day than females. Colorado does not report county or health statistic region data for youths.

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{youth_fruit_vegetable_consumption.png}
\caption{Youth Fruit and Vegetable Consumption by Gender\textsuperscript{48}}
\end{figure}

\textsuperscript{46} http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5935a1.htm?s_cid=mm5935a1_w
\textsuperscript{47} http://www.cdphe.state.co.us/pp/COPAN/5-a-day/5ADAYCoalition.html#5 A Day Goals for Colorado
\textsuperscript{48} Chart Source: Youth Risk Behavior Surveillance System, Colorado Department of Public Health and Environment and Centers for Disease Control (National data).
CHILDHOOD FRUIT AND VEGETABLE CONSUMPTION

Colorado Child Health Survey: Percent of children (aged 1-14 years) who ate fruit 2 or more times per day and vegetables 3 or more times per day 2007-2009

Figure 21: Children Fruit and Vegetable Consumption

Colorado data collection for consumption of fruit and vegetable data in children is not large enough to draw conclusions about differences between counties in Colorado. All county measures are statistically the same as the state. However, state levels are well below the HP 2010/Colorado goal.

49 Chart Source: CDPHE, Colorado Child Health Survey, Limited County Data is available.
CHILDREN FRUIT AND VEGETABLE CONSUMPTION DEMOGRAPHICS

- Children aged 2 to 5 years had significantly higher total fruit and juice intakes than 6- to 11- and 12- to 18-year-olds.
- Total vegetable and french fry intake was significantly higher among 12- to 18-year-old adolescents.
- Boys consumed significantly more fruit juice and french fries than girls.
- Non-Hispanic African-American children and adolescents consumed significantly more dark-green vegetables and fewer mean deep-yellow vegetables than Mexican-American and non-Hispanic white children and adolescents.
- Children and adolescents most at risk for higher intakes of energy-dense fruits and vegetables (fruit juice and french fries) were generally boys, and adolescents, at risk for overweight or overweight and living in households below 350% of the poverty level.

CHILDHOOD FRUIT AND VEGETABLE CONSUMPTION TRENDS

The prevalence of children in Colorado eating at least two servings of fruit and three servings of vegetables experienced a significant increase between 2009 and 2010.

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51 Chart Source: Colorado Department of Public Health and Environment, Colorado Child Health Survey
YOUTH SODA CONSUMPTION

YRBS Survey: During the past 7 days, how many times did you drink a can, bottle, or glass of soda or pop, such as Coke, Pepsi, or Sprite? (Do not include diet soda or diet pop.)

High-school students in Colorado drink fewer sodas per day than the Nation. Males drink significantly more sodas than females; particularly males aged sixteen or seventeen.

Colorado does not report county or health statistic region data for youths.

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52 Chart Source: Youth Risk Behavior Surveillance System, Colorado Department of Public Health and Environment and Centers for Disease Control (National data).
Colorado Child Health Survey: Percent of children aged 1-14 years who consumed sugars-sweetened beverages one or more times per day

Twenty three percent of Colorado children drink sugar-sweetened beverages one or more times a day. More children in HSR 11 drink sugar-sweetened beverages one or more times per day than the State. Strong evidence supports the conclusion that greater intake of sugar-sweetened beverages is associated with increased adiposity in children. No data is available for Routt and Moffat Counties.

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53 Chart Source: CDPHE, Colorado Child Health Survey, Limited County Data is available.
54 http://www.nutritionevidencelibrary.com/conclusion.cfm?conclusion_statement_id=250242
PhySical ActiVity

OvErVieW

In 2008, the Department of Health and Human Services released the first-ever publication of national guidelines for physical activity, Physical Activity Guidelines for Americans. Regular physical activity includes participation in moderate and vigorous physical activities and muscle-strengthening activities.

More than 80 percent of adults do not meet the guidelines for both aerobic and muscle-strengthening activities. Similarly, more than 80 percent of adolescents do not do enough aerobic physical activity to meet the guidelines for youth.

Physical activity has been defined as any bodily movement produced by the contraction of skeletal muscle that increases energy expenditure above a basal level. Bodily movement can be divided into two categories:

- Baseline activity refers to the light-intensity activities of daily life, such as standing, walking slowly, and lifting lightweight objects. People vary in how much baseline activity they do. People who do only baseline activity are considered to be inactive. They may do very short episodes of moderate- or vigorous-intensity activity, such as climbing a few flights of stairs, but these episodes aren’t long enough to count toward meeting the Guidelines. The Guidelines don’t comment on how variations in types and amounts of baseline physical activity might affect health, as this was not addressed by the Advisory Committee report.

- Health-enhancing physical activity is activity that, when added to baseline activity, produces health benefits. Brisk walking, jumping rope, dancing, lifting weights, climbing on playground equipment at recess, and doing yoga are all examples of physical activity. Some people (such as postal carriers or carpenters on construction sites) may get enough physical activity on the job to meet the Guidelines.

Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. Among adults and older adults, physical activity can lower the risk of:

- Early death
- Coronary heart disease
- Stroke

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• High blood pressure
• Type 2 diabetes
• Breast and colon cancer
• Falls
• Depression

Among children and adolescents, physical activity can:
• Improve bone health
• Improve cardiorespiratory and muscular fitness
• Decrease levels of body fat
• Reduce symptoms of depression
• For people who are inactive, even small increases in physical activity are associated with health benefits

Personal, social, economic, and environmental factors all play a role in physical activity levels among youth, adults, and older adults. Understanding the barriers to and facilitators of physical activity is important to ensure the effectiveness of interventions and other actions to improve levels of physical activity.

Factors negatively associated with adult physical activity include:58
• Advancing age
• Low income
• Lack of time
• Low motivation
• Rural residency
• Perception of great effort needed for exercise
• Overweight or obesity
• Perception of poor health
• Being disabled

**KEY GUIDELINES**

Substantial health benefits are gained by doing physical activity according to the Guidelines presented below for different groups.59

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CHILDREN AND ADOLESCENTS (AGED 6–17)

- Children and adolescents should do 1 hour (60 minutes) or more of physical activity every day.
- Most of the 1 hour or more a day should be either moderate- or vigorous-intensity aerobic physical activity.
- As part of their daily physical activity, children and adolescents should do vigorous-intensity activity on at least 3 days per week. They also should do muscle-strengthening and bone-strengthening activity on at least 3 days per week.

ADULTS (AGED 18–64)

- Adults should do 2 hours and 30 minutes a week of moderate-intensity, or 1 hour and 15 minutes (75 minutes) a week of vigorous-intensity aerobic physical activity, or an equivalent combination of moderate- and vigorous-intensity aerobic physical activity. Aerobic activity should be performed in episodes of at least 10 minutes, preferably spread throughout the week.
- Additional health benefits are provided by increasing to 5 hours (300 minutes) a week of moderate-intensity aerobic physical activity, or 2 hours and 30 minutes a week of vigorous-intensity physical activity, or an equivalent combination of both.
- Adults should also do muscle-strengthening activities that involve all major muscle groups performed on 2 or more days per week.

OLDER ADULTS (AGED 65 AND OLDER)

- Older adults should follow the adult guidelines. If this is not possible due to limiting chronic conditions, older adults should be as physically active as their abilities allow. They should avoid inactivity. Older adults should do exercises that maintain or improve balance if they are at risk of falling.
**ADULT ANY PHYSICAL ACTIVITY**

*BRFSS Survey Question: During the past 30 days, other than your regular job, did you participate in any physical activities?*

The percentage of adults who are physically active in Colorado is significantly higher than the national percentage. Adults in Routt County participate in physical activity above the national rate or above.

Adults in Moffat County participate in physical activity at a rate below the State.

Neither the Healthy People 2020 goals nor the new Physical Activity Guidelines are comparable to Colorado data.

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ADULT PHYSICAL ACTIVITY DEMOGRAPHICS

A significantly lower percentage of adult females participated in physical activity than males.

Physical activity varied by age. Younger adult age groups are significantly more active compared with adults 65 years and older.

Physical activity levels varied by race/ethnicity. Non-Hispanic White adults are significantly more physically active than all other race/ethnicities. “Other” adults are significantly more active than both Non-Hispanic Black adults and Hispanic adults. There was no significant difference between Non-Hispanic Black and Hispanic Adults.

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62 Ibid.
63 Ibid.
Physical activity levels by annual household income followed a similar pattern as that seen by education level. Adults with lower household incomes are less physically active. Differences between categories are statistically significant.

**ADULT MODERATE PHYSICAL ACTIVITY**

**BRFSS Survey Question:** During the past 30 days, other than your regular job, did you participate in any physical activities?

The percentage of adults who are moderately active in both Routt and Moffat Counties is higher than the State.

Both Routt and Moffat Counties are exceeding the Healthy People 2020 goal for moderate physical activity.

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64 Chart Source: Behavioral Risk Factor Surveillance System, Colorado Department of Public Health and Environment.

**YOUTH PHYSICAL ACTIVITY**

YRBS Survey: Percentage of students who were physically active doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time for a total of 60 minutes every day in the past 7 days.

In Colorado in 2009, 26.9% of high-school students met the Department of Health and Human Services recommendation of 60 minutes of physical activity per day. This percentage is above the Healthy People goal set for 2020.

![Physical Activity for 60 Minutes per Day Everyday in Last 7 Days - Youths](chart.png)

*Figure 30: Youth Physical Activity* 

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66 Chart Source: Youth Risk Behavior Surveillance System, Colorado Department of Public Health
Colorado Child Health Survey: The percent of children who were physically active at least 60 minutes/day for the past 7 days

In 2009-2010, 33.8% of Colorado children met the Department of Health and Human Services recommendation to spend 60 minutes per day doing physical activity. There is no Healthy People 2020 goal for this measure.

In HSR 11, 52.1% of children were physically active for at least 60 minutes per day. County data is not available. No demographic information is available.

Figure 31: Children Physical Activity

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67 Chart Source: Youth Risk Behavior Surveillance System, Colorado Department of Public Health
CHILDREN “SCREEN TIME”

Colorado Child Health Survey: The percent of children who spent 2 hours or less per day watching TV or videos, playing video games or playing on a computer

Health experts recommend that parents limit combined screen time from television, DVDs, computers, and video games to 2 hours per day or less.68

Children in HSR 11 have less screen time than the State. County data is not available.

Figure 32: Children Screen Time69

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69 Chart Source: Youth Risk Behavior Surveillance System, Colorado Department of Public Health
CHILDREN “SCREEN TIME” DEMOGRAPHICS

Prevalence of Television Watching (Children Ages 2-14 Years) and Computer and Video Game Use (Children Ages 5-14 Years) by Race/Ethnicity – Colorado, 2006-2008 (Combined Years)\(^7\)°

Non-Hispanic Whites and Asians were significantly more likely to watch television for two hours per day or less compared with non-Hispanic Blacks. Non-Hispanic Whites also were significantly more likely to watch two hours of television or less compared with Hispanics. Computer or video game use did not differ significantly between racial/ethnic groups.

CHILDREN “SCREEN TIME” TRENDS

From 2004 through 2008, the prevalence of television watching for two hours per day or less remained relatively stable in Colorado.\(^7\)° The prevalence of computer or video game use for two hours per day or less also remained stable during the same period. In 2008, most children ages 2-14 watched television for two hours per day or less, and most children aged 5-14 years used a computer or played video games for two hours per day.


\(^{71}\) Ibid.
COLORADO PHYSICAL ACTIVITY AND NUTRITION (COPAN) PROGRAM

In 2003, the Colorado Department of Public Health and Environment initiated the COPAN program. The COPAN program uses a comprehensive, community-based approach to promote healthy eating and physical activity as a means of preventing and reducing overweight, obesity and related chronic diseases in Colorado.

In the Fall of 2006, COPAN contracted an independent consulting firm, Conservation Impact, to survey statewide efforts in obesity reduction and prevention and provide guidance toward the potential of developing a statewide obesity prevention system. The project sought to provide strategic direction for closing gaps, leveraging opportunities, and enhancing effectiveness towards Department of Health and Human Services’ Healthy People 2010 goals.

Key Findings Included:

- **Strategic focus areas** and community sectors that COPAN identifies as necessary for a community to successfully address obesity include breastfeeding, childcare, schools, worksites, older adults, healthy food options, healthcare, and active community environments. COPAN also follows a socio-ecological model that looks at a variety of intervention levels, comprising individual, interpersonal, organizational, community, and public policy environments.

- An effective statewide system to address obesity requires focused leadership at the highest levels, providing vision, setting direction, and holding the statewide system and individual organizations and agencies accountable for success. Leadership should begin with the governor and legislature and include the CEO’s and executive directors of major foundations, corporations, NGO’s, and public agencies.

- To broadly influence individual and cultural change, statewide strategies must be founded on innovative and effective policies and supported by social marketing to raise awareness and influence behavior. The necessary systems and structures must be in place to support behavioral changes, especially in the healthcare and educational systems. Intervention strategies must be focused and initiated at the state level, but also community-based and reaching disparate populations.

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73 Colorado Physical Activity and Nutrition Program (COPAN) Obesity System Scan, Project Report October 17, 2006
• Effective support for interventions requires adequate, **coordinated funding that encourages true collaboration** across traditional programs, agencies, and organizations. This new approach to funding would reduce redundancies and encourage integration of interventions and messages so that obesity is addressed through programs and services that traditionally target related chronic diseases, encourage physical activity, and promote healthy nutrition. Coordinated funding will also encourage longer-term studies with rigorous evaluation components.

• Data on outcomes are critical to the development of effective strategies for obesity prevention and reduction. **Documenting effective and ineffective interventions** is needed to guide on-going work, inform decision-makers, and encourage investment in effective strategies. Without reliable data, adaptive management and investment at all levels of a statewide system, from policy and messaging to intervention and research are based on best guesses alone.

• Accomplishing any of this will first require **agreement on desired outcomes** and strategies. Without common vision, unified goals, and definitions, there will be nothing to coordinate around. System development and alignment should fulfill specific functions, with relevant players invited to the table for deliberate purposes. Participants must decisively clarify approaches and strategies prior to developing structures for implementation (form follows function).

• The highest levels of leadership attention are required for a statewide system to be effective. Neither COPAN nor Prevention Services Division of CDPHE are at a high enough level to spearhead creation a system across government departments, philanthropies, for-profit and non-profit entities, media outlets, and so on. This **top-level leadership will preferably come from the governor’s office and/or the state legislature**. COPAN, for PSD and CDPHE, can then provide the coordination and convening functions that will be necessary to maintain an effective statewide obesity prevention effort.
COPAN promotes preventive strategies through healthy eating and active living as detailed in the Roadmap to Healthy Eating and Active Living. The roadmap recognizes the contribution community life plays in promoting physical activity and nutrition. It focuses on 11 key community targets.

- Providing businesses with tools for creating incentives and welcoming environments for employees to be healthy and physically active
- Promoting best practices for schools to provide daily physical activity for students, adopt nutrition guidelines and partner with local farmers to serve fresh produce in school meals
- Encouraging health care professionals to adopt Colorado Adult and Childhood Obesity Guidelines to provide healthy lifestyle advice to their patients
- Assisting restaurant patrons in selecting healthy menu items with the Smart Meal seal
• Partnering with communities to **design streets and neighborhoods to include bike paths and sidewalks** and convenient linkages to parks, schools, grocery stores and community gathering places
• Supporting communities in developing **community gardens**, sponsoring affordable healthy-cooking and exercise classes, and offering team sports opportunities for people of all ages

### COPAN COMMUNITY PARTNERSHIPS

Public-private partnerships are important for effective obesity prevention. The COPAN program at the state health department has a number of partners, each with a well-defined purpose. A sample of these partners includes the Colorado Health Foundation, Kaiser Permanente, the Colorado Department of Education and the Colorado Department of Transportation. **In 2008, the Colorado Health Foundation, Kaiser Permanente, COPAN, and a number of other partners came together to create a new nonprofit organization: LiveWell Colorado.** LiveWell Colorado was created to spearhead state and local partnerships to address obesity prevention by coordinating efforts, reducing duplication, streamlining program funding and promoting collaborations among stakeholders throughout Colorado. LiveWell Colorado’s mission is: “to inspire and advance policy, environmental and lifestyle changes that promote health through the prevention and reduction of obesity.” LiveWell Colorado is a strategic partner of COPAN. Currently in 2009, **LiveWell Colorado supports 25 communities** and COPAN provides additional content expertise to these communities.74

### CENTERS FOR DISEASE CONTROL (CDC) RECOMMENDATIONS75

COPAN obesity interventions are based on known best practices and follow the Centers for Disease Control and Prevention’s recommended strategies and measurements to prevent obesity in the United States.

### CDC STRATEGIES TO PROMOTE THE AVAILABILITY OF AFFORDBALE HEALTH FOOD AND BEVERAGE

1. Communities Should Increase Availability of Healthier Food and Beverage Choices in Public Service Venues
2. Communities Should Improve Availability of Affordable Healthier Food and Beverage Choices in Public Service Venues
3. Communities Should Improve Geographic Availability of Supermarkets in Underserved Areas

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75 [http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5807a1.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5807a1.htm)
4. Communities Should Provide Incentives to Food Retailers to Locate in and/or Offer Healthier Food and Beverage Choices in Underserved Areas
5. Communities Should Improve Availability of Mechanisms for Purchasing Foods from Farms
6. Communities Should Provide Incentives for the Production, Distribution, and Procurement of Foods from Local Farms
7. Communities Should Restrict Availability of Less Healthy Foods and Beverages in Public Service Venues
8. Communities Should Institute Smaller Portion Size Options in Public Service Venues
9. Communities Should Limit Advertisements of Less Healthy Foods and Beverages
10. Communities Should Discourage Consumption of Sugar-Sweetened Beverages

**STRATEGY TO ENCOURAGE BREASTFEEDING**
11. Communities Should Increase Support for Breastfeeding

**STRATEGIES TO ENCOURAGE PHYSICAL ACTIVITY OR LIMIT SEDENTARY ACTIVITY AMONG CHILDREN AND YOUTH**
12. Communities Should Require Physical Education in Schools
13. Communities Should Increase the Amount of Physical Activity in PE Programs in Schools
14. Communities Should Increase Opportunities for Extracurricular Physical Activity
15. Communities Should Reduce Screen Time in Public Service Venues

**STRATEGIES TO CREATE SAFE COMMUNITIES THAT SUPPORT PHYSICAL ACTIVITY**
16. Communities Should Improve Access to Outdoor Recreational Facilities
17. Communities Should Enhance Infrastructure Supporting Bicycling
18. Communities Should Enhance Infrastructure Supporting Walking
19. Communities Should Support Locating Schools within Easy Walking Distance of Residential Areas
20. Communities Should Improve Access to Public Transportation
21. Communities Should Zone for Mixed-Use Development
22. Communities Should Enhance Personal Safety in Areas Where Persons Are or Could Be Physically Active
23. Communities Should Enhance Traffic Safety in Areas Where Persons Are or Could Be Physically Active

**STRATEGY TO ENCOURAGE COMMUNITIES TO ORGANIZE FOR CHANGE**
24. Communities Should Participate in Community Coalitions or Partnerships to Address Obesity
In the United States, 16.5 percent of children and adolescents between the ages of two and 19 are obese. This epidemic has exploded over just three decades. Among children two to five years old, obesity prevalence increased from 5 percent to 12.4 percent; among children six to 11, it increased from 6.5 percent to 17 percent; and among adolescents 12 to 19 years old, it increased from 5 percent to 17.6 percent (see Figure 1).

The prevalence of obesity is so high that it may reduce the life expectancy of today’s generation of children and diminish the overall quality of their lives. Obese children and adolescents are more likely than their lower-weight counterparts to develop hypertension, high cholesterol, and type 2 diabetes when they are young, and they are more likely to be obese as adults.

In 2008, the Institute of Medicine (IOM) Committee on Childhood Obesity Prevention Actions for Local Governments was convened to identify promising ways to address this problem on what may well be the epidemic’s frontlines. The good news is that there are numerous actions that show potential for use by local governments. Of course, parents and other adult caregivers play a fundamental role in teaching children about healthy behaviors, in modeling those behaviors, and in making decisions for children when needed. But those positive efforts can be undermined by local environments that are poorly suited to supporting healthy behaviors—and may even promote unhealthy behaviors. For example, many communities lack ready sources of healthy food choices, such as supermarkets and grocery stores. Or they may not provide safe places for children to walk or play. In such communities, even the most motivated child or adolescent may find it difficult to act in healthy ways.

**FIGURE 1: PREVALENCE OF OBESITY AMONG CHILDREN, 1971-2006**

<table>
<thead>
<tr>
<th></th>
<th>Ages 2-5</th>
<th>Ages 6-11</th>
<th>Ages 12-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>1971-1974</td>
<td>5%</td>
<td>7%</td>
<td>10%</td>
</tr>
<tr>
<td>1975-1980</td>
<td>7%</td>
<td>9%</td>
<td>12%</td>
</tr>
<tr>
<td>1985-1994</td>
<td>10%</td>
<td>12%</td>
<td>15%</td>
</tr>
<tr>
<td>2003-2006</td>
<td>15%</td>
<td>17%</td>
<td>20%</td>
</tr>
</tbody>
</table>

SOURCE: Centers for Disease Control and Prevention, National Health and Nutrition Examination Survey
ACTING LOCALLY

Local governments are experienced in promoting children’s health, as they historically have implemented policies intended to ensure, among other things, that children are immunized or they wear helmets when riding a bike. In the same way, local governments—with jurisdiction over many aspects of land use, food marketing, community planning, transportation, health and nutrition programs, and other community issues—are ideally positioned to promote behaviors that will help children and adolescents reach and maintain healthy weights. Promoting children’s healthy eating and activity will require the involvement of an array of government officials, including mayors and commissioners or other leaders of counties, cities, or townships. Many departments, including those responsible for public health, public works, transportation, parks and recreation, public safety, planning, economic development, and housing will also need to be involved.

In addition, community involvement and evaluation are vital to childhood obesity prevention efforts. It is critical for local government officials and staff to involve constituents in determining local needs and identifying top priorities. Engaging community members in the process will help identify local assets, focus resources, and improve implementation plans. And, as obesity prevention actions are implemented, they need to be evaluated in order to provide important information on what does and does not work.

CREATING EQUAL OPPORTUNITIES FOR HEALTHY WEIGHT

In adopting policies and practices tailored to raising healthy children, local communities have an added opportunity to achieve health equity—put simply, the fair distribution of health resources among all population groups, regardless of their social standing. Poverty, poor housing, racial segregation, lack of access to quality education, and limited access to health care contribute to the uneven well-being of some groups of people, especially those living in historically disadvantaged communities. If local officials observe, for example, that many children in certain neighborhoods do not engage in sufficient physical activity or consume too few fruits and vegetables, they should examine the equity of access to recreation opportunities and grocery stores in those areas. These officials may then find themselves uniquely positioned to catalyze, support, or lead collaborations in the community and engage diverse constituent groups in efforts to improve the places where children live and play.

RECOMMENDING PROMISING ACTIONS

Evidence on the best childhood obesity prevention practices is still accumulating and is limited in many important topic areas. However, local government officials want to act now on the best available information. The IOM committee reviewed published literature, examined reports from organizations that work with local governments, heard presentations from experts on the role of local government in obesity prevention, and explored a variety of tool kits that have been developed for communities and their leaders.

In arriving at its recommendations, the committee looked for actions that are within the jurisdiction of local governments; likely to directly affect children; based on the experience of local governments or sources that work with local governments; take place outside of the school day; and have the potential to promote healthy eating and adequate physical activity. Healthy eating is characterized as consuming the types and amounts of foods, nutrients, and calories recommended by the Dietary Guidelines for Americans, and adequate physical activity for children constitutes a total of 60 minutes per day.

The committee recommends nine healthy eating strategies and six physical activity strategies for local government officials to consider in planning, implementing, and refining childhood obesity prevention efforts. The committee also recommends a number of specific action steps for each strategy and highlights 12 steps overall judged to have the most promise.
ACTIONS FOR HEALTHY EATING

GOAL 1: IMPROVE ACCESS TO AND CONSUMPTION OF HEALTHY, SAFE, AND AFFORDABLE FOODS

Strategy 1: Retail Outlets
Increase community access to healthy foods through supermarkets, grocery stores, and convenience/corner stores.

Action Steps
- Create incentive programs to attract supermarkets and grocery stores to underserved neighborhoods (e.g., tax credits, grant and loan programs, small business/economic development programs, and other economic incentives).
- Realign bus routes or provide other transportation, such as mobile community vans or shuttles to ensure that residents can access supermarkets or grocery stores easily and affordably through public transportation.
- Create incentive programs to enable current small food store owners in underserved areas to carry healthier, affordable food items (e.g., grants or loans to purchase refrigeration equipment to store fruits, vegetables, and fat-free/low-fat dairy; free publicity; a city awards program; or linkages to wholesalers distributors).
- Use zoning regulations to enable healthy food providers to locate in underserved neighborhoods (e.g., "as-of-right" and "conditional use permits").
- Enhance accessibility to grocery stores through public safety efforts, such as better outdoor lighting and police patrolling.

Strategy 2: Restaurants
Improve the availability and identification of healthful foods in restaurants.

Action Steps
- Require menu labeling in chain restaurants to provide consumers with calorie information on in-store menus and menu boards.
- Encourage non-chain restaurants to provide consumers with calorie information on in-store menus and menu boards.
- Offer incentives (e.g., recognition or endorsement) for restaurants that promote healthier options (for example, by increasing the offerings of healthier foods, serving age-appropriate portion sizes, or making the default standard options healthy – i.e., apples or carrots instead of French fries, and non-fat milk instead of soda in “kids’ meals”).

Strategy 3: Community Food Access
Promote efforts to provide fruits and vegetables in a variety of settings, such as farmers’ markets, farm stands, mobile markets, community gardens, and youth-focused gardens.

Action Steps
- Encourage farmers markets to accept Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) food package vouchers and WIC Farmers Market Nutrition Program coupons; and encourage and make it possible for farmers markets to accept Supplemental Nutrition Assistance Program (SNAP, formerly the Food Stamp Program) and WIC Program Electronic Benefit Transfer (EBT) cards by allocating funding for equipment that uses electronic methods of payment.
- Improve funding for outreach, education, and transportation to encourage use of farmers markets and farm stands by residents of lower-income neighborhoods, and by WIC and SNAP recipients.
• Introduce or modify land use policies/zoning regulations to promote, expand, and protect potential sites for community gardens and farmers’ markets, such as vacant city-owned land or unused parking lots.

• Develop community-based group activities (e.g., community kitchens) that link procurement of affordable, healthy food with improving skills in purchasing and preparing food.

**Strategy 4: Public Programs and Worksites**

Ensure that publicly-run entities such as after-school programs, child-care facilities, recreation centers, and local government worksites implement policies and practices to promote healthy foods and beverages and reduce or eliminate the availability of calorie-dense, nutrient-poor foods.

**Action Steps**

• Mandate and implement strong nutrition standards for foods and beverages available in government-run or regulated after-school programs, recreation centers, parks, and child care facilities (which includes limiting access to calorie-dense, nutrient-poor foods).

• Ensure that local government agencies that operate cafeterias and vending options have strong nutrition standards in place wherever foods and beverages are sold or available.

• Provide incentives or subsidies to government-run or regulated programs and localities that provide healthy foods at competitive prices and limit calorie-dense, nutrient-poor foods (e.g., after-school programs that provide fruits or vegetables every day, and eliminate calorie-dense, nutrient poor foods in vending machines or as part of the program).

**Strategy 5: Government Nutrition Programs**

Increase participation in federal, state, and local government nutrition assistance programs (e.g., WIC, school breakfast and lunch, the Child and Adult Care Food Program [CACFP], the Afterschool Snacks Program, the Summer Food Service Program, SNAP).

**Action Steps**

• Put policies in place that require government-run and -regulated agencies responsible for administering nutrition assistance programs to collaborate across agencies and programs to increase enrollment and participation in these programs (i.e., WIC agencies should ensure that those who are eligible are also participating in SNAP, etc.)

• Ensure that child care and after-school program licensing agencies encourage utilization of the nutrition assistance programs and increase nutrition program enrollment (CACFP, Afterschool Snacks Program, and the Summer Food Service Program).

**Strategy 6: Breastfeeding**

Encourage breastfeeding and promote breastfeeding-friendly communities.

**Action Steps**

• Adopt practices in city and county hospitals that are consistent with the Baby-Friendly Hospital Initiative USA (United Nations Children’s Fund/World Health Organization). This initiative promotes, protects, and supports breastfeeding through ten steps to successful breastfeeding for hospitals.

• Permit breastfeeding in public places and rescind any laws or regulations that discourage or do not allow breastfeeding in public places and encourage the creation of lactation rooms in public places.

• Develop incentive programs to encourage government agencies to ensure breastfeeding-friendly workplaces, including providing lactation rooms.

• Allocate funding to WIC clinics to acquire breast pumps to loan to participants.
Strategy 7: Drinking Water Access

Increase access to free, safe drinking water in public places to encourage water consumption instead of sugar-sweetened beverages.

**Action Steps**
- Require that plain water be available in local government-operated and administered outdoor areas and other public places and facilities.
- Adopt building codes to require access to and maintenance of fresh drinking water fountains (e.g., public restroom codes).

**GOAL 2: REDUCE ACCESS TO AND CONSUMPTION OF CALORIE-DENSE, NUTRIENT-POOR FOODS**

Strategy 8: Policies and Ordinances

Implement fiscal policies and local ordinances to discourage the consumption of calorie-dense, nutrient-poor foods and beverages (e.g., taxes, incentives, land use and zoning regulations).

**Action Steps**
- Implement a tax strategy to discourage consumption of foods and beverages that have minimal nutritional value, such as sugar-sweetened beverages.
- Adopt land use and zoning policies that restrict fast food establishments near school grounds and public playgrounds.
- Implement local ordinances to restrict mobile vending of calorie-dense, nutrient-poor foods near schools and public playgrounds.
- Implement zoning designed to limit the density of fast food establishments in residential communities.
- Eliminate advertising and marketing of calorie-dense, nutrient-poor foods and beverages near school grounds and public places frequently visited by youths.
- Create incentive and recognition programs to encourage grocery stores and convenience stores to reduce point-of-sale marketing of calorie-dense, nutrient-poor foods (i.e., promote “candy-free” check out aisles and spaces).

**GOAL 3: RAISE AWARENESS ABOUT THE IMPORTANCE OF HEALTHY EATING TO PREVENT CHILDHOOD OBESITY**

Strategy 9: Media and Social Marketing

Promote media and social marketing campaigns on healthy eating and childhood obesity prevention.

**Action Steps**
- Develop media campaigns, utilizing multiple channels (print, radio, internet, television, social networking, and other promotional materials) to promote healthy eating and active living using consistent messages.
- Design a media campaign that establishes community access to healthy foods as a health equity issue and reframes obesity as a consequence of environmental inequities and not just the result of poor personal choices.
- Develop counter-advertising media approaches against unhealthy products to reach youth as has been used in the tobacco and alcohol prevention fields.
ACTIONS FOR INCREASING PHYSICAL ACTIVITY

GOAL 1: ENCOURAGE PHYSICAL ACTIVITY

Strategy 1: Built Environment
Encourage walking and bicycling for transportation and recreation through improvements in the built environment.

Action Steps
- Adopt a pedestrian and bicycle master plan to develop a long-term vision for walking and bicycling in the community and guide implementation.
- Plan, build, and maintain a network of sidewalks and street crossings that creates a safe and comfortable walking environment and that connects to schools, parks, and other destinations.
- Plan, build, and retrofit streets so as to reduce vehicle speeds, accommodate bicyclists, and improve the walking environment.
- Plan, build, and maintain a well-connected network of off-street trails and paths for pedestrians and bicyclists.
- Increase destinations within walking and bicycling distance.
- Collaborate with school districts and developers to build new schools in locations central to residential areas and away from heavily trafficked roads.

Strategy 2: Programs for Walking and Biking
Promote programs that support walking and bicycling for transportation and recreation.

Action Steps
- Adopt community policing strategies that improve safety and security of streets, especially in high-crime neighborhoods.
- Collaborate with schools to develop and implement a Safe Routes to School program to increase the number of children safely walking and bicycling to schools.
- Improve access to bicycles, helmets, and related equipment for lower-income families, for example, through subsidies or repair programs.
- Promote increased transit use through reduced fares for children, families, and students, and improved service to schools, parks, recreation centers, and other family destinations.
- Implement a traffic enforcement program to improve safety for pedestrians and bicyclists.

Strategy 3: Recreational Physical Activity
Promote other forms of recreational physical activity.

Action Steps
- Build and maintain parks and playgrounds that are safe and attractive for playing and in close proximity to residential areas.
- Adopt community policing strategies that improve safety and security for park use, especially in higher crime neighborhoods.
- Improve access to public and private recreational facilities in communities with limited recreational options through reduced costs, increased operating hours, and development of culturally appropriate activities.

* These two action steps on community policing were combined for the most promising 12 action steps list.
- Create after-school activity programs, e.g., dance classes, city-sponsored sports, supervised play, and other publicly or privately supported active recreation.
- Collaborate with school districts and other organizations to establish joint use of facilities agreements allowing playing fields, playgrounds, and recreation centers to be used by community residents when schools are closed; if necessary, adopt regulatory and legislative policies to address liability issues that might block implementation.
- Create and promote youth athletic leagues and increase access to fields, with special emphasis on income and gender equity.
- Build and provide incentives to build recreation centers in neighborhoods.

**Strategy 4: Routine Physical Activity**
Promote policies that build physical activity into daily routines.

**Action Steps**
- Institute regulatory policies mandating minimum play space, physical equipment, and duration of play in preschool, after-school, and child-care programs.
- Develop worksite policies and practices that build physical activity into routines (for example, exercise breaks at a certain time of day and in meetings, or walking meetings). Target worksites with high percentages of youth employees and government-run and regulated worksites.
- Create incentives for remote parking and drop-off zones and/or disincentives for nearby parking and drop-off zones at schools, public facilities, shopping malls, and other destinations.
- Improve stairway access and appeal, especially in places frequented by children.

**GOAL 2: DECREASE SEDENTARY BEHAVIOR**

**Strategy 5: Screen Time**
Promote policies that reduce sedentary screen time.

**Action Steps**
- Adopt regulatory policies limiting screen time in preschool and after-school programs.

**GOAL 3: RAISE AWARENESS OF THE IMPORTANCE OF INCREASING PHYSICAL ACTIVITY**

**Strategy 6: Media and Social Marketing**
Develop a social marketing program that emphasizes the multiple benefits for children and families of sustained physical activity.

**Action Steps**
- Develop media campaigns, utilizing multiple channels (print, radio, internet, television, other promotional materials) to promote physical activity using consistent messages.
- Design a media campaign that establishes physical activity as a health equity issue and reframes obesity as a consequence of environmental inequities and not just the result of poor personal choices.
- Develop counter-advertising media approaches against sedentary activity to reach youth as has been done in the tobacco and alcohol prevention fields.
FOR MORE INFORMATION . . .

Copies of Local Government Actions to Prevent Childhood Obesity are available from the National Academies Press, 500 Fifth Street, N.W., Lockbox 285, Washington, DC 20036; (800) 624-6242 or (202) 334-3313 (in the Washington metropolitan area); Internet: www.nap.edu. The full text of this report is available at www.nap.edu.

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LYNN PARKER, Study Director; ANNINA CATHERINE BURNS, Program Officer; CATHARIN T. LIVERMAN, Scholar; NICOLE FERRING, Research Associate; MATTHEW B. SPEAR, Senior Program Assistant; ANTON L. BANDY, Financial Associate; GERALDINE KENNEDO, Administrative Assistant; LINDA D. MEYERS, Director, Food and Nutrition Board; ROSEMARY CHALK, Director, Board on Children, Youth, and Families; NANCY HUMPHREY, Senior Program Officer, Transportation Research Board; ROSE MARIE MARTINEZ, Director, Board on Population Health and Public Health Practice.
Collaborative work with many partners has led to several important successes in the promotion and implementation of policy and environmental change strategies to reduce obesity. The state-level policies include the following:

- **Senate Bill 103 (2004)** supported school-based policies to decrease the consumption of low-nutrition, high-sugar containing foods. Senate Bill 103 encouraged each school district board of education to adopt a policy on or before July 1, 2004, that would ensure that, by the 2006-07 school year, at least 50 percent of all items offered in vending machines in the school district be healthful foods or healthful beverages that meet acceptable nutritional standards.

- **Senate Bill 88 (2004)** supports and promotes breast-feeding and supports breast-feeding mothers. This legislation recognizes the benefits of breast-feeding, encourages mothers to breast-feed and allows a mother to breast-feed in any place she has a right to be.

- **Amendment 35 (passed by voters in November 2004)** substantially increased the state’s tobacco excise tax and designated revenues for several health initiatives. Since January 2005, the Prevention Services Division at the Colorado Department of Public Health and Environment has used these funds to prevent and reduce tobacco use; prevent, detect and treat cancer, cardiovascular disease and pulmonary disease; expand breast and cervical cancer screening services; and reduce health disparities.

- **Senate Bill 81 (2005)** addresses the combined work of the Early Childhood and School Site Task Forces to support healthful eating and physical activity in schools with the encouragement to adopt coordinated school health policy standards. The bill recognizes overweight among children and youth as a major public health threat and encourages school district boards of education to adopt policies to improve children’s nutrition by offering healthful foods at school, providing culturally sensitive nutrition education, establishing local school wellness policies in accordance with the federal Child Nutrition and WIC Reauthorization Act of 2004, ensuring student access to fresh produce (especially Colorado-grown) and ensuring student access to daily physical activity. The bill also encourages the inclusion of goals for nutrition education in local wellness policies.

- **House Bill 309 (2005)** created a Safe Routes to School program in the Department of Transportation to distribute federal funds to local governments to create and promote active communities and lifestyles. This is directly related to the work of the COPAN Active Community Environments Task Force.

- **Senate Bill 127 (2006)** created a program to make free fruits and vegetables available to students in public schools and requires that Colorado-grown produce be used in the program to the maximum extent possible.

- **House Bill 1093 (2007)** is specific to the work of the original 5-A-Day Task Force, in that it encourages the purchase of Colorado-grown produce by government entities.

- **Senate Bill 129 (2008)** requires that all beverages sold to public school students must meet minimum nutritional standards. Beverages sold in elementary and middle schools can be only water, milk or 100 percent juice. Beverages sold in high schools must include the previous standards, but high schools can sell sports drinks. Soft drinks are not allowed for sale in elementary, middle or high schools.

- **House Bill 1276 (2008)** also is known as “Workplace Accommodation for Nursing Mothers.” This bill establishes a standard for employers to make a reasonable effort to provide breast-feeding mothers with unpaid break time, paid break time and/or meal time to express breast milk for their nursing children for up to two years after the child’s birth; to provide a private location in close proximity to the breast-feeding mother’s work area (other than a toilet stall) in which to express milk; and to not discriminate against women for expressing milk in the workplace.

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<tr>
<th>County or Statewide Program</th>
<th>Provider</th>
<th>Contact Person</th>
<th>Phone / Email</th>
<th>Website</th>
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<tbody>
<tr>
<td>Statewide</td>
<td>Colorado Physical Activity and Nutrition Program</td>
<td>Eric Aakko</td>
<td>(303) 692-2441</td>
<td><a href="http://www.cdphe.state.co.us/pp/COPAN/COPAN.html">http://www.cdphe.state.co.us/pp/COPAN/COPAN.html</a></td>
<td>4300 Cherry Creek Drive South (PSD-A5) Denver, CO 80246-1530</td>
<td>The Program has established and coordinates the COPAN Coalition including an executive committee. Together the Program and the Coalition have developed and are implementing the Colorado Physical Activity and Nutrition State Plan 2010 that promotes healthy eating and physical activity in order to successfully prevent and reduce overweight, obesity, and related chronic diseases.</td>
</tr>
<tr>
<td>Statewide</td>
<td>Center for Obesity Research and Prevention</td>
<td>Andra Price</td>
<td>(303) 556-2400</td>
<td><a href="http://www.ucdenver.edu/academics/colleges/medicalschool/centers/HumanNutrition/NORC/Pages/ColoradoNORC.aspx">http://www.ucdenver.edu/academics/colleges/medicalschool/centers/HumanNutrition/NORC/Pages/ColoradoNORC.aspx</a></td>
<td>The Anschutz Medical Campus 13001 E 17th Place Aurora, Colorado</td>
<td>Provide education about management of weight/obesity issues, informational/educational resources, community outreach and advocacy to foster health improvement, clinic trials, programs and services</td>
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<tr>
<td>Statewide</td>
<td>Children’s Hospital of Colorado Weight Loss Program</td>
<td>*</td>
<td>(720) 777-3552</td>
<td><a href="http://www.childrenscolorado.org/conditions/nutrition/index.aspx">http://www.childrenscolorado.org/conditions/nutrition/index.aspx</a></td>
<td>13123 East 16th Ave Aurora, CO 80045</td>
<td>Children’s Hospital Colorado offers the region’s largest pediatric weight management program.</td>
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<td>County or Statewide Program</td>
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<td>Statewide</td>
<td>9 Health Fair</td>
<td>Becky Aragon</td>
<td>(303) 698-4455</td>
<td><a href="http://www.9healthfair.org/default.aspx">http://www.9healthfair.org/default.aspx</a></td>
<td>1139 Delaware Street Denver, CO 80204</td>
<td>Statewide Health Fairs that encourage the public to partake in weight loss programs and develop healthy eating habits</td>
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<tr>
<td>Statewide</td>
<td>Volunteers of America: Nutrition Program</td>
<td>Dianna L. Kunz</td>
<td>(303)297-0408 <a href="mailto:info@voacolorado.org">info@voacolorado.org</a></td>
<td><a href="http://www.voacolorado.org/">http://www.voacolorado.org/</a></td>
<td>2660 Larimer St. Denver, CO 80205</td>
<td>Provides nutrition education, services and assistance for Colorado population +60</td>
</tr>
<tr>
<td>Statewide</td>
<td>DOE: Nutrition Unit</td>
<td>Jane Brand</td>
<td>(303) 866-6661 <a href="mailto:brand_j@cde.state.co.us">brand_j@cde.state.co.us</a></td>
<td><a href="http://www.cde.state.co.us/index_nutrition.htm">http://www.cde.state.co.us/index_nutrition.htm</a></td>
<td>1580 Logan St, #760 Denver, CO 80203</td>
<td>School based programs focusing on nutrition for public schools in Colorado</td>
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<tr>
<td>Statewide</td>
<td>Colorado Connections for Healthy Kids</td>
<td>Carol Muller</td>
<td><a href="mailto:cmuller@actionforhealthykids.org">cmuller@actionforhealthykids.org</a></td>
<td><a href="http://take.actionforhealthykids.org/site/Clubs?club_id=1104&amp;pg=main">http://take.actionforhealthykids.org/site/Clubs?club_id=1104&amp;pg=main</a></td>
<td>*</td>
<td>Statewide initiative in support of Coordinated School Health Programs. Through this coordination of programs, resources, messages and training school staff, students, families and community resources we will work together for healthy students, healthy living, and better learners</td>
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<tr>
<td>Statewide</td>
<td>CDPHE: WIC</td>
<td>Patricia Daniluk</td>
<td>(303) 692.2400 <a href="mailto:Patricia.Daniluk@state.co.us">Patricia.Daniluk@state.co.us</a></td>
<td><a href="http://www.cdphe.state.co.us/ps/wic/index.html">http://www.cdphe.state.co.us/ps/wic/index.html</a></td>
<td>4300 Cherry Creek Drive South Denver, CO 80246</td>
<td>Nutrition education including breast feeding support, screening and referral</td>
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<td>Statewide</td>
<td>Elevate Your Health Colorado</td>
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<td><a href="http://www.elevateyourhealthco.com/node/534">http://www.elevateyourhealthco.com/node/534</a></td>
<td>*</td>
<td>Kaiser Permanente Program that offers the public advice via the web on weight loss and maintaining and developing a healthy lifestyle</td>
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<tr>
<td>Statewide</td>
<td>Kaiser Permanente Weigh and Win</td>
<td>Katie Hamilton</td>
<td>(303) 694-8012 <a href="mailto:khamilton@weighandwin.com">khamilton@weighandwin.com</a></td>
<td><a href="http://weighandwin.com/">http://weighandwin.com/</a></td>
<td>*</td>
<td>Kaiser Permanente is offering weight loss participants cash to lose weight over a given period in a statewide campaign/program.</td>
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<tr>
<td>Statewide</td>
<td>CDPHE: 5 A Day Program</td>
<td>Shana Patterson</td>
<td>(303)692-2572 <a href="mailto:shana.patterson@state.co.us">shana.patterson@state.co.us</a> <a href="mailto:cdphe.psdrequests@state.co.us">cdphe.psdrequests@state.co.us</a></td>
<td><a href="http://www.cdphe.state.co.us/pp/copan/5-a-day/5ADAY.html">http://www.cdphe.state.co.us/pp/copan/5-a-day/5ADAY.html</a></td>
<td>4300 Cherry Creek Drive South Denver, CO 80246</td>
<td>5 A Day for is a nutrition education program that encourages the consumption of 5 to 9 servings of fruits and vegetables each day for better health.</td>
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<tr>
<td>Statewide</td>
<td>Colorado Weigh</td>
<td>Shannon Brown</td>
<td>(303)892-0128</td>
<td><a href="http://www.coloradoweigh.com/what.html">http://www.coloradoweigh.com/what.html</a></td>
<td>7476 E. 29th Avenue Town Center, PMB 113 Denver, Colorado, 80238</td>
<td>The Colorado Weigh program is an innovative, research-based weight loss program developed over the last four years by the renowned Center for Human Nutrition at the University of Colorado School of Medicine.</td>
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<tr>
<td>Statewide</td>
<td>Action For Healthy Kids Colorado</td>
<td>Carol Muller</td>
<td>(1-800) 416-5136 <a href="mailto:cmuller@actionforhealthykids.org">cmuller@actionforhealthykids.org</a></td>
<td><a href="http://take.actionforhealthykids.org/site/Clubs?club_id=1104&amp;pg=main">http://take.actionforhealthykids.org/site/Clubs?club_id=1104&amp;pg=main</a></td>
<td>*</td>
<td>Build awareness and encourage positive role modeling among administrators, teachers, food service workers, develop and implement policies that are consistent with dietary guidelines, provide age appropriate education to children and offer opportunities for youth to explore nutrition and physical activity topics</td>
</tr>
<tr>
<td>Statewide</td>
<td>UCDHSC: Center for Human Nutrition</td>
<td>*</td>
<td>(303) 724-9975 <a href="mailto:CHN@uchsc.edu">CHN@uchsc.edu</a></td>
<td><a href="http://www.ucdenver.edu/academics/colleges/medicalschool/centers/HumanNutrition/Pages/HumanNutrition.aspx">http://www.ucdenver.edu/academics/colleges/medicalschool/centers/HumanNutrition/Pages/HumanNutrition.aspx</a></td>
<td>Mailstop C263 13001 E. 17th Place Aurora, CO 80045</td>
<td>Research and education on human nutrition located on the Anschutz Medical Campus</td>
</tr>
<tr>
<td>Statewide</td>
<td>Colorado Foundation for Physical Fitness-Shape Up Colorado</td>
<td>Jeff Taylor</td>
<td><a href="mailto:jtaylor@jefftaylor.com">jtaylor@jefftaylor.com</a></td>
<td><a href="http://www.coloradofitness.org/?page_id=3">http://www.coloradofitness.org/?page_id=3</a></td>
<td>*</td>
<td>Community outreach program to encourage individuals to incorporate physical activity into everyday living to increase healthful lifestyles and habits</td>
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<tr>
<td>Statewide</td>
<td>DOT: Walk To School Colorado</td>
<td>Marissa Robinson</td>
<td>(303) 757-9088 <a href="mailto:srts@dot.state.co.us">srts@dot.state.co.us</a></td>
<td><a href="http://www.coloradodot.info/programs/bikeped/safe-routes/walk-to-school">http://www.coloradodot.info/programs/bikeped/safe-routes/walk-to-school</a></td>
<td>4201 E Arkansas Ave Denver, CO 80222</td>
<td>Community programs that encourage people to walk (use alternate modes of transportation) to incorporate physical activity into daily life, healthy living, weight loss</td>
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<td>Statewide</td>
<td>Live Well Colorado</td>
<td>Maren C. Stewart</td>
<td>(720) 353-4120</td>
<td><a href="http://www.livewellcolorado.org">www.livewellcolorado.org</a></td>
<td>1490 Lafayette Street #404 Denver, CO 80218</td>
<td>LiveWell Colorado is a nonprofit organization committed to reducing obesity in Colorado by promoting healthy eating and active living. In addition to educating and inspiring people to make healthy choices.</td>
</tr>
<tr>
<td>Statewide</td>
<td>Colorado Child and Adult Care Food Program</td>
<td>*</td>
<td>(303) 692-2330 <a href="mailto:cdphepsdrequests@state.co.us">cdphepsdrequests@state.co.us</a></td>
<td><a href="http://www.cdphe.state.co.us/ps/cdfp/contact.html">http://www.cdphe.state.co.us/ps/cdfp/contact.html</a></td>
<td>4300 Cherry Creek Drive South Denver, CO 80246</td>
<td>provides reimbursement for nutritious meals and snacks served to eligible children in child care centers, family day care homes, as well as to eligible adults in adult care centers.</td>
</tr>
<tr>
<td>Statewide</td>
<td>Colorado Nutrition Education Plan-Live Well Colorado</td>
<td>Jennifer Anderson</td>
<td>(970) 491-7334 <a href="mailto:anderson@cahs.colostate.edu">anderson@cahs.colostate.edu</a></td>
<td><a href="http://about.livewellcolorado.org/state-initiatives/colorado-nutrition-education-plan">http://about.livewellcolorado.org/state-initiatives/colorado-nutrition-education-plan</a></td>
<td>Colorado State University Fort Collins, CO 80523</td>
<td>Education in community about nutrition, healthy eating and physical activity.</td>
</tr>
<tr>
<td>Statewide</td>
<td>SEA: Coordinated School Health Program</td>
<td>Jon Gallegos</td>
<td>(303) 692-2319 <a href="mailto:Jon.gallegos@state.co.us">Jon.gallegos@state.co.us</a></td>
<td><a href="http://www.cdphe.state.co.us/ps/cash/schoolagehealth/cshpprogram.html?col3=open,col4=open,col6=open">http://www.cdphe.state.co.us/ps/cash/schoolagehealth/cshpprogram.html?col3=open,col4=open,col6=open</a></td>
<td>4300 Cherry Creek Drive South Denver, CO 80246</td>
<td>Community programs in state schools that focus on education.</td>
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<td>Statewide</td>
<td>Eat Right Colorado</td>
<td>Athena Evans</td>
<td>(303) 757-2060 <a href="mailto:eatrightcolorado@gmail.com">eatrightcolorado@gmail.com</a></td>
<td><a href="http://www.eatrightcolorado.org/">http://www.eatrightcolorado.org/</a></td>
<td>1805 South Bellaire Street Suite 505 Denver, CO 80222</td>
<td>Individual nutritional assessment and counseling, education, resources and referral</td>
</tr>
<tr>
<td>Moffat County</td>
<td>Head Start Craig</td>
<td>Judi Whilden</td>
<td>970-824-9307 <a href="mailto:sunrisekids@yahoo.com">sunrisekids@yahoo.com</a></td>
<td></td>
<td>700 School Street Craig, CO 81625</td>
<td>Head Start partners with the families and the communities served to value children, families, and their cultures. We are committed to our role in expanding lifelong educational, nutritional, health, and mental health opportunities for head start families and their children</td>
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<td>Moffat County</td>
<td>Family Health Northwest Colorado Visiting Nurse Association</td>
<td>Stephanie Anderson</td>
<td>(970) 871-7636 <a href="mailto:sanderso@nwcovna.org">sanderso@nwcovna.org</a></td>
<td><a href="http://www.nwcvnana.org">www.nwcvnana.org</a></td>
<td>745 Russell Street Craig, CO 81625</td>
<td>Programs for Young Families include: -Community Health Care - Primary Care -Womens Health Prenatal Care -NFP - Nurse Family Partnership -New Arrivals -WIC (Women, Infants, and Children Nutrition Program) -Children with Special Needs -CHP (Child Health Plan Plus)-health and dental care for uninsured children -Medicaid Eligibility and Enrollment -Immunizations</td>
</tr>
<tr>
<td>Grand County</td>
<td>Grand County Nutrition Services</td>
<td>Shelly Cecil, Coordinator</td>
<td>970-725-3288 <a href="mailto:scceil@co.grand.co.us">scceil@co.grand.co.us</a></td>
<td>co.grand.co.us/homehealth.html</td>
<td>150 Moffat Ave Hot Sulphur Springs, CO 80451</td>
<td>Provides health and affordable meals to Grand County Seniors on Monday, Tuesday, and Thursday or home delivered meals are available to homebound seniors. Meals located at Granby Community Center and Silver Spruce apartments in Kremmling</td>
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<td>County or Statewide Program</td>
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<td>Moffat County, Routt County, Wyoming, Rio Blanco</td>
<td>Craig VA Telehealth Clinic</td>
<td>April Branstetter, RN, BSN, CPAN</td>
<td>970-824-6721</td>
<td></td>
<td>785 Russell St. Suite 400 Craig, CO 81625</td>
<td>Veteran Health Administration Outreach Clinic that does primary care, mental health, retinal, wound care, physical assessments, MOVE (weight loss) tele-surgical -all through a telehealth (video)- via Grand Junction VA Medical Center (GJVAMC) providers. By appointment only. No walk-ins.</td>
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<tr>
<td>Moffat County</td>
<td>Meals on Wheels</td>
<td>Ute Jantz, Executive Director</td>
<td>970-824-3911 <a href="mailto:ujantz@moffatcounty.net">ujantz@moffatcounty.net</a></td>
<td><a href="http://www.colorado.gov/moffatcounty">www.colorado.gov/moffatcounty</a></td>
<td>633 Ledford Street Craig, CO 81625</td>
<td>Meals On Wheels is a program of Moffat County Housing Authority. It provides hot, low-cost, nutritional meals to seniors and others who may qualify.</td>
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<td>County or Statewide Program</td>
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<td>Rio Blanco County</td>
<td>Rio Blanco County Nursing Service</td>
<td>Diane Banta, Director</td>
<td>970-878-9520 <a href="mailto:nrs-rgly@co.rio-blanco.co.us">nrs-rgly@co.rio-blanco.co.us</a></td>
<td><a href="http://www.co.rio-blanco.co.us">www.co.rio-blanco.co.us</a></td>
<td>345 Market St. Meeker, Co 81641</td>
<td>Public health program including Family Planning, EPSDT, Immunization and other health services. WIC program for women, pregnant-breast-feeding mothers, infants and children provides nutrition education infants up to 1 year and children up to 5 years of age. Gives vouchers for specific nutritious foods only.</td>
</tr>
<tr>
<td>Rio Blanco County</td>
<td>Senior Nutrition Department of Social Services</td>
<td>Rhonda Hilk ey, Paula Davis (Rangely), Eligibility Specialist</td>
<td>970-878-9640</td>
<td><a href="http://www.co.rio-blanco.co.us/socialservices/">http://www.co.rio-blanco.co.us/socialservices/</a></td>
<td>345 Market Street Meeker, Co 81641</td>
<td>Provides meals to persons aged 60 and over in a congregate setting to assure a nutritionally balanced diet and to provide opportunity for socialization. Nutrition sites are located in both Meeker and Rangely.</td>
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<td>County or Statewide Program</td>
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<td>Routt County</td>
<td>Community Action Network</td>
<td>Athena Fren tress, Director</td>
<td>970-276-3262 <a href="mailto:tfrentress@q.com">tfrentress@q.com</a></td>
<td>495 W. Jefferson Hayden, Co 81639</td>
<td>To provide opportunities for youth to promote positive relationships between the community, school, and home environments. Promotes community volunteer work and healthy living in Hayden. Programs have included: anti-smoking, anti-bullying, health fair for elementary and high students, summer youth recreation program, Christmas candy and pictures, red-ribbon day and highway clean-up.</td>
<td></td>
</tr>
<tr>
<td>Routt County</td>
<td>Yampa Valley Housing Authority</td>
<td>Mary Alice Page-Allen, Manager</td>
<td>970-870-0167 <a href="mailto:mapageallen@yvha.org">mapageallen@yvha.org</a></td>
<td>1370 Bob Adams Drive, Suite 203 Steamboat Springs, CO 80487</td>
<td>Promotes a healthy and diverse community by increasing the availability of affordable housing for the people of Routt County.</td>
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</tr>
<tr>
<td>Routt County</td>
<td>Self-Help Housing Program- Yampa Valley</td>
<td><a href="mailto:inquiry@yvha.org">inquiry@yvha.org</a></td>
<td>1370 Bob Adams Drive Steamboat Springs, CO 80477</td>
<td>Promotes a healthy and diverse community by increasing the availability of affordable housing for the people of Yampa Valley.</td>
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<tr>
<td>County or Statewide Program</td>
<td>Provider</td>
<td>Contact Person</td>
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</tr>
<tr>
<td>Routt County</td>
<td>Steamboat Springs Chamber Resort Association</td>
<td>Sandy Evans-Hall, Executive Director</td>
<td>970-875-7007 <a href="mailto:sevans@steamboatchamber.com">sevans@steamboatchamber.com</a></td>
<td><a href="http://www.steamboatchamber.com/">www.steamboatchamber.com/</a></td>
<td>125 Anglers Way Steamboat Springs, CO 80487</td>
<td>To support, encourage and sustain a vibrant, healthy economy in Steamboat Springs and surrounding areas; to act as a spokesperson for the business and professional community; to support all existing industries and welcome and nurture new industries; to preserve our environment and workforce as internal components of our economic well-being.</td>
</tr>
<tr>
<td>Rio Blanco County, Moffat, Routt</td>
<td>Nurse Family Partnership-Northwest Colorado Visiting Nurse Association</td>
<td>Ann Irvin R.N., Program Supervisor</td>
<td>970-824-8233 <a href="mailto:airvin@nwcovna.org">airvin@nwcovna.org</a></td>
<td><a href="http://www.nwcovna.org">www.nwcovna.org</a></td>
<td>745 Russell Street Craig, CO 81625</td>
<td>Prenatal and Early Childhood-Nurse Home Visitation Program-for First Time Mothers. Clients who qualify for the program receive home visits by a Registered Nurse as early in pregnancy as possible and continue through the first two years of the child's life. The nurse partners with and empowers families by helping them learn about healthy behaviors, child development, parenting and community resources. The program is offered at no cost to the family.</td>
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<td>County or Statewide Program</td>
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</tr>
<tr>
<td>Jackson</td>
<td>CSU Jackson County Extension</td>
<td>Debbie Alpe, Extension Agent</td>
<td>970-723-4298</td>
<td><a href="http://www.ext.colostate.edu">www.ext.colostate.edu</a></td>
<td>312 5th St. Walden, CO 80480</td>
<td>Provide Information and education for Agriculture, Horticulture, Food Safety, parenting, Healthy Indoor Air, food preparation and preservation.</td>
</tr>
<tr>
<td>Rio Blanco County</td>
<td>Wellness Center-Pioneer Medical Center</td>
<td>Gina Spaay, Manager</td>
<td>970-878-9298</td>
<td><a href="http://www.pioneershospital.org">www.pioneershospital.org</a></td>
<td>345 Cleveland St Meeker, Co 81641</td>
<td>Wellness services. Equipped to accommodate cardiovascular, strength, and endurance training. Personal fitness trainers are available to develop individualized workout programs.</td>
</tr>
<tr>
<td>Routt County</td>
<td>Community Action Network</td>
<td>Athena Fren tress, Director</td>
<td>970-276-3262</td>
<td><a href="mailto:tfrentress@q.com">tfrentress@q.com</a></td>
<td>495 W. Jefferson Hayden, Co 81639</td>
<td>To provide opportunities for youth to promote positive relationships between the community, school, and home environments. Promotes community volunteer work and healthy living in Hayden. Programs have included: anti-smoking, anti-bullying, health fair for elementary and high students, summer youth recreation program, Christmas candy and pictures, red-ribbon day and highway clean-up.</td>
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<td>County or Statewide Program</td>
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<tr>
<td>Routt County</td>
<td>Steamboat Springs Parks, Recreation, and Open Space Department</td>
<td>Chris Wilson, Director</td>
<td>970-879-4300</td>
<td><a href="http://www.steamboatsprings.net">www.steamboatsprings.net</a></td>
<td>245 Howelsen Parkway Steamboat Springs, CO 80477</td>
<td>Provides quality facilities, recreational programs, and open space that fulfills the needs of a diverse community and visitors while working to preserve Steamboat's rich western and skiing heritage.</td>
</tr>
<tr>
<td>Routt County</td>
<td>Totally Kids</td>
<td>Amy J. Williams, President</td>
<td>970-276-2532</td>
<td><a href="mailto:amywilliams@mybrokers.com">amywilliams@mybrokers.com</a></td>
<td>Hayden Valley Elementary Hayden, CO 81639</td>
<td>Provides youth services in the Hayden community including an after school program, summer day camp, youth sports, swimming lessons and dance lessons.</td>
</tr>
<tr>
<td>Routt, Moffat</td>
<td>Yampa Valley Community Foundation</td>
<td>Jennifer Shea, Program Manager</td>
<td>970-879-8632</td>
<td><a href="http://www.yvcf.org">www.yvcf.org</a></td>
<td>465 Anglers Dr. Suite 2G Steamboat Springs, CO 80487</td>
<td>The mission of the Yampa Valley Community Foundation is to develop annual and growing funds to support organizations and innovative programs that preserve traditions and maintains the character of the community we serve, while respecting the wishes of our donors. Yampa Valley Community Foundation provides grants to organizations, not individuals. We connect people who care with causes that matter.</td>
</tr>
<tr>
<td>County or Statewide Program</td>
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</tr>
<tr>
<td>Jackson County</td>
<td>4-H Youth Development Program</td>
<td>Debbie Alpe, Extension Agent</td>
<td>970-723-4298</td>
<td><a href="http://www.ext.colostate.edu">www.ext.colostate.edu</a></td>
<td>312 5th St. Walden, CO 80480</td>
<td>Education programs that emphasize the total development of young people who are members through engaging work on the animal, engineering, family/consumer, health, resource, plant or social science. Members also participate in camping activities, leadership conferences, awards programs and community service activities.</td>
</tr>
</tbody>
</table>
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OVERVIEW

Oral health is essential to overall health. Good oral health improves a person’s ability to speak, smile, smell, taste, touch, chew, swallow, and make facial expressions to show feelings and emotions. However, oral diseases, from cavities to oral cancer, cause pain and disability for many Americans. Oral and craniofacial diseases and conditions include:

- Dental caries (tooth decay)
- Periodontal (gum) diseases
- Cleft lip and palate
- Oral and facial pain
- Oral and pharyngeal (mouth and throat) cancers

Major improvements have occurred in the Nation’s oral health, but some challenges remain and new concerns have emerged. One important emerging oral health issue is the increase of tooth decay in preschool children. A recent Centers for Disease Control and Prevention (CDC) publication reported that, over the past decade, dental caries (tooth decay) in children ages 2 to 5 has increased.

UNDERLYING CAUSES OF ORAL DISEASE

Poor oral health has many causes. At the start of life, parents can transmit cavity-causing bacteria directly to their children.

The following factors impact oral health:

- Our mouths: Bacteria, acid-base level (pH), saliva flow, chronic diseases affecting the mouth
- Our children: Regular dental exams, brushing twice a day with fluoridated toothpaste and flossing
- Our families: Families’ overall health status, nutrition, daily habits, income and composition

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3 http://www.cdphe.state.co.us/hs/winnableBattles/oralHealth.html
• Our community: Community water fluoridation, resources for oral health, providers who accept new patients and patients with Medicaid or CHP+, social and cultural attitudes toward oral care

### SOCIAL DETERMINANTS OF ORAL DISEASE

Colorado kids miss an estimated 900,000 days of school every year due to mouth pain. This increases the achievement gap, making it difficult for children to perform as well as their peers. This nationwide trend, reported in 2007 by the Department of Health and Human Services, is especially true for poor and minority children. They continue to suffer the most from dental decay and receive less preventive care, such as tooth sealants (Colorado Oral Health Survey).

Almost a third of Hispanic children in Colorado have untreated cavities and/or decay. Hispanic adults have similar rates. More than 40 percent of African-American adults have lost five or more teeth because of cavities.

Low-income children who visit a dentist by age 1 year are less likely to get cavities and need expensive dental procedures or emergency room visits. Regular dental visits reduce average dental costs by nearly 40 percent.

### ORAL HEALTH AND OVERALL HEALTH

Oral health is an essential part of overall health. Everyone can be affected by oral disease, even people without teeth. Poor oral health can escalate into far more serious problems later in life. Cavity-causing bacteria can be passed from parents to children. Children without dental sealants (protective tooth coatings) and communities without fluoride in their water are unprotected and at a higher risk of tooth decay at every age.

Periodontal disease (gum disease) is linked to cardiovascular disease, diabetes and stroke. Medications to control chronic diseases can cause a dry mouth, leading to fast-growing cavities. People with ill-fitting dentures are at risk for nutritional deficiencies and poor quality of life.

### ACCESS TO DENTAL SERVICES

Access barriers include lack of dental insurance and limited availability of dental providers accepting publicly funded programs, as well as lack of knowledge about the importance of oral health as it relates to general health and well-being. While an

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4 [http://www.cdphe.state.co.us/hs/winnableBattles/oralHealth.html](http://www.cdphe.state.co.us/hs/winnableBattles/oralHealth.html)

5 [Ibid.](#)

6 [http://www.cdphe.state.co.us/pp/oralhealth/Impact.pdf](http://www.cdphe.state.co.us/pp/oralhealth/Impact.pdf)
estimated 43 million Americans currently are without medical insurance, there are more than 150 million Americans with limited or no dental insurance. The most vulnerable populations are those least likely to receive preventive and restorative dental services, such as the low income, the least educated, racial and ethnic minorities, immigrants, the elderly, persons with HIV, the developmentally and medically disabled, and the uninsured. In Colorado, 42 percent of adults reported not having dental insurance, and 30.5 percent of Colorado children are estimated to be without coverage. Less than half of the state’s at-risk children use their Medicaid and/or CHP+ dental benefits. Many areas of Colorado do not have dentists or hygienists, and many of them do not accept Medicaid or CHP+ or treat young children. Finally, oral health care must be part of primary prevention for every Coloradan.

### ORAL HEALTH GOALS

Reducing the burden of oral disease has been identified as one of Colorado’s greatest opportunities for ensuring the health of citizens and has been selected as a top ten “Winnable Battle” by the Colorado Department of Public Health and Environment.7

In January, 2012, CDPHE released three oral health goals for 2016:

- Increase to 4.6 percent the percentage of Colorado infants who get a dental checkup by age 1 year.

- Increase to 39 percent the percentage of Colorado third-graders who have dental sealants on permanent molars.

- 75 percent or more of the population served by community water systems receives optimally fluoridated water.

The Colorado Oral Health Coalition is in the process of updating its Oral Health Strategic Plan, which will be released in the spring of 2012.

---

7 [http://www.cdphe.state.co.us/hs/winnableBattles/oralHealth.html](http://www.cdphe.state.co.us/hs/winnableBattles/oralHealth.html)
COLORADO CHILD HEALTH SURVEY: How would you rate the condition of your child’s teeth?

Figure 1: Percent of Colorado Children with Fair or Poor Teeth

Routt County and HSR 11 parents rate the health of their children’s teeth as ‘Fair or Poor’ more often than on a state level. No data is available for Moffat County. In general, people with lower levels of education and income, and people from specific racial/ethnic groups, have higher rates of disease.

---

8 Chart Source: Colorado Child Health Survey, CDPHE. Data for Children 1-14
For children, untreated cavities can cause pain, dysfunction, school absences, difficulty concentrating, and poor appearance—problems that greatly affect a child's quality of life and ability to succeed. Children from lower-income families often do not receive timely treatment for tooth decay, and they are more likely to suffer from these problems.\(^9\)

The majority of pediatric emergency room visits for dental problems are related to complications of untreated decay.\(^10\)

Children in Moffat County have a prevalence rate of untreated decay that is highest in YVMC’s Primary Service Area, however; both Moffat and Routt county prevalence rates are below the State.

---

\(^9\) [http://www.cdc.gov/chronicdisease/resources/publications/AAG/doh.htm](http://www.cdc.gov/chronicdisease/resources/publications/AAG/doh.htm)

\(^10\) [http://jada.ada.org/content/137/3/379.abstract](http://jada.ada.org/content/137/3/379.abstract)

\(^\text{11}\) Chart Source: Children’s Basic Screening Survey, Oral Health Unit, Colorado Department of Public Health and Environment. 2011 Data was reported incorrectly, 2007 is most recent data. The information in this table is based on the oral health of children examined in Colorado and the proportion of children in each county enrolled in schools with varying levels of eligibility for the free and/or reduced price meal program (\(<25\%\), \(25-49\%\), \(50-74\%\), and \(>75\%\)).
THIRD-GRADE CHILDREN WITH SEALANTS

Colorado Oral Health Survey: County Level Estimates of the Colorado Third Graders with Dental Sealants in at Least One Permanent Molar

Many children still go without simple measures that have been proven to be effective in preventing oral diseases and reducing dental care costs.

One effective way to prevent cavities is through the use of dental sealants—plastic coatings applied to the chewing surfaces of the back teeth, where most decay occurs. Yet, nationally, only about one-third of children aged 6–19 years have sealants.

Colorado State levels of sealants are equivalent to National levels. Routt County has sealant placement rates higher than the State and is already meeting the Colorado 2016 goal. Moffat County sealant rates are below the State.

Figure 3: Percent of Colorado Third Graders with Dental Sealants

---

15 Chart Source: Children's Basic Screening Survey, Oral Health Unit, Colorado Department of Public Health and Environment. 2011 Data was reported incorrectly, 2007 is most recent data. The information in this table is based on the oral health of children examined in Colorado and the proportion of children in each county enrolled in schools with varying levels of eligibility for the free and/or reduced price meal program (<25%, 25-49%, 50-74%, and >75%).
THIRD-GRADE CHILDREN ORAL DISEASE DEMOGRAPHICS

In schools with more than 25% of children eligible for free/reduced price meals, sealant placement in molars was significantly lower than schools with less than 25% of children eligible for free/reduced price meals.

**Percent of Third Graders who have Dental Sealants on Permanent Molars by Free and Reduced Price Meal Status of School for 2006-2007**

<table>
<thead>
<tr>
<th></th>
<th>Percentage</th>
<th>Lower Limit</th>
<th>Upper Limit</th>
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<tbody>
<tr>
<td>&lt;25%</td>
<td>47.2</td>
<td>44.3</td>
<td>50.2</td>
</tr>
<tr>
<td>25-49%</td>
<td>29.9</td>
<td>26.9</td>
<td>32.9</td>
</tr>
<tr>
<td>50-74%</td>
<td>35.9</td>
<td>31.9</td>
<td>39.9</td>
</tr>
<tr>
<td>75%+</td>
<td>28.1</td>
<td>23.8</td>
<td>32.3</td>
</tr>
<tr>
<td>All</td>
<td>37.1</td>
<td>35.3</td>
<td>38.8</td>
</tr>
</tbody>
</table>

*Figure 4: Third-grade Sealants by Free/Reduced Meal Status*

Hispanic children have significantly lower rates of sealants than White/Non-Hispanic children.

**Percent of Third Graders who have Dental Sealants on Permanent Molars by Race/Ethnicity for 2006-2007**

<table>
<thead>
<tr>
<th></th>
<th>Percentage</th>
<th>Lower Limit</th>
<th>Upper Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>42.4</td>
<td>40.0</td>
<td>44.8</td>
</tr>
<tr>
<td>Hispanic</td>
<td>30.8</td>
<td>27.9</td>
<td>33.8</td>
</tr>
<tr>
<td>All</td>
<td>37.1</td>
<td>35.3</td>
<td>38.8</td>
</tr>
</tbody>
</table>

*Figure 5: Third-grade Sealants by Race/Ethnicity*

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13 Children’s Basic Screening Survey, Oral Health Unit, Colorado Department of Public Health and Environment. Data prepared by: Oral Health Unit, Colorado Department of Public Health and Environment. 2011 Data was reported incorrectly, 2007 is most recent data. The information in this table is based on the oral health of children examined in Colorado and the proportion of children in each county enrolled in schools with varying levels of eligibility for the free and/or reduced price meal program (<25%, 25-49%, 50-74%, and >75%).

14 Ibid.
INFANTS WHO GET A DENTAL CHECKUP BY AGE ONE YEAR

Colorado Child Health Survey: Percent of children ages 1-5 who first went to the dentist by 12 months of age

The early detection of oral disease is a key strategy in reducing the overall burden of oral disease in Colorado.

In 2009, Colorado Medicaid began reimbursing medical providers for conducting dental well-child visits, in an effort to increase the number of infants and toddlers who have received a dental exam.

Due to the small amount of data collected, differences in County-level data is not for Routt or Moffat County or the Health Statistics Region. The 2010 state percentage of children aged 1-5 who first went to the dentist by 12 months of age is 3.5%. The Colorado 2016 goal is 4.6%.
CHILDREN WITH A REGULAR SOURCE OF DENTAL CARE

Colorado Child Health Survey Question: Does [child’s name] have a regular source of dental care, including a dentist, hygienist, orthodontist, or oral surgeon?

![Pie chart showing percentage of children with and without regular source of dental care in 2010.]

Figure 6: Colorado Children with Regular Source of Dental Care

People who have the least access to preventive services and dental treatment have greater rates of oral diseases. A person’s ability to access oral health care is associated with factors such as education level, income, race, and ethnicity.

Increasing access to dental services is a Healthy People 2020 Objective, though Colorado data is not comparable due to differences in measurement. Colorado, overall, appears to be performing well in this area for children. County data are not available, however; it could be reasonably assumed that counties with high rates of untreated decay also have a lower percentage of children with a regular source of care compared to state levels.

---

15 Chart Source: Colorado Child Health Survey, CDPHE. Data for Children 1-14
While rates have improved, less than half of the Colorado’s at-risk children use their Medicaid and/or CHP+ dental benefits. Nationally, fifty-eight percent of children with private dental insurance received preventive dental services in 2007.

The Colorado Department of Health Care Policy and Financing monitors oral health benchmarks for children on Medicaid. The Pew Center on the States estimates that preventable dental conditions were the primary diagnosis in 830,590 visits to ERs nationwide in 2009—a 16 percent increase from 2006.17 For many low-income children, emergency rooms are the first and last resort because their families struggle to find a dentist who either practices in their area or accepts Medicaid patients.

17 http://www.pewcenteronthestates.org/uploadedFiles/A%20Costly%20Dental%20Destination.pdf
18 http://www.colorado.gov/cs/Satellite?c=Page&childpagename=HCPF%2FHCPFLayout&cid=1251607707486&pagename=HCPFWrapper
ADULTS WITH TOOTH LOSS DUE TO TOOTH DECAY AND GUM DISEASE

BRFSS Survey Question: Percent of Adults Who Ever Lost Any Teeth Due to Decay or Periodontal Disease

Tooth decay (cavities) is a common, preventable problem for many adults. When severe, it can lead to tooth loss. Periodontal (gum) disease is an infection caused by bacteria that gets under the gum tissue and begins to destroy the gums and bone. Teeth become loose, chewing becomes difficult, and teeth may have to be extracted.

The prevalence rate of adults in Moffat County who have lost teeth is higher than the State. Routt County has a rate of adults that have lost teeth that is lower than the State.

Figure 9: Percent of Colorado Adults with Permanent Teeth Removed

19 http://www.cdc.gov/chronicdisease/resources/publications/AAG/doh.htm
20 Chart Source: Behavioral Risk Factor Surveillance System, CDPHE.
ADULTS WITH TOOTH LOSS DUE TO TOOTH DECAY AND GUM DISEASE

DEMOGRAPHICS

Percentage of Adults with Chronic Disease
Who have Lost Teeth, 2002

Research has linked oral infections with diabetes, heart disease, stroke, and premature, low-weight births. Further research is under way to examine these connections. Adults with diabetes are significantly more likely to lose teeth than adults overall. A recent study demonstrated that diabetic patients receiving regular dental care had lower ER and hospital utilizations rates due to diabetes than diabetic patients who did not receive regular dental care.  

Rates of tooth loss increase significantly with age.

Hispanic adults have significantly higher rates of tooth loss than White/Non-Hispanic adults.

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21 The Journal of the American Dental Association January 1, 2012 vol. 143 no. 1 20-30
22 Chart Source: Behavioral Risk Factor Surveillance System, CDPHE, as charted in http://www.cdphe.state.co.us/pp/oralhealth/Impact.pdf
23 Chart Source: Behavioral Risk Factor Surveillance System, CDPHE.
24 Ibid.
Adults with income $50,000 or above have significantly lower rates of tooth loss than other income groups. All other differences in income are not statistically significant.

![Figure 13: Adults Who Have Lost Teeth by Income](image)

Adults with some post-high school education and adults with college degrees have significantly lower rates of tooth loss than other groups.

![Figure 14: Adults Who Have Lost Teeth by Education](image)

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25 Chart Source: Behavioral Risk Factor Surveillance System, CDPHE.
26 Ibid.
**ADULT DENTAL VISITS**

*BRFSS Survey Question:*  How long has it been since you last visited a dentist or a dental clinic for any reason? Include visits to dental specialists, such as orthodontists.

![Graph showing adults who saw a dentist within the last 12 months in Colorado](image)

Figure 15: Colorado Adults Who Saw a Dentist Within the Last 12 Months

While State rates are similar to National rates, this measure does not necessarily indicate a regular source of care. A growing number of adults seek emergency dental care each year. People with lower levels of education and income end up in an emergency room for dental issues more often than others. Sometimes it is severe enough for hospital admission.

A Study of Emergency Department Visits for Preventable Dental Conditions in California in 2009[^28] found that people more likely to visit the Emergency Department were:

- People without private insurance (7 times more likely to visit the ED, controlling for other demographic characteristics)
- People living in rural areas.
- People ages 18 to 34 are significantly more likely to visit the Emergency Department

The Statewide Emergency Department visit rate, without hospitalization, for ambulatory dental conditions runs higher than that for diabetes.

[^27]: Source: Behavioral Risk Factor Surveillance System, CDPHE. Data for Adults 18 years and older. Percents are weighted to the total population.

[^28]: [http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/E/PDF%20EDUseDentalConditions.pdf](http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/E/PDF%20EDUseDentalConditions.pdf)
The 2009 rate of fluoridated water in Colorado communities is 73.9%. Colorado just misses the national goal of providing fluoridated water to 75 percent of its population on community water supplies.\(^{30}\) A 2001 CDC study estimated that for every $1 invested in water fluoridation, communities save $38 in dental treatment costs.\(^{31}\) Both Routt and Moffat Counties have fluoridated water.

\(^{29}\) http://www.cdphe.state.co.us/pp/oralhealth/Impact.pdf

\(^{30}\) http://www.pewcenteronthestates.org/uploadedFiles/wwwpewcenteronthestatesorg/Initiatives/ChildrensDental_Health/011_10_DENT%20Cost%20of%20Delay%20Factsheets_Colorado.pdf

**INTerventions**

**colorado Department of public Health and environment: oral health Department**

Oral Health Awareness Colorado! (OHAC!) is a state-wide oral health coalition made up of federal, state and local organizations and individuals formed to address the burden of oral diseases in Colorado and to develop a formal Colorado Oral Health Plan. OHAC engages providers, business representatives, educators, third-party payers and community leaders around their mission “to develop and promote strategies to achieve optimal oral health for all Coloradans.” OHAC raises awareness of the connections between oral health and general health through their media campaign, “Be A Smart Mouth.”


The OHAC plan for 2010 focused on six major areas for achieving oral health for all Colorado citizens. Within each area, priority outcomes have been identified:

<table>
<thead>
<tr>
<th>Financing Outcomes</th>
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<tbody>
<tr>
<td>Increase, proportionally, the amount of dollars spent on oral health care relative to overall health care.</td>
</tr>
<tr>
<td>Increase the number of Coloradans who have access to dental insurance coverage.</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Health Promotion Outcomes</th>
</tr>
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<tbody>
<tr>
<td>Change the paradigm of how oral health is viewed by health care providers.</td>
</tr>
<tr>
<td>Increase at-risk populations’ awareness and understanding of prevention and treatment availability.</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Policy and Advocacy Outcomes</th>
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<tbody>
<tr>
<td>Advocate for changing the Dental Practice Act regarding licensing registered dental hygienists and foreign-trained dentists.</td>
</tr>
<tr>
<td>Improve reimbursement to oral health care providers, from private and public-funded sectors, for all services.</td>
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<tr>
<th>Promising Practices Outcomes</th>
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<td>Expand oral disease prevention and referral services into school health programs throughout the state.</td>
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<tr>
<td>Achieve greater than 90% of the population on public water systems receiving optimal fluoridation.</td>
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32 [http://www.cdphe.state.co.us/pp/oralhealth/Impact.pdf](http://www.cdphe.state.co.us/pp/oralhealth/Impact.pdf)
Assure that Colorado children at greatest risk of dental disease receive dental sealants.

### Systems of Care Outcomes

- Integrate an oral check-up with the standard physical exam.
- Improve coordination and communication between the public and private sectors and systems of care.
- Develop a collaborative workforce.

### Workforce Outcomes

- Increase the number of providers willing to serve low-income and underserved clients.
- Enhance access to care through recruitment of providers who are diverse, culturally competent, and representative of the populations they serve.
- Increase curriculum time for medical, dental, nursing students and allied health professionals regarding oral health as a component of general health.
- Actively recruit non-traditional, ethnically and culturally diverse candidates into dental and dental hygiene programs.

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**THE PEW CENTER ON STATES**

The Pew Center on the States is a division of The Pew Charitable Trusts that identifies and advances effective solutions to critical issues facing states. Pew is a nonprofit organization that applies a rigorous, analytical approach to improve public policy, inform the public and stimulate civic life. The Pew Center ranks the states based on their dental policies in *The Cost of Delay: State Dental Policies Fail One in Five Children*.33

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34 Ibid.

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*Figure 17: Colorado Progress on Dental Policy Approaches*³⁴
SEALANT PROGRAMS IN HIGH-RISK SCHOOLS

Studies have shown that targeting sealant programs to schools with many high-risk children is a cost effective strategy for providing sealants to children who need them—but this strategy is vastly underutilized. New data collected for Pew by the Association of State and Territorial Dental Directors show that only 10 states have school-based sealant programs that reach half or more of their high-risk schools. These 10 states are Alaska, Illinois, Iowa, Maine, New Hampshire, Ohio, Oregon, Rhode Island, South Carolina and Tennessee.

BE SMART AND SEAL THEM!

Be Smart and Seal Them is an oral health prevention program supported by the Colorado Department of Public Health & Environment Oral Health Program. It is a school-based or school-linked dental sealant project specifically geared toward second grade children in Colorado.

AUTHORIZATION OF NEW PROVIDERS

An increasing number of states are exploring new types of dental professionals to expand access and fill specific gaps. Some are primary care providers who could play a similar role on the dental team as nurse practitioners and physician assistants do on the medical team, expanding access to basic care and referring more complex cases to dentists who may provide supervision on- or off-site. In a model proposed by the ADA, these professionals would play a supportive role similar to a social worker or community health worker. In remote locations, the most highly trained professionals could provide basic preventive and restorative care as part of a dental team with supervision by an off-site dentist. Colorado recently approved Medicaid reimbursements to primary care physicians for providing preventive dental services to kids.

COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

The Colorado Department of Health Care Policy and Financing has created a toolkit for Primary Care Physicians and other medical providers to provide guidance on

36 http://www.cdphe.state.co.us/pp/oralhealth/BeSmartandSealThem.pdf
how to document and address preventive care in oral health for Medicaid and the Children’s Health Insurance Program (CHP+) clients. Primary care providers should screen all children for oral health problems like tooth decay during pediatric well child visits. Trained medical personnel (see qualifications below) may administer fluoride varnish at a well-child visit to Medicaid and CHP+ children ages birth through 4 (until the day before their fifth birthday) who have moderate to high caries risk after they complete a risk assessment and document it in the medical record.

Medicaid will reimburse for a maximum of three fluoride varnish administrations per year for each eligible and high risk child, and CHP+ will reimburse for a maximum of two per year for CHP+ clients. Additionally, State Managed Care Network CHP+ clients must be treated by a CHP+ participating primary care provider. Dental and medical providers are encouraged to communicate with one another to avoid duplication and nonpayment of services.

CAVITY FREE AT THREE

Cavity Free at Three is a three-year, statewide effort to prevent oral disease in young children. The effort aims to engage dentists, physicians, nurses, dental hygienists, public health practitioners and early childhood educators in the prevention and early detection of oral disease in pregnant women, infants and toddlers.

The Colorado AHEC System Office is to provide leadership and management of the Cavity Free at Three Program. This program takes advantage of the statewide efforts of AHEC. AHEC will help incorporate the CF3 training into the University of Colorado Medical School, University of Colorado School of Dental Medicine, and University of Colorado School of Nursing, as well as other allied health curricula. Community marketing efforts will help educate the public regarding the importance of establishing a dental home for a child by age one. Through these efforts CF3 aims to reduce oral disparities in children, and concentrate our efforts toward the uninsured and impoverished population with the greatest barriers in access to care.

HEALTHY TEETH HAPPY BABIES

Since 2006, this critical public health campaign has been working to reduce oral disease in infants and pregnant women in Colorado. Healthy Teeth Happy Babies and the Delta Dental of Colorado Foundation run bilingual advertising throughout the Denver area to raise awareness about the link between mother and baby oral health while providing information to prevent the spread of dental disease.

The campaign also works with dentists, pediatricians, OBGYNs, health clinics, hospitals and community organizations such as Salud Family Health Centers, Tri-County Health, WIC Clinics and Nurse-Family Partnership to educate new mothers and pregnant women directly and to encourage them to see a dentist regularly.

The campaign has produced many successful results including:

- Over 500,000 bilingual infant oral health patient education cards have been requested and distributed in the oral health and medical community.
- In 2009, requests for Spanish language patient education materials consisted of nearly 30% of total requests with distribution of nearly 50,000 pieces!
- The campaign coordinated two segments about the importance of infant oral health with local television news stations (Fox31 and ABC7) featuring Lieutenant Governor Barbara O’Brien and Kate Paul speaking on the issue.
- Other community partners have collaborated on this initiative, such as Salud Family Health Centers, Denver Health, Rose Hospital, The Children’s Hospital and many safety net clinics.

For more information about the Healthy Teeth Happy Babies campaign, to order patient education materials or ask a question, contact Colleen Rauscher at Info@HealthyTeethHappyBabies.com or (303) 825-6100.
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<th>County or Statewide Program</th>
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<tr>
<td>Colorado, State-wide</td>
<td>Denver</td>
<td>Oral Health Awareness Colorado</td>
<td>Karen Cody Carlson, Executive Director of OHAC!</td>
<td>(303) 205-1924 <a href="mailto:kcodycarlson@gmail.com">kcodycarlson@gmail.com</a></td>
<td><a href="http://www.beasmartmouth.com/awareness.php">http://www.beasmartmouth.com/awareness.php</a></td>
<td>4300 Cherry Creek Drive South, PSD-OH-A4 Denver, CO 80249</td>
<td>Oral Health Awareness Colorado! (OHAC!) is a coalition of professionals representing a wide range of public, private and non-profit organizations interested in advancing oral health care in Colorado. Its mission is to develop and promote strategies that achieve optimal oral health for all Coloradans. OHAC! activities focus on the following goals: Reducing the burden of oral disease in Colorado Maximizing preventive strategies Increasing collaboration among oral health professionals and others Changing public perception about the importance of oral health</td>
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<tr>
<td>Colorado, State-wide</td>
<td>Denver</td>
<td>Oral Health in Colorado</td>
<td>Katya Mauritson, Director, Oral Health Unit</td>
<td>303-692-2470 Katya.Maurits <a href="mailto:on@state.co.us">on@state.co.us</a></td>
<td><a href="http://www.cdphe.state.co.us/pp/oralhealth/OralHealth.html">http://www.cdphe.state.co.us/pp/oralhealth/OralHealth.html</a></td>
<td>4300 Cherry Creek Drive South PSD-OH-A4 Denver, CO 80246-1530</td>
<td>The Oral Health Unit is part of the Prevention Services Division at the Colorado Department of Public Health and Environment. Staff members are working on programs to improve the oral health of Coloradans.</td>
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<tr>
<td>Colorado, State-wide</td>
<td>Denver</td>
<td>Child Health Plan Plus Division-Oral Health, Delta Dental</td>
<td>*</td>
<td>800.233.0860 <a href="mailto:customer_service@ddpco.com">customer_service@ddpco.com</a></td>
<td><a href="http://www.chp.org/">http://www.chp.org/</a>, <a href="http://www.deltadentalco.com">www.deltadentalco.com</a></td>
<td>4582 South Ulster Street, Suite 800 Denver, Colorado 80237</td>
<td>Delta Dental of Colorado provides dental benefits to all CHP+ members. These benefits include preventive and diagnostic services, basic restorative services, oral surgery and endodontics care. There will be a maximum allowable of $600 per child per calendar year (January 1 - December 31). As with all CHP+ benefits, higher income families may be required to pay a small fee when they receive services. If you have any questions about CHP+ dental benefits or Delta Dental, call Delta Dental.</td>
</tr>
<tr>
<td>Grand County</td>
<td>Hot Sulphur Springs</td>
<td>Cavity free at three-Grand County Public Health</td>
<td>Brene Belew-Ladue, Public Health Director</td>
<td><a href="mailto:bbelew@co.grand.us">bbelew@co.grand.us</a> 970-725-3288</td>
<td>co.grand.co.us.org</td>
<td>150 Moffat Ave. Hot Sulphur Springs, Co 80451</td>
<td>Cavity free at threeis a statewide effort to prevent oral disease in young children. Works with pregnant women, new mothers, and children with dental care and education.</td>
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<tr>
<td>Rio Blanco, Moffat And Routt Counties</td>
<td>Rangely</td>
<td>Colorado Northwestern Community College-Rangely</td>
<td>Sandy Kloos, Director</td>
<td><a href="mailto:skloos@cncc.cc.co.us">skloos@cncc.cc.co.us</a> 970-675-2261</td>
<td><a href="http://www.cncc.edu">www.cncc.edu</a></td>
<td>500 Kennedy Drive Rangely, Co 81648</td>
<td>Colorado northwestern community college is a two-year, co-ed, residential community college. The main campus is located in rangely. Cncc offers academic programs in dental hygiene, aviation technology, cosmetology, aviation maintenance technology, paralegal, criminal justice, business, natural resources, athletic training, fine arts, wild land firefighting, nursing, and general education. Cncc offers students a variety of distance delivery options such as telecourses, interactive tv and internet courses, in order to fit busy schedules.</td>
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<tr>
<td>Northwest Colorado, Moffat, Routt, Rio Blanco, Jackson, Grand.</td>
<td>Craig</td>
<td>Northwest Colorado Dental Coalition</td>
<td>Janet Pearcey, Executive Director</td>
<td><a href="mailto:nwcodental@qwestoffice.net">nwcodental@qwestoffice.net</a> 970-824-8000</td>
<td><a href="mailto:nwcodental@qwestoffice.net">nwcodental@qwestoffice.net</a></td>
<td>485 Yampa Street Craig, Co 81625</td>
<td>Nwcdc runs a nonprofit dental clinic that provides comprehensive dental care. In order to qualify for services, one must be medicaid eligible, chp+ eligible, or, uninsured and financially qualify for sliding fee services.</td>
</tr>
<tr>
<td>Moffat</td>
<td>Craig</td>
<td>Family Health CVNA</td>
<td>Stephanie Anderson</td>
<td><a href="mailto:sanderso@nwcovna.org">sanderso@nwcovna.org</a> (970) 871-7636</td>
<td><a href="http://www.nwcvna.org">www.nwcvna.org</a></td>
<td>745 Russell Street Craig, Co 81625</td>
<td>Programs for young families include: - community health care-primary care -womens health prenatal care -nfp - nurse family partnership -new arrivals -wic (women, infants, and children nutrition program) -children with special needs -chp (child health plan plus)-health and dental care for uninsured children -medicaid eligibility and enrollment -immunizations</td>
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<td>Grand County</td>
<td>Hot Sulphur Springs</td>
<td>Child Health Services-Grand County Public Health</td>
<td>Brene Belew-Ladue, Public Health Director</td>
<td><a href="mailto:bbelew@co.grand.us">bbelew@co.grand.us</a> 970-725-3288</td>
<td>co.grand.co.us.org</td>
<td>150 Moffat Ave.  Hot Sulphur Springs, Co 80451</td>
<td>Immunizations, injury prevention education, vouchers for medical, mental and dental care referrals based on income. Referral to resources for well child care and development concerns.</td>
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<tr>
<td>Grand, Jackson, Moffat, Routt, And Rio Blanco</td>
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<td>Oral health data systems my water’s fluoride</td>
<td></td>
<td>1-888-275-4772</td>
<td><a href="Http://apps.nccd.cdc.gov/mwf/countydata.asp?state=co">Http://apps.nccd.cdc.gov/mwf/countydata.asp?state=co</a></td>
<td>National Center For Chronic Disease Prevention And Health Promotion Centers For Disease Control And Prevention 4770 Buford Highway, Ne, Ms F-10 Atlanta, Ga 30341-3717</td>
<td>Safe, effective prevention of tooth decay for people of all ages: know if your water is optimally fluoridated.</td>
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SEXUAL HEALTH AND HIV/AIDS

OVERVIEW

Sexual health is a state of physical, emotional, mental, and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.¹

The current concerns include unintended pregnancy, use of prevention methods during sex, sexually transmitted diseases such as Chlamydia and Gonorrhea, and HIV/AIDS prevention.

UNINTENDED PREGNANCY

An unintended pregnancy is a pregnancy that is either mistimed or unwanted at the time of conception.² It is a core concept in understanding the fertility of populations and the unmet need for contraception. Unintended pregnancy is associated with an increased risk of morbidity for women, and with health behaviors during pregnancy that are associated with adverse effects. For example, women with an unintended pregnancy may delay prenatal care, which may affect the health of the infant. Women of all ages may have unintended pregnancies, but some groups, such as teens, are at a higher risk.

Nearly half of all pregnancies in Colorado are unintended, defined as pregnancies occurring sooner than desired, or occurring when no pregnancy is desired at any time.³ Women under the age of 25, with a high school education or less, who are African-American or Hispanic/Latina, or are classified as low-income are more likely to have an unintended pregnancy. Teen birth rates in the United States have been steadily declining; yet, U.S. rates remain the highest of any developed country.

Unintended pregnancy stretches the state budget, costing Medicaid in Colorado more than $160 million annually.⁴ Nationally, for every public dollar spent on prevention, $3.74 is saved in Medicaid costs. Unintended pregnancies are linked to late entry into prenatal care, birth defects, low birth weight, elective abortions, maternal depression, reduced rates of breastfeeding and increased risk of physical violence during pregnancy. Teen mothers are less likely than their peers to earn a high school diploma or GED. Children born as a result of an unintended pregnancy are more likely to experience child abuse, poor mental and physical health, lower educational attainment and behavioral problems.

¹ http://www.who.int/reproductivehealth/topics/gender_rights/sexual_health/en/
² http://www.cdc.gov/reproductivehealth/unintendedpregnancy/
³ http://www.cdphe.state.co.us/hs/winnableBattles/unintendedPregnancy.html
⁴ Ibid.
CHLAMYDIA

Chlamydia is a common sexually transmitted disease (STD) caused by the bacterium, chlamydia trachomatis, which can damage a woman's reproductive organs. Even though symptoms of chlamydia are usually mild or absent, serious complications that cause irreversible damage, including infertility, can occur "silently" before a woman ever recognizes a problem. Chlamydia also can cause discharge from the penis of an infected man.

Chlamydia is the most frequently reported bacterial sexually transmitted disease in the United States. In 2010, 1,307,893 chlamydial infections were reported to CDC from 50 states and the District of Columbia. Under-reporting is substantial because most people with chlamydia are not aware of their infections and do not seek testing. Also, testing is not often done if patients are treated for their symptoms. An estimated 2.8 million infections occur annually in the U.S. Women are frequently re-infected if their sex partners are not treated.

GONORRHEA

Gonorrhea is a sexually transmitted disease (STD). Gonorrhea is caused by Neisseria gonorrheae, a bacterium that can grow and multiply easily in the warm, moist areas of the reproductive tract, including the cervix (opening to the womb), uterus (womb), and fallopian tubes (egg canals) in women, and in the urethra (urine canal) in women and men. The bacterium can also grow in the mouth, throat, eyes, and anus. Gonorrhea is a very common infectious disease. CDC estimates that more than 700,000 persons in the U.S. get new gonorrheal infections each year. Less than half of these infections are reported to CDC. In 2009, 301,174 cases of gonorrhea were reported to CDC.

HIV/AIDS

Acquired immune deficiency syndrome (AIDS) is an infectious disease caused by the human immunodeficiency virus (HIV). There are two variants of the HIV virus, HIV-1 and HIV-2, both of which ultimately cause AIDS.

According to a report by CDC, 1.2 million people in the United States (US) are living with HIV infection. 20% of those people are unaware of their infection. Despite increases in the total number of people in the US living with HIV infection in recent years, the annual number of new HIV infections has remained relatively stable. However, new infections continue at far too high of a level, with approximately 50,000 Americans becoming infected with HIV each year.

---

5 http://www.cdc.gov/std/chlamydia/STDFact-Chlamydia.htm
6 http://www.cdc.gov/std/gonorrhea/STDFact-gonorrhea.htm
UNINTENDED PREGNANCY

PRAMS: Was pregnancy unintended?

The prevalence rate of unintended pregnancy is 37.4% in Colorado which is lower than estimated national rates of 49% in 2006.9

Routt County and HSR 11 have unintended pregnancy prevalence rates that are below the State. Routt County met the Healthy People 2010 goal. Healthy People 2020 goals are not comparable.

Figure 1: Type 1 Unintended Pregnancy Rate in Colorado

UNINTENDED PREGNANCY DEMOGRAPHICS

The prevalence of unintended pregnancy is highest in the 15 to 19 age group.

![Figure 2: Unintended Pregnancy by Age](image)

The prevalence rate of unintended pregnancy in White/Non-Hispanic adults is significantly lower than other race/ethnicity categories. The difference between Black, Hispanic, and other adults is not statistically significant.

![Figure 3: Unintended Pregnancy by Race/Ethnicity](image)

The prevalence rate of unintended pregnancy in adults with some college or more is significantly lower than adults with less education.

![Figure 4: Unintended Pregnancy by Education](image)

---

12 Ibid.
13 Ibid.
The prevalence rate of unintended pregnancy in Colorado has not changed significantly since 2006.

---

**Figure 5: Unintended Pregnancy Trends**

The prevalence rate of unintended pregnancy in Colorado has not changed significantly since 2006.

---

The fertility rate for females aged 15-17 is lower in Colorado than the Nation.
Moffat County has a teen fertility rate that is higher than the State and the same as the Nation.
Routt County has a teen fertility rate that is lower than the State and is already meeting the 2016 Colorado Winnable Battle goal of 16 births per 1000 females aged 15-17.

Figure 6: Teen Fertility Rates

TEEN FERTILITY RATES – DEMOGRAPHICS

Teen fertility rates for Hispanic females aged 15-17 are significantly higher than teens from other race/ethnicity groups. White/Non-Hispanic and Asian American/Pacific Islander teenagers have significantly lower rates.

TEEN FERTILITY RATES - TRENDS

Teen fertility rates are on the decline in Colorado.

---

16 Chart Source: Health Statistics and Vital Records (http://www.cdphe.state.co.us/hs/index.html)
17 Chart Source: http://www.cdphe.state.co.us/hs/winnableBattles/unintendedPregnancy.html
**SEXUAL ACTIVITY AND BIRTH CONTROL USE - ADULTS**

**BRFSS Survey**: The percent of sexually active adults age 18-44 using an effective method of birth control to prevent pregnancy.

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To reduce the number of unintended pregnancies, Colorado has identified increasing the use of birth control by sexually active adults as a 2016 Winnable Battle goal.

No data was collected on the prevalence of sexually active adults using birth control in Moffat and Routt Counties or HSR 11.

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\[\text{Figure 9: Sexually Active Adults Using Birth Control}^{18}\]

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\[\text{\textsuperscript{18} Chart Source: Behavioral Risk Factor Surveillance System, Colorado Department of Public Health and Environment. Data prepared by Health Statistics Section, Colorado Department of Public Health and Environment. Data is for adults aged 18-44.}\]
SEXUAL ACTIVITY AND BIRTH CONTROL USE – ADULTS DEMOGRAPHICS

The prevalence rate of sexually active adults using birth control is significantly lower in adults aged 18 to 24 than other age groups.

White/Non-Hispanic sexually active adults have a significantly higher prevalence rate of birth control use.

The prevalence rate of sexually active females using birth control is significantly higher than males.

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19 Ibid.
20 Ibid.
Differences in birth control use in sexually active adults by education are not statistically significant.

Differences in birth control use in sexually active adults by income are not statistically significant.

The prevalence rate of sexually active adults living at 150% below the poverty level using birth control is significantly lower than for adults living at or above 150% of the poverty level.

Trend data is not available.

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24 Ibid.
**SEXUAL ACTIVITY AND BIRTH CONTROL USE - YOUTHS**

**YRBS Survey:** The percent of sexually active high school students using an effective method of birth control to prevent pregnancy.

![Sexually Active Youth Using Birth Control](image)

Figure 16: Sexually Active Youth Using Birth Control

In Colorado, females report a higher rate of use of birth control than males, however these differences are not statistically significant. No data was collected on the prevalence of sexually active adults using birth control in Moffat and Routt Counties or HSR 11. Trend data is not available.

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The incidence of new chlamydia cases in 15-29 year olds per 100,000 population is 1514.7 in Colorado. Comparable national rates are not available.

Moffat County and HSR 11 have rates that are below the State. Data for Routt County is not available. Healthy People 2020 goals are not comparable.

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Similar to national trends, Colorado has experienced a significant increase in the number of reported Chlamydia cases from 2003 to 2007. The calculated rate of chlamydia in 2003 was 281.7 per 100,000 population. In 2007, this number increased to 350.2 per 100,000 population, representing an overall percent increase of 33.1 percent for this time frame.

Females continue to have higher rates of chlamydia reported than males (520.8 and 181.5 per 100,000 population, respectively). The largest proportion of chlamydia cases in 2007 was reported among young adults 20 to 24 years old; accounting for 36.4 percent of the statewide infections. Among females, the age group 20-24 accounts for 36.7 percent of all female cases. Males 20 to 24 years old account for 35.5 percent of all male cases.

Chlamydia continues to disproportionately affect people of color, especially Non-Hispanic Blacks. While Non-Hispanic Whites make of the majority of Colorado’s population (74.5 percent), this population only represented 13.6 percent of the chlamydia disease burden in 2007. In 2007 Non-Hispanic Blacks accounted for 9.1 percent of reported chlamydia case, but only represented 3.7 percent of the state’s population. Hispanics account for 16.0 percent of chlamydia cases in 2007, but represents 14.8 percent of the state population.

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29 US Census Bureau. Community Survey 2006. Demographic Profile: http://factfinder.census.gov/servlet/ADPTable?_bm=y&-geo_id=04000US08&-qr_name=ACS_2006_EST_G00_DP5&-context=adp&-ds_name=&-tree_id=306&_lang=en&-redoLog=false&-forma
GONORRHEA

STI/HIV Surveillance Program: Total number of reported gonorrhea cases and rates, Ages 15-29) per 100,000 population by county.

The incidence of new gonorrhea cases in 15-29 year olds per 100,000 population is 234.4 in Colorado. Comparable national rates are not readily available.

Moffatt and HSR 11 have rates that are below the State. No data is available for Routt County. Healthy People 2020 goals are not comparable. The Colorado 2016 goal is to decrease the state rate of new gonorrhea cases in 15-29 year olds by 3% each year.

Figure 19: Gonorrhea Rates per 100,000  

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In Colorado, gonorrhea cases continued to mirror national trends with an increase in reported cases from 2,792 cases in 2003 to 3,396 cases in 2007. Unlike the gender distribution of reported chlamydia cases, gonorrhea is more evenly distributed among males (46.5 percent) and females (53.5 percent). In 2007, the gonorrhea rate for males was 63.6 per 100,000 population and 74.4 per 100,000 population for females. Overall, CDPHE has observed significant increases in the number of reported gonorrhea cases since 2003, although the number of reported gonorrhea cases decreased from 2006 to 2007.

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HIV SCREENING

BRFSS Survey: Have you ever been tested for HIV? Do not count tests you may have had as part of a blood donation (ages 18-64)

The prevalence rate of adults tested for HIV is 39.7% in Colorado. Comparable national data is not available.

Routt and Moffat Counties have prevalence rates of adults tested for HIV that are lower than the State.

HP 2020 goals for HIV are not comparable to this data.

Figure 21: Tested for HIV

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HIV SCREENING DEMOGRAPHICS

The prevalence rate for female adults tested for HIV is significantly higher than for male adults.

Adults aged 25-44 have a significantly higher prevalence rate of being tested for HIV.

Black adults have a significantly higher prevalence rate of being tested for HIV than adults of other race/ethnicities.

Figure 22: Tested for HIV by Age

Figure 23: Tested for HIV by Race/Ethnicity

Figure 24: Tested for HIV by Income

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34 Ibid.
35 Ibid.
There are no significant differences in the prevalence rate of adults tested for HIV by income groups.

The prevalence rate of adults tested for HIV is higher in adults with some college or more, or less than a high school education, than for high school graduates.

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37 Ibid.

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HIV INCIDENCE

STI/HIV Surveillance Program: Rate of new HIV cases per 100,000 population, 2007-2009.

The incidence of new cases of HIV per 100,000 is 5.6 in Colorado. Comparable national data is not available.

HSR 11 and Routt County have incidence rates that are below the State. No data is available for Moffat County. HP 2020 goals for HIV are not comparable to this data.

Figure 28: New HIV Cases per 100,000

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39 Chart Source: Colorado Division of Disease Control and Environmental Epidemiology-STI/HIV Section.
AIDS INCIDENCE

STI/HIV Surveillance Program: Rate of new AIDS cases per 100,000 population, 2007-2009.

The incidence of new cases of AIDS per 100,000 is 6.0 in Colorado. Comparable national data is not available.

Moffat County has an incidence rate of zero. No data is available for Routt County or HSR 11. HP 2020 goals for AIDS are not comparable to this data.

Figure 29: New AIDS Cases per 100,000

40 Chart Source: Colorado Division of Disease Control and Environmental Epidemiology-STI/HIV Section.
INTERVENTIONS

Teen Pregnancy Prevention Program:

As part of the President’s Teen Pregnancy Prevention Initiative (TPPI), CDC is partnering with the federal Office of the Assistant Secretary for Health (OASH) to reduce teenage pregnancy and address disparities in teen pregnancy and birth rates. The OASH Office of Adolescent Health (OAH) is supporting public and private entities to fund medically accurate and age appropriate evidence-based or innovative program models to reduce teen pregnancy. The purpose of this program is to demonstrate the effectiveness of innovative, multicomponent, communitywide initiatives in reducing rates of teen pregnancy and births in communities with the highest rates, with a focus on reaching African American and Latino/Hispanic youth aged 15–19. A communitywide model is an intervention implemented in defined communities (specified geographic area) applying a common approach with different strategies. Communitywide approaches will be tailored to the specified community, and will include broad-based strategies that reach a majority of youth in the community (e.g., through communication strategies and media campaigns); and intensive strategies reaching youth most in need of prevention programming (e.g., through implementation of evidence-based programs and improved links to services).

The four key components to be addressed by this program are:

- **Component 1**
  Evidence-based and evidence-informed prevention program implementation: Providing teens with evidence-based and evidence-informed, medically accurate and age-appropriate teen pregnancy prevention programs. These include youth development and curriculum-based programs that reduce risk factors associated with teen pregnancy. Evidence-based programs are those that have been proven to be effective through rigorous evaluation and identified through an independent review for the Department of Health and Human Services.

- **Component 2**
  Linking teens to quality health services: Ensuring linkages between teen pregnancy prevention programs and community-based clinical services, as allowable under federal law

- **Component 3**
  Stakeholder Education: Educating stakeholders (community leaders, parents and other constituents) about relevant evidence-based and evidence-informed strategies to reduce teen pregnancy and data on needs and resources in target communities;

- **Component 4**
  Sustainability: Supporting the sustainability of the communitywide teen pregnancy prevention effort.
CLINICAL RECOMMENDATIONS

The following clinical recommendations come from the US Preventive Services Task Force (USPSTF).

BEHAVIORAL COUNSELING TO PREVENT SEXUALLY TRANSMITTED INFECTIONS

The U.S. Preventive Services Task Force (USPSTF) recommends high-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs.

SCREENING FOR CHLAMYDIAL INFECTION

The U.S. Preventive Services Task Force (USPSTF) recommends screening for chlamydial infection for all pregnant women aged 24 and younger and for older pregnant women who are at increased risk. The U.S. Preventive Services Task Force (USPSTF) recommends screening for chlamydial infection for all sexually active non-pregnant young women aged 24 and younger and for older non-pregnant women who are at increased risk.

SCREENING FOR GONORRHEA

The U.S. Preventive Services Task Force (USPSTF) recommends that clinicians screen all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection (that is, if they are young or have other individual or population risk factors).

SCREENING FOR HIV

The U.S. Preventive Services Task Force (USPSTF) recommends that clinicians screen all pregnant women for HIV. The U.S. Preventive Services Task Force (USPSTF) strongly recommends that clinicians screen for human immunodeficiency virus (HIV) all adolescents and adults at increased risk for HIV infection.

SCREENING FOR SYPHILIS INFECTION

The U.S. Preventive Services Task Force (USPSTF) strongly recommends that clinicians screen persons at increased risk for syphilis infection.

SCREENING FOR SYPHILIS INFECTION IN PREGNANCY

The U.S. Preventive Services Task Force (USPSTF) recommends that clinicians screen all pregnant women for syphilis infection.
COMMUNITY INTERVENTIONS

The following evidence-based community interventions come from the Guide to Community Preventive Services, Centers for Disease Control and Prevention (CDC).

ADOLESCENT HEALTH: PERSON-TO-PERSON INTERVENTIONS TO IMPROVE CAREGIVERS’ PARENTING SKILLS

Person-to-person interventions aim to modify adolescents’ risk/protective behaviors and health outcomes by improving their caregivers’ parenting skills.

HEALTH COMMUNICATION & SOCIAL MARKETING: HEALTH COMMUNICATION CAMPAIGNS THAT INCLUDE MASS MEDIA & HEALTH-RELATED PRODUCT DISTRIBUTION

Health communication campaigns can increase the use of health-related products when they use mass media messaging and distribute the products at free or reduced prices.

PREVENTION OF HIV/AIDS, OTHER STIS AND PREGNANCY: GROUP-BASED COMPREHENSIVE RISK REDUCTION INTERVENTIONS FOR ADOLESCENTS

Comprehensive risk reduction (CRR) promotes behaviors that prevent or reduce the risk of pregnancy, HIV, and other sexually transmitted infections (STIs).

YOUTH DEVELOPMENT BEHAVIORAL INTERVENTIONS COORDINATED WITH COMMUNITY SERVICE TO REDUCE SEXUAL RISK BEHAVIORS IN ADOLESCENTS

Youth development behavioral interventions emphasize social, emotional, or cognitive competence training that promotes pro-social norms; improved decision making; self-determination; improved communication skills; and positive bonding experiences between youth and their peers or non-parental role models. Community service may involve scheduled activities in one or more community settings.

YOUTH DEVELOPMENT BEHAVIORAL INTERVENTIONS COORDINATED WITH COMMUNITY SERVICE TO REDUCE SEXUAL RISK BEHAVIORS IN ADOLESCENTS

Youth development behavioral interventions employ a holistic approach to adolescent health and wellness, and may or may not include components that are focused directly on pregnancy and STI prevention.
### LOCAL RESOURCES

#### FAMILY PLANNING AND MATERNAL HEALTH

<table>
<thead>
<tr>
<th>County</th>
<th>City</th>
<th>Provider</th>
<th>Contact Person</th>
<th>Email</th>
<th>Website</th>
<th>Address</th>
<th>Phone Number</th>
<th>Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorado State-wide</td>
<td>Denver</td>
<td>Colorado Organization for Latino Opportunity and Reproductive Rights</td>
<td>Lorena Garcia, Executive Director</td>
<td>*</td>
<td><a href="http://www.colorlatina.org/">http://www.colorlatina.org/</a></td>
<td>P.O. Box 40991 Denver, CO 80204</td>
<td>303-393-0382</td>
<td>COLOR is an organization for Latinas and their families focused on providing education and advocacy for reproductive rights and quality healthcare.</td>
</tr>
<tr>
<td>Colorado State-wide</td>
<td>Denver</td>
<td>CDPHE: Family Planning</td>
<td>*</td>
<td>cdphe.pswo <a href="mailto:menshealth@state.co.us">menshealth@state.co.us</a></td>
<td><a href="http://www.colorado.gov/cs/Satellite/CDPHE-PSD/DBON/125161836665">http://www.colorado.gov/cs/Satellite/CDPHE-PSD/DBON/125161836665</a></td>
<td>4300 Cherry Creek Drive South Denver, CO 80246</td>
<td>303.692.2229</td>
<td>Colorado family planning clinics provide a range of preventive health services. Patient fees are determined by the patient's income and the ability to pay. Family planning clinics often are an entry point into the health care system for women and families who otherwise lack access to health care services.</td>
</tr>
<tr>
<td>Routt</td>
<td>Steamboat Springs</td>
<td>Family Health CVNA</td>
<td>Stephanie Anderson</td>
<td><a href="mailto:Sanderso@nwcovna.org">Sanderso@nwcovna.org</a></td>
<td><a href="http://www.nwcovna.org">www.nwcovna.org</a></td>
<td>940 Central Park Drive Suite 101 Steamboat Springs, CO 80487</td>
<td>(970) 879-1632</td>
<td>Programs for Young Families include: - Prenatal Care - NFP - Nurse Family Partnership - New Arrivals - WIC (Women, Infants, and Children Nutrition Program) - School Health - CHP (Child Health Plan Plus - health and dental care for uninsured children) medical eligibility and enrollment</td>
</tr>
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Yampa Valley Medical Center | Sexual Health And HIV/AIDS
<table>
<thead>
<tr>
<th>Routt, Steamboat Springs, Hayden, Walden, Oak Creek, Yampa, Clark</th>
<th>Steamboat Springs</th>
<th>Steamboat Springs Pregnancy Resource Center</th>
<th>Melinda Clark, Executive Director</th>
<th><a href="mailto:Director@steamboatpregnancy.com">Director@steamboatpregnancy.com</a></th>
<th><a href="mailto:Director@steamboatpregnancy.com">Director@steamboatpregnancy.com</a></th>
<th>544 Oak Street Pine Grove Road, Suite D Steamboat Springs, CO 80487</th>
<th>970-871-1307</th>
<th>Agency supports women facing an unexpected pregnancy. Service areas include: free pregnancy test, parenting education, peer options counseling, pre and post adoption support, parenting education and mentoring, assistance with infant clothing, emergency diapers, and formula, and community referrals. Faith-based agency that serves anyone without regard to religious preference. No financial criteria apply.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routt</td>
<td>Steamboat Springs</td>
<td>Baby care/kids care, DHHS</td>
<td>Fran Jenkins, Case Manager</td>
<td><a href="mailto:Fjenkins@co.routt.co.us">Fjenkins@co.routt.co.us</a></td>
<td>Co.routt.co.us</td>
<td>135 6th Street Steamboat Springs, CO 80477</td>
<td>970-879-1540</td>
<td>This program provides medical assistance for children and for pregnant mothers.</td>
</tr>
<tr>
<td>Moffat</td>
<td>Craig</td>
<td>Nurse Family Partners CVNA</td>
<td>Ann Irvin R.N., Program Supervisor</td>
<td><a href="mailto:airvin@nwcovna.org">airvin@nwcovna.org</a></td>
<td><a href="http://www.nwcvna.org">www.nwcvna.org</a></td>
<td>745 Russell Street Craig, CO 81625</td>
<td>970-824-8233</td>
<td>Prenatal and Early Childhood-Nurse Home Visitation Program-for First Time Mothers. Clients who qualify for the program receive home visits by a Registered Nurse as early in pregnancy as possible and continue</td>
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<td>Region</td>
<td>City</td>
<td>Service Name</td>
<td>Contact Person</td>
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<tr>
<td>Moffat</td>
<td>Craig</td>
<td>Yampa Valley Pregnancy Center</td>
<td>Katie Grobe, Director</td>
<td>yyvp@rocket mail.com</td>
<td>580 Green St Craig, CO 81625</td>
<td>970-824-5204</td>
<td>Provides free and confidential resources to women in crisis situations: pregnancy tests and limited amount of food and formula; emergency supplies of diapers; loan maternity and infant clothing as well as baby accessories.</td>
<td></td>
</tr>
<tr>
<td>Routt</td>
<td>Steamboat Springs</td>
<td>Planned Parenthood</td>
<td>Allison Whitney</td>
<td><a href="mailto:allison.whitney@pprm.org">allison.whitney@pprm.org</a></td>
<td>1104 B 11th St Steamboat Springs, Co 80477</td>
<td>970-879-2213</td>
<td>We see men, women, and teens in a confidential environment. Some services we offer include: annual exams, birth control, std testing, pregnancy testing, and breast exams.</td>
<td></td>
</tr>
<tr>
<td>Grand junction</td>
<td>Granby</td>
<td>Post-Abortion Support Group Pregnancy Resource Connection</td>
<td>June Matson, Executive Director</td>
<td><a href="mailto:prc@rkymtnhi.com">prc@rkymtnhi.com</a></td>
<td>244 East Agate Ave. Ste. A Granby, Co 80446</td>
<td>970-887-3617</td>
<td>A support group for women who are hurting due to the effects of an abortion. Gives an opportunity for a woman to be open about her pain and experience healing. Free and confidential.</td>
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<td>Grand County</td>
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<tr>
<td>Grand County</td>
<td>Hot Sulphur Springs</td>
<td>Women's Health</td>
<td>Brene Bel ew-Ladue, Public Health Director</td>
<td><a href="mailto:bbelew@co.grand.us">bbelew@co.grand.us</a></td>
<td>co.grand.co.us.org</td>
<td>150 Moffat Ave. Hot Sulphur Springs, Co 80451</td>
<td>970-725-3288</td>
<td>Women's health services provides prenatal medicaid and chp+. Referrals for prenatal care and pregnancy information. Newborn home visitation by rn available. Breastfeeding education and support. Childbirth education information. Also offers pregnancy testing.</td>
</tr>
<tr>
<td>Grand County</td>
<td>Granby</td>
<td>Childbirth Preparation on Class for Pregnancy</td>
<td>June Mats on, Executive Director</td>
<td><a href="mailto:prc@rkymtnhi.com">prc@rkymtnhi.com</a></td>
<td><a href="http://www.pregnancyresourceconnection.org">www.pregnancyresourceconnection.org</a></td>
<td>244 East Agate Ave. Ste. A Granby, Co 80446</td>
<td>970-887-3617</td>
<td>5-week childbirth preparation class administered by a registered nurse. Class covers topics related to labor and delivery and assists expectant parents in preparing for the birth of their baby.</td>
</tr>
<tr>
<td>Grand County</td>
<td>Granby</td>
<td>Free Pregnancy Testing</td>
<td>June Mats on, Executive Director</td>
<td><a href="mailto:prc@rkymtnhi.com">prc@rkymtnhi.com</a></td>
<td><a href="http://www.pregnancyresourceconnection.org">www.pregnancyresourceconnection.org</a></td>
<td>244 East Agate Ave. Ste. A Granby, Co 80446</td>
<td>970-887-3617</td>
<td>Free and confidential pregnancy testing. They also offer limited ultrasound services</td>
</tr>
<tr>
<td>Grand County</td>
<td>Granby</td>
<td>Pregnancy Resource Connection</td>
<td>June Mats on, Executive Director</td>
<td><a href="mailto:prc@rkymtnhi.com">prc@rkymtnhi.com</a></td>
<td><a href="http://www.pregnancyresourceconnection.org">www.pregnancyresourceconnection.org</a></td>
<td>244 East Agate Ave. Ste. A Granby, Co 80446</td>
<td>970-887-3617</td>
<td>Pregnancy resource connections offers free pregnancy tests and personal one-on-one sessions that share factual information about important issues related to an unplanned pregnancy. All services are free and confidential.</td>
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<tr>
<td>Grand County</td>
<td>Granby</td>
<td>One-on-One Sessions</td>
<td>June Matsen, Executive</td>
<td><a href="mailto:prc@rkmtnhi.com">prc@rkmtnhi.com</a></td>
<td>244 East Agate Ave. Ste. A</td>
<td>970-887-3617</td>
<td>One-on-one sessions for issues dealing with pregnancy, parenting or post-abortion.</td>
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<td>Pregnancy Connection</td>
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<tr>
<td>Jackson</td>
<td>Walden</td>
<td>Baby care/Kid care</td>
<td>Jamie Viefhaus</td>
<td><a href="mailto:jamie.viefhausuzak@state.co.us">jamie.viefhausuzak@state.co.us</a></td>
<td>350 Mckinley St Walden, Co 80480</td>
<td>970-723-4750</td>
<td>This is a program which will pay for health care for qualified pregnant women and new born babies up to one year of age. Pays for delivery as well as prenatal care no cost to client.</td>
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<tr>
<td>Grand County</td>
<td>Hot Sulphur Springs</td>
<td>Grand County Public Health</td>
<td>Brene Bel ew-Ladue, Public Health Director</td>
<td><a href="mailto:bbelew@co.grand.us">bbelew@co.grand.us</a></td>
<td>150 Moffat Ave. Hot Sulphur Springs, Co 80451</td>
<td>970-725-3288</td>
<td>Public health nursing service providing public health and home health services in grand county.</td>
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<tr>
<td>County</td>
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</tr>
<tr>
<td>Colorado State wide</td>
<td></td>
<td>Colorado Coalition for STD Prevention</td>
<td>*</td>
<td>*</td>
<td><a href="http://www.cdphe.state.co.us/dc/HIVandSTD/ccsp/">http://www.cdphe.state.co.us/dc/HIVandSTD/ccsp/</a></td>
<td>4300 Cherry Creek Drive South Denver, CO 80246</td>
<td>303.692.2767</td>
<td>The primary goal of the CCSP is to develop a coordinated network of STD prevention activities in Colorado through leadership, advocacy and collaboration.</td>
</tr>
<tr>
<td>Colorado State wide</td>
<td></td>
<td>Colorado Department of Public Health and Environment, STI/HIV Section</td>
<td>*</td>
<td>*</td>
<td><a href="http://www.cdphe.state.co.us/dc/HIVandSTD/index.html">http://www.cdphe.state.co.us/dc/HIVandSTD/index.html</a></td>
<td>4300 Cherry Creek Drive South Denver, CO 80246</td>
<td>303-692-2688</td>
<td>HIV testing, counseling, risk reduction education, partner notification services, training and prevention case management</td>
</tr>
<tr>
<td>Colorado State wide</td>
<td>Alamosa</td>
<td>Planned Parenthood of the Rocky Mountains</td>
<td>*</td>
<td>*</td>
<td><a href="http://www.plannedparenthood.org/">http://www.plannedparenthood.org/</a></td>
<td>1560 12th Street #7 Alamosa, CO 81101</td>
<td>719-589-4906</td>
<td>HIV/STI testing and referral. Sexual Health Education. Please see website for clinic locations in Colorado.</td>
</tr>
<tr>
<td>County</td>
<td>City</td>
<td>Provider</td>
<td>Contact Person</td>
<td>Email</td>
<td>Website</td>
<td>Address</td>
<td>Phone Number</td>
<td>Programs</td>
</tr>
<tr>
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<td>----------------------------------------------</td>
<td>--------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Colorado State wide</td>
<td>Denver</td>
<td>The Colorado HIV/AIDS Care and Prevention Coalition</td>
<td>Coalition Coordinator: Richard Weinert</td>
<td><a href="mailto:richard.weinert@state.co.us">richard.weinert@state.co.us</a></td>
<td><a href="http://www.cdphe.state.co.us/dc/hivandstd/cw/index.html">http://www.cdphe.state.co.us/dc/hivandstd/cw/index.html</a></td>
<td>4300 Cherry Creek Drive South              Denver, CO 80246-1530</td>
<td>303.692.2786</td>
<td>Community outreach programs, education, advocacy, serves the entire state of Colorado</td>
</tr>
<tr>
<td>Grand County</td>
<td>Hot Sulphur Springs</td>
<td>Communiicable Disease Control</td>
<td>Brene Belw-Ladue, Public Health Director</td>
<td><a href="mailto:bbelew@co.grand.us">bbelew@co.grand.us</a></td>
<td>co.grand.co.us.org</td>
<td>150 Moffat Ave. Hot Sulphur Springs, Co 80451</td>
<td>970-725-3288</td>
<td>Provides services related to communicable disease control such as reporting, education, investigation, referral, and control. Prevention of infectious diseases. Tuberculosis screening and control.</td>
</tr>
<tr>
<td>Grand County</td>
<td>Granby</td>
<td>Reproductive Healthcare</td>
<td></td>
<td></td>
<td><a href="http://www.pprm.org">www.pprm.org</a></td>
<td>236 Agate Ave Granby, Co 80446</td>
<td>(970) 887-2454-2454-clinic</td>
<td>The following services are available at planned parenthood: birth control services emergency contraception general health care hiv testing hpv &amp; hepatitis vaccines lgbt services men's health services patient education pregnancy testing, options &amp; services std testing &amp; treatment women's health services</td>
</tr>
<tr>
<td>Routt</td>
<td>Steamboat Springs</td>
<td>Planned Parenthood</td>
<td>Allison Whitney</td>
<td><a href="mailto:allison.whitney@pprm.org">allison.whitney@pprm.org</a></td>
<td><a href="http://www.pprm.org">www.pprm.org</a></td>
<td>1104 B 11th St. Steamboat Springs, Co 80477</td>
<td>970-879-2213</td>
<td>We see men, women, and teens in a confidential environment. Some services we offer include: annual exams, birth control, std testing, pregnancy testing, and breast exams.</td>
</tr>
</tbody>
</table>
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SUBSTANCE ABUSE

OVERVIEW

In 2005, approximately 22 million people were battling a drug or alcohol problem in the nation. Almost all of them, or about 95%, were not aware or would not admit that they had a problem. Denial of a substance abuse problem continues to make this issue difficult to treat. Preventing a substance abuse problem before it even starts is thus a key factor in reducing its prevalence in a community.

Substance abuse is associated with mind and behavior-altering characteristics; it typically involves a lack of inhibition that when normally present, keeps high risk behaviors in check. For example, under the influence of a substance, unplanned and unprotected sexual encounters can lead to teenage pregnancy, abortion, human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), and other sexually transmitted diseases (STDs). Undetected, some STDs can lead to infertility and other health problems. Other potential consequences of substance abuse can include domestic violence, child abuse, violent crime, suicide, motor vehicle crashes and fatalities. The effects of substance abuse are felt by all those who are linked to the abusing individual: spouses, children, employers, friends, and the surrounding community.

Substance abuse has generated many discussions about its causes. Is it a disease with a genetic predisposition, or is it a matter of personal choice? How much influence do the environment, culture, and peer pressure have on the individual? One thing that is currently understood about this disorder is that it typically develops in adolescence, and for some people, will go on to develop into a chronic illness with a lifelong negative impact on their lives.¹

Most of this report focuses on alcohol abuse, one of the most commonly abused substances in society and from which much information has already been collected. Supporting topic areas such as the drinking patterns of adolescents are included in order to better understand how high risk drinking starts.

Binge drinking rates in the United States made headlines in January 2012. The latest report by the Centers for Disease Control stated that “new estimates show that binge drinking is a bigger problem than previously thought. More than 38 million US adults binge drink, about four times a month, and the largest number of drinks per binge is eight on average. This behavior greatly increases the chances of getting hurt or hurting others due to car crashes, violence, and suicide. Drinking too much, including binge drinking, causes 80,000 deaths in the US each year and in 2006 cost the economy $223.5 billion. Binge drinking is a problem in all states, even in states with fewer binge drinkers, because they are binging more often and in larger amounts.”

Binge drinking behaviors differ among demographic groups. The CDC reports the following profiles.

- “Age group with most binge drinkers: 18-34 years
- Age group that binge drinks most often: 65+ years
- Income group with most binge drinkers: more than $75,000
- Income group that binge drinks the most often and drinks the most per binge: less than $25,000”

In addition, the following behaviors were associated with binge drinkers.

- “Most alcohol-impaired drivers binge drink.
- Most people who binge drink are not alcohol dependent or alcoholics.
- More than half of the alcohol adults drink is while binge drinking.
- More than 90% of the alcohol youth drink is while binge drinking.”

---

2 Binge drinking means men drinking 5 or more alcoholic drinks within a short period of time or women drinking 4 or more drinks within a short period of time.
4 Ibid.
5 Ibid.
BRFSS Survey Question: How many times during the past month did you have 5 or more drinks on an occasion?

Colorado has higher binge drinking rates than the nation. The rates of binge drinking are generally higher in the mountain resort communities than along the Front Range with the exception of Denver. The mountain and Denver communities have younger, more single populations than the more rural parts of the state. Routt and Moffat Counties have binge drinking rates that are higher than the state average.

Figure 1 Binge Drinking at Least Once a Month

The adult binge drinking rates in Colorado decreased from 2009 to 2010, with the latest rate at 15.4%. The Colorado Winnable Battle rate is 12% for 2016.

---

7 Chart Source: Colorado Winnable Battles, Colorado Department of Health and Environment.
In Colorado, the rate of binge drinking directly decreases with age in Colorado. People of White race and Hispanics have significantly higher rates of binge drinking compared to those of Black race.

Figure 3 Binge Drinkers by Age Group

Figure 4 Binge Drinkers by Race/Ethnicity

9 Ibid.
People who have never married are significantly more likely to binge drink.

Binge drinkers tend to have higher incomes, consistent with CDC findings. Differences among education levels were not statistically significant in Colorado.

---

11 Ibid.
Binge drinking is widespread on college campuses. The most excessive forms of binge drinking have increased in college, as shown in the chart below. Binge drinking among college students and adolescents is associated with a higher likelihood of developing alcoholism in adults.\textsuperscript{12}

\textbf{Previous 30 Days’ Drinking on College Campuses}

![Figure 7 Previous 30 Days’ Drinking on College Campuses\textsuperscript{13}](image)


YOUTH BINGE DRINKING

As a prior demographic description indicates, binge drinking is more prevalent at younger ages. The rate of binge drinking increases with each grade of high school. It also appears that the rate of binge drinking among youth is increasing over time, although the second chart shows a drop in 2009.

![Youth Binge Drinking in Past Month](figure8)

The Colorado Winnable Battles goal for 2016 is a 20% binge drinking rate for grades 9-12.

![Youth Binge Drinking Rates for Grades 9-12](figure9)

---

HIGH RISK / HEAVY DRINKING

**BRFSS Question:** Did you exceed guidelines for low-risk drinking in the past month? (male guideline is 2 drinks per day, female guideline is 1 drink per day)

The percent of people who exceeded the guidelines for low-risk drinking on a daily basis is identified in the following chart. Routt and Moffat Counties have high rates of high risk drinking, although Moffat’s rate is based on weak data.

![High Risk Drinking at Least Once in Past Month](chart-source)

**Figure 10 High Risk Drinking at Least Once in Past Month**

---

15 Chart Source: Colorado’s 10 Winnable Battles, Colorado Department of Health and Environment.
High risk drinkers tend to be middle aged and of White race. Differences among people of varying income and education levels in Colorado are not significant.

Figure 11 High Risk Drinkers by Age Group

Figure 12 High Risk Drinkers by Race/Ethnicity

---


18 Ibid.
People who are single due to never being married, or are divorced/separated/widowed are significantly more likely to be heavy daily drinkers than people in married or coupled relationships.

![Figure 13 High Risk Drinkers by Marital Status](chart)

Figure 13 High Risk Drinkers by Marital Status

---

**DRUNK DRIVING**

*BRFSS Question:* **During the past 30 days, how many times have you driven when you’ve had perhaps too much to drink?**

The chart below is based on weak data and is therefore inconclusive. However, it is interesting to note that even though Routt County’s data was based on one year’s worth of data, no one reported driving drunk in that sample of 119 residents.

---

Figure 14 Drove Drunk One or More Times in Past Month

---

Those least likely to drive drunk are those aged 65 and over. No statistically significant differences are found among the other age groups. Males are significantly more likely to drive drunk than females.

People who are married or part of a couple are least likely to drive drunk. Differences among education and income are not statistically significant in Colorado.

---

22 Ibid.
The following chart shows that the rates for youth riding in cars with drivers who had been drinking were usually less in 2007 than in 2003. However, the prevalence of riding with an at-risk driver increases with age, with a leveling off in the later years of high school.

Figure 18 Percent of Students Riding with Driver Who Had Been Drinking Alcohol in Colorado

24 Ibid.
MOTOR VEHICLE DEATH RATES

Counties’ rates of alcohol related fatalities are reported in the following chart. Both Routt and Moffat Counties have small sample sizes and inconclusive rates.

<table>
<thead>
<tr>
<th>Counties</th>
<th>2011 Fatalities</th>
<th>Alcohol-Related</th>
<th>Total</th>
<th>% Alcohol Related</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nation</td>
<td></td>
<td></td>
<td></td>
<td>32%</td>
</tr>
<tr>
<td>State</td>
<td>261</td>
<td>185</td>
<td>446</td>
<td>42%</td>
</tr>
<tr>
<td>Moffat</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>50%</td>
</tr>
<tr>
<td>Routt</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>100%</td>
</tr>
</tbody>
</table>

Figure 19 Motor Vehicle Deaths Due to Alcohol

Table Source: Colorado Fatality Analysis Reporting System (FARS), Colorado Department of Transportation. (National Source: http://www-fars.nhtsa.dot.gov/QueryTool/QuerySection/SelectYear.aspx) (National rates for 2009.)
MORTALITY RATES FOR CHRONIC LIVER DISEASE AND CIRRHOSIS

The county information in the following chart is all based on weak data due to small population numbers; therefore the findings are inconclusive.

Figure 20 Chronic Liver Disease and Cirrhosis Mortality Rates

26 Chart Source: National Vital Statistics System, Centers for Disease Control. Note: Rates per 100,000. Weak data for all counties. (National and state rates 2009).
Marijuana is the most frequently abused illicit drug in Colorado. The percent of young adults in Colorado who used marijuana in the past year was 38.5% compared to the national average of 29.1%. Consumption has increased 3% over a prior survey in 2007, most likely due to increased access from legalized medical marijuana.27

The percent of students who used marijuana in Colorado increased during high school. Many experts believe that marijuana is a gateway drug to other drugs.

---

Among high school seniors, marijuana was the most commonly abused illicit drug, followed by prescription drugs and over the counter medicines. The most likely method for obtaining prescription pain relievers was through a friend or relative (59%).

Figure 22 Prescription and Over-the-Counter Drugs

ABUSE OF PRESCRIPTION AND OVER THE COUNTER DRUGS

Prescription drug abuse is the “intentional use of a medication without a prescription; in a way other than as prescribed; or for the experience or feeling that it causes....Prescription drug abuse remains a significant problem in the United States.” ³⁰ In fact, the CDC reported that “enough painkillers were prescribed last year to medicate every American adult around the clock for a month.” ³¹

Pain relievers are the most commonly abused prescription drugs, followed by tranquilizers, stimulants and sedatives. The retail sale of opioids has increased significantly over the past decade, as the following chart demonstrates. Although not shown, sales of opioids on the black market add even more drugs to the national amounts. ³²

![Opioid Medications and Stimulants](image_url)

Figure 23 Opioid Medications and Stimulants³³

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³⁰ National Institute on Drug Abuse, NIDA Rx Drug Abuse 2011.
³¹ [http://online.wsj.com/article/SB10001424052970204062704577223573533933402.html](http://online.wsj.com/article/SB10001424052970204062704577223573533933402.html?KEYWORDS=pharmacies+drugs)
³³ Ibid.
DEATH RATES FROM OTHER OPIOIDS AND SELECTED DRUGS

The following chart shows the rise in death rates in the general population in Colorado from opioids other than heroin (including narcotic analgesics). These opioids are primarily oxycodone and hydrocodone. Hydrocodone and acetaminophen are the primary ingredients in Vicodin, one of the most frequently abused prescription drugs by teens. Many previous users of cocaine are switching to other drugs such as opioids.

Figure 24 Death Rates from Other Opioids and Selected Drugs in Colorado

---

34 Chart Source: Colorado Department of Public Health and Environment, as reported by Kristen Dixion at the January 2011 CEWG meeting.
Based on the 2003 National Survey on Drug Use and Health, the lower the family income, the more likely youths age 12 to 17 had used cigarettes or an illegal drug in their lifetime. The rates for alcohol or inhalants were the same for the lowest and highest income levels. Prescription-type drugs for nonmedical use were more common among youths from lower income families.\textsuperscript{35} Statistical significance of differences among income groups was unavailable.

\textsuperscript{35} Substance Abuse and Mental Health Services Administration, http://oas.samhsa.gov/2k4/youthIncome/youthIncome.htm

\textsuperscript{36} Chart Source: Substance Abuse and Mental Health Services Administration, http://oas.samhsa.gov/2k4/youthIncome/youthIncome.htm
**INTERVENTIONS**

**SUBSTANCE ABUSE PREVENTION AND TREATMENT: COLORADO PRIORITY INITIATIVES, Technical Assistance, and Training Providers**

*Colorado Family Education, Resources and Training (CFERT)* is dedicated to being a partner and resource for strengthening and supporting today’s families. CFERT translates research into practice and works Statewide to assist agencies and communities in implementing and evaluating family education programs.

CFERT offers technical assistance and training classes focused on professional development of parent educators, prevention specialists and early childhood professionals and childcare providers. The Resource Center, housed at Colorado State University, provides publications and disseminates information on effective programs, policies, practices and positive parenting techniques as a prevention strategy. *Services provided by CFERT are made possible by a grant funded by the Colorado Division of Behavioral Health (DBH).*

**COLORADO FETAL ALCOHOL SPECTRUM DISORDERS-PREVENTION OUTREACH PROJECT (COFAS-POP)** is a statewide fetal alcohol spectrum disorder and prenatal substance abuse prevention outreach program housed within the Colorado Area Health Education Center System of the University of Colorado Denver. COFAS-POP provides a variety of education and trainings for health and human service providers, educators, and criminal justice. *Funded by Colorado Department of Human Services, Division of Behavioral Health.*

**PREVENTION EVALUATION PARTNERS (PEP)** is a collaborative project to develop, implement and evaluate an outcome/impact evaluation system to be used statewide among all funded prevention program contractors of the Community Prevention Programs within the Division of Behavioral Health, Colorado Department of Human Services. OMNI provides evaluation-based technical assistance and training to each of the Substance Abuse Prevention Block Grant-funded programs in Colorado. The goal of the technical assistance and training is to build evaluation capacity among prevention providers. *Funded by Colorado Department of Human Services, Division of Behavioral Health.*

**THE REGIONAL PREVENTION SERVICES PROJECT (RPS)** is a regionally-based system, funded by the Division of Behavioral Health (DBH - formerly known as ADAD) of the Colorado Department of Human Services and administered by OMNI INSTITUTE. The goal of the RPS project is to help build capacity within local communities to ensure long-term sustainability of services that promote healthy living for children, youth and families. The RPS project has a Regional Prevention Consultant (RPC) residing in each of the six defined regions across the state. The RPCs provide training, group facilitation, consultation and support to Colorado agencies, communities, and coalitions working with children, youth and families.
Workplace Prevention Services (WPS) is an Employee Assistance Program designed to assist Colorado small businesses in their efforts to reduce the negative effects of alcohol and other drugs on the workplace. Funded by Colorado Department of Human Services, Division of Behavioral Health

Prescription Drug Abuse Prevention Funded by Colorado Department of Human Services, Division of Behavioral Health

The Prevention Information Center (PIC) is a library and information center providing access to a broad spectrum of substance abuse prevention and health promotion topics. The PIC staff will help you find answers to your substance abuse related questions; and help connect you to the resources you can use to enhance your services to individuals, organizations, and communities throughout Colorado. Materials are available on loan to anyone living in Colorado. If you work in Colorado to reduce the impact of substance abuse on personal health, all of our services are entirely free of charge.

Screening, Brief Intervention, and Referral to Treatment. Colorado is one of ten states with this program that conducts substance abuse screening at 12 clinics throughout the counties of Arapahoe, Denver, Eagle, El Paso, Gunnison, Larimer, Mesa, Prowers, Summit and Weld. The programs incorporate client screening and instruction about health consequences related to substance abuse, and collaborate with HealthTeamWorks to provide standardized substance abuse screening guidelines in health care settings throughout Colorado.37

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The following section is an excellent resource for communities evaluating programs that reduce substance abuse. It includes a description of various programs as well as their rate of success in reducing substance abuse when available.

“Alcohol Alert from the National Institute on Alcohol Abuse and Alcoholism Prevention measures aims to reduce alcohol abuse and its consequences. Such measures include policies regulating alcohol-related behavior on the one hand and community and educational interventions seeking to influence drinking behavior on the other.

Researchers use scientific methods, such as randomized controlled trials, time-series analysis, and computer simulation, to determine the effectiveness of prevention initiatives. The resulting data may both inform policy and guide community and educational prevention efforts. This Alcohol Alert summarizes research on the effectiveness of selected initiatives in each of these areas.

Policy Interventions

Alcohol Taxes. Researchers find that alcohol taxes and prices affect alcohol consumption and associated consequences (1). Studies demonstrate that increased beer prices lead to reductions in the levels and frequency of drinking and heavy drinking among youth (2,3). Higher taxes on beer are associated with lower traffic crash fatality rates, especially among young drivers (4,5), and with reduced incidence of some types of crime (6). Research suggests that the heaviest-drinking 5 percent of drinkers do not reduce their consumption significantly in response to price increases, unlike drinkers who consume alcohol at lower levels (7). In one study, heavy drinkers who were unaware of the adverse health consequences of their drinking were less responsive to price changes than either moderate drinkers or better informed heavy drinkers (8).

Raising the Minimum Legal Drinking Age (MLDA). MLDA legislation is intended to reduce alcohol use among those under 21, to prevent traffic deaths, and to avoid other negative outcomes (9-11). Raising the MLDA has been accompanied by reduced alcohol consumption, traffic crashes, and related fatalities among those under 21 (11,12). A nationwide study found a significant decline in single-vehicle nighttime (SVN) fatal crashes--those most likely to involve alcohol--among drivers under 21 following increases in the MLDA (9).

Zero-Tolerance Laws. The National Highway Systems Act provides incentives for all States to adopt "zero-tolerance laws" that set maximum blood alcohol concentration (BAC) limits for drivers under 21 to 0.02 percent or lower beginning October 1, 1998 (13). An analysis of the effect of zero-tolerance laws in the first 12 States enacting them found a 20-percent relative reduction in the proportion of SVN fatal crashes among drivers under 21, compared with nearby States that did not pass zero-tolerance laws (12,14).
Other BAC Laws. Fourteen States have lowered BAC limits from 0.10 to 0.08 percent to reduce alcohol-related fatal motor vehicle crashes. One study found that States with the reduced limit experienced a 16-percent decline in the proportion of fatal crashes involving fatally injured drivers whose BAC’s were 0.08 percent or higher, compared with nearby States that did not reduce their BAC limit. In a separate analysis, this study found that States that lowered their BAC limit also experienced an 18-percent decline in the proportion of fatal crashes involving fatally injured drivers whose BAC’s were 0.15 or higher, relative to comparison States (15).

Administrative License Revocation Laws. Laws permitting the withdrawal of driving privileges without court action have been adopted by 38 States to prevent traffic crashes caused by unsafe driving practices, including driving with a BAC over the legal limit (16). These laws were associated with a 5-percent decline in nighttime fatal crashes in some studies (17,18). Other studies observed six- to nine-percent reductions in nighttime fatal crashes following their adoption (17).

Server Liability. Alcohol servers are increasingly held liable for injuries and deaths from traffic crashes following the irresponsible selling and serving of alcohol. Researchers assessed the effect of potential server liability on the rates of alcohol-related fatal crashes in Texas (19). SVN fatal traffic crashes decreased 6.5 percent after the filing of a major server-liability court case in 1983 and decreased an additional 5.3 percent after a 1984 case was filed. However, before concluding that server liability is effective, these results need replication (19).

Warning Labels. The mandated warning label on containers of alcoholic beverages aims to inform and remind drinkers that alcohol consumption can result in birth defects, impaired ability to drive a car or operate machinery, and health problems. Research indicates that public support for warning labels is extremely high; that awareness of the label’s content has increased substantially over time (20); that perception of the described risks was high before the label appeared and has not generally increased (21); and that the label has not had important effects on hazardous behavior, although certain effects may be indicative of the early stages of behavioral change (20). One study of pregnant women found that after the label appeared, alcohol consumption declined among lighter drinkers but not among those who drank more heavily (22).

The Saving Lives Program. The Saving Lives Program in six communities in Massachusetts was designed to reduce drinking and driving and to promote safe driving practices. Saving Lives involved the media, businesses, schools and colleges, citizens’ advocacy groups, and the police in activities such as high school peer-led education, college prevention programs, increased liquor-outlet surveillance, and other efforts. Participating communities reduced fatal crashes by 25 percent during the program years compared with the rest of Massachusetts. The decline in alcohol-related fatal crashes was 42 percent greater in Saving Lives communities than in comparison cities during the program years. The proportion of drivers under 21 who reported driving after drinking in the month before being interviewed also declined in participating communities (17).
Life Skills Training (LST). LST teaches students in grades seven to nine skills to resist social influences to use alcohol and other drugs and to enhance general competence and self-esteem. LST has been found to increase students' knowledge of the negative consequences of drinking and to promote realistic, not inflated, perceptions of drinking prevalence (23). A study of LST’s long-term effects among 12th grade students who had received a relatively complete version of the program showed significantly lower rates of weekly drinking, heavy drinking, and getting drunk than did control students. The full sample exposed to the program also showed significantly lower rates of drunkenness than did the controls (24).

Project Northland. Project Northland is a multicomponent, school- and community-based intervention to delay, prevent, and reduce alcohol use and related problems among adolescents. It includes social-behavioral curricula, peer leadership, parental involvement/education, and communitywide task force activities (25,26). The first 3 years of intervention, conducted in grades six through eight, resulted in significantly lower prevalence of past-month and past-week alcohol use among students in intervention communities compared with controls. These beneficial effects were particularly notable among students who had not yet begun experimenting with alcohol when the program began (27).

Alcohol Misuse Prevention Study (AMPS). The AMPS curriculum, for students in grades five through eight, focuses primarily on teaching peer-resistance skills and on clarifying students' misperceptions of their peers' alcohol use. Among adolescents at greatest risk for escalating alcohol misuse--those who engaged in early unsupervised use of alcohol--the AMPS intervention had a modest, but lasting, statistically significant effect of slowing the increase in alcohol misuse through grade 8 (28,29) and into grade 12 (30). Replication of this research again showed a significant effect for the highest risk subgroup (29).

Project STAR. Project STAR--involving schools, mass media, parents, community organizations, and health policy components in two sites in the Midwest--attempts to delay the onset and decrease the prevalence of alcohol and other drug use among students beginning in sixth grade. Project STAR teaches skills to resist alcohol use and educates students about the actual, as opposed to the perceived, prevalence of alcohol use among their peers. Early follow-up studies showed that the program had little effect on alcohol use (31,32). However, in a 6-year follow-up in Kansas City, students in program schools showed lower rates of increase in alcohol use and episodes of drunkenness over time than did students in control schools. Similar but smaller effects were observed at 3.5-year follow-up in Indianapolis (33).

Drug Abuse Resistance Education (DARE). DARE, typically taught to 10- and 11-year-old students in grades five and six by police officers, aims to inform about alcohol and other drugs and to teach social and decision-making skills to help students resist their use. Studies have found that DARE essentially has no impact on alcohol use (34-36).

Informational Programs. Programs attempting to persuade students not to use alcohol by arousing fear do not work to change behavior (30,37). Emphasizing the
dangers of alcohol may attract those who tend to be risk-takers. Programs providing information about the pharmacological effects of alcohol may arouse curiosity and lead to drinking (37).

**Server Training.** Server training, mandatory in some States, educates alcohol servers to alter their serving practices, particularly with underage customers and those who show obvious signs of intoxication. Server training explains the effects of alcohol, applicable laws, how to refuse service to obviously intoxicated patrons, and how to assist customers in obtaining transportation as an alternative to driving. Some, but not all, studies report more interventions with customers after server training than before. One evaluation of the effects of Oregon’s mandatory server-training policy indicates that it had a statistically significant effect on reducing the incidence of SVN traffic crashes in that State (38).

**Preventing Alcohol Abuse and Related Problems--A Commentary by NIAAA Director Enoch Gordis, M.D.**

Prevention encompasses activities or actions ranging from those affecting the whole population through social and regulatory controls to those affecting specific groups, such as adolescents, or the individual. Many of these activities overlap. For example, health warning labels, a product of legislation (social and regulatory control), also are educational. In this Alcohol Alert, we have tried to give a "flavor" of this broad spectrum; the prevention areas described are by no means exhaustive, and some areas described in one category could well be in others.

The good news is that, using contemporary tools of science, prevention can be rigorously studied. Currently, research evidence shows that some prevention efforts are effective and others have little or no effect. This knowledge will help local communities, the States, and others who have made significant investments in prevention activities develop or refine existing programs to achieve their desired objectives.” 38

38 http://alcoholism.about.com/library/blnaa34.htm
<table>
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<th>County</th>
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<th>Provider</th>
<th>Contact Person</th>
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<th>Phone Number</th>
<th>Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>21 Counties in Western Colorado</td>
<td>Grand Junction</td>
<td>Western Colorado Suicide Prevention Foundation</td>
<td>*</td>
<td>*</td>
<td><a href="http://www.suicidepreventionfoundation.org/">http://www.suicidepreventionfoundation.org/</a></td>
<td>619 Main Street, Grand Junction CO 81501</td>
<td>(970) 683-6626</td>
<td>The Western Colorado Suicide Prevention Foundation is committed to reducing suicide in Western Colorado and other adjacent geographical areas by providing suicide awareness and prevention programs, suicide prevention education and training programs, and funding other suicide prevention efforts and activities. The Western Colorado Suicide Prevention Foundation spans twenty-one counties in Western Colorado.</td>
</tr>
<tr>
<td>Colorado Statewide</td>
<td>Colorado</td>
<td>Colorado Division of Behavioral Health</td>
<td>Webster Hendricks, Specialist</td>
<td><a href="mailto:webster.hendricks@state.co.us">webster.hendricks@state.co.us</a></td>
<td><a href="http://www.colorado.gov/cs/Satellite/CDHS-BehavioralHealth/CBON/1251581448773">http://www.colorado.gov/cs/Satellite/CDHS-BehavioralHealth/CBON/1251581448773</a></td>
<td>3824 W. Princeton Cir., Denver CO 80236</td>
<td>(303) 866-7400</td>
<td>Intervention, treatment, recovery, support</td>
</tr>
<tr>
<td>Colorado Statewide</td>
<td>Colorado</td>
<td>Colorado Community Health Networks</td>
<td>Annette Kowal, CEO</td>
<td><a href="mailto:annette@cchn.org">annette@cchn.org</a></td>
<td><a href="http://www.cchn.org/about_us.php">http://www.cchn.org/about_us.php</a></td>
<td>600 Grant Street, Suite 800, Denver, CO 80203</td>
<td>(303) 861-5165</td>
<td>The Colorado Community Health Network (CCHN) represents Colorado’s 15 Community Health Centers (CHCs). The CHCs are working on a plan to provide a medical home for more than one million low-income uninsured and medically underserved Coloradans. MH services at CHCs.</td>
</tr>
<tr>
<td>Colorado Statewide</td>
<td>Denver</td>
<td>Empower Colorado</td>
<td>Cheri Bena</td>
<td><a href="mailto:info@empowercolorado.com">info@empowercolorado.com</a></td>
<td><a href="http://www.empowercolorado.com/">http://www.empowercolorado.com/</a></td>
<td>2200 S. Jasmine Street, Denver, CO 80222</td>
<td>1-866-213-4631</td>
<td>Collaborates with other organizations and utilizes a list serve to educate and advocate for children with mental health needs.</td>
</tr>
<tr>
<td>Colorado Statewide</td>
<td>Denver</td>
<td>Federation of Families for Children’s Mental Health, Colorado Chapter</td>
<td>Tom Dillingham, Executive Director</td>
<td><a href="mailto:tdillingham@coloradofederation.org">tdillingham@coloradofederation.org</a></td>
<td><a href="http://www.coloradofederation.org/">http://www.coloradofederation.org/</a></td>
<td>2950 Tennyson Street Denver, CO 80212</td>
<td>303.572.0302</td>
<td>Advocacy, family involvement, support groups, crisis line</td>
</tr>
<tr>
<td>County</td>
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<td>Provider</td>
<td>Contact Person</td>
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<tr>
<td>Colorado, State-wide</td>
<td>Denver</td>
<td>Colorado Department of Human Services, Office of Behavioral Health</td>
<td>Paulette St. James, Deputy Director</td>
<td><a href="mailto:paulette.stjames@state.co.us">paulette.stjames@state.co.us</a></td>
<td><a href="http://www.colorado.gov/cs/Satellite/CDHSMain/1251575083520">http://www.colorado.gov/cs/Satellite/CDHSMain/1251575083520</a></td>
<td>3824 W Princeton Circle Denver, CO 80236</td>
<td>303.866.7400</td>
<td>The Division of Behavioral Health (DBH) is dedicated to strengthening the health, resiliency, and recovery of Coloradans through quality and effective behavioral health prevention, early intervention and treatment services. DBH staff are responsible for a wide array of programs, services, and mission-critical functions including, but not limited to, licensing, designation and regulatory standards, policy development, contracting for service delivery, consultation, training, and technical assistance, interagency collaborations and partnerships, data collection, reporting and analysis, evaluation, and grants management.</td>
</tr>
<tr>
<td>Colorado, State-wide</td>
<td>Denver</td>
<td>CDPHE: Office of Suicide Prevention</td>
<td>*</td>
<td><a href="mailto:cdphe.psdrequests@state.co.us">cdphe.psdrequests@state.co.us</a></td>
<td><a href="http://www.cdphe.state.co.us/pp/suicide/">http://www.cdphe.state.co.us/pp/suicide/</a></td>
<td>4300 Cherry Creek Drive South, Denver, CO 80246-1530</td>
<td>303.692.2590</td>
<td>The Office of Suicide Prevention was established to: Review trends, risk factors, methods, and demographics; Review and analyze suicide prevention plans in other states; Look at existing strategies that recognize and respond to people who are at risk.</td>
</tr>
<tr>
<td>Eagle, Garfield, Grand, Mesa, Montrose, Pitkin, Rio Blanco, Routt, Summit, Delta</td>
<td>Denver</td>
<td>Colorado West Regional Mental Health</td>
<td>*</td>
<td>*</td>
<td><a href="http://cwrmhc.org/">http://cwrmhc.org/</a></td>
<td>137 Howard Street P.O. Box 1620 – Eagle, CO 81631</td>
<td>(970) 328-6969</td>
<td>Sliding Fee Scale. Employee Assistance Program, Outpatient Services, Chemical Dependency Recovery and Psychiatric Hospital. Emergency Recovery Services, Women's Recovery Center and Family Programs. See website for all clinic locations.</td>
</tr>
<tr>
<td>Routt</td>
<td>Steamboat Springs</td>
<td>Steamboat Springs Outpatient Clinic - Colorado West Regional Mental Health Center</td>
<td>John Fleeker, County Director</td>
<td><a href="mailto:jfleeker@cwrmhc.org">jfleeker@cwrmhc.org</a></td>
<td>cwrmhc.org</td>
<td>407 S. Lincoln Ave. Steamboat Springs, CO 80487</td>
<td>970-879-2141 ext 4183</td>
<td>To plan, deliver, and facilitate quality, cost-effective mental health and substance abuse services based on local needs and available resources. To provide evaluation and assistance for admission to mental hospitals on a voluntary and involuntary basis. To offer treatment, training, education and consultation services to employees and administrators in business and government. Also provides court-ordered DUI and DWI courses and groups.</td>
</tr>
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<td>County</td>
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</table>
| Routt      | Steamboat Springs | Grand Futures Prevention Coalition Routt       | Kate Elkins, Routt County Director | kate@grandfutures.org       | www.grandfutures.org      | 445 Angler's Drive Steamboat Springs, CO 80477 | 970-879-6188 | The mission of Grand Futures Prevention Coalition is to engage our community in the creation and promotion of healthy, positive lifestyle choices as alternatives to substance abuse.  
Programs and activities include  
- alcohol and tobacco compliance checks  
- youth leadership and advocacy activities  
- Teen Council  
- parent and community substance abuse prevention education and awareness  
- policy change, including social host ordinances, athletic code revisions, medical marijuana dispensary regulation, parent, student and community data collection,  
- Healthy Kids Colorado survey, prevention media campaigns, social norms and marketing campaigns, tailored alcohol, tobacco and other drug prevention, presentation and curricula for schools and community organizations. The Excellence Project, TIPS trainings for servers, and substance free events for youth and teens.  
Grand Futures also has a lending library of books, videos and education materials related to substance abuse prevention.  
Grand Futures Prevention Coalition works collaboratively with schools, governmental agencies, nonprofit organizations, and businesses within communities to make most of limited resources. GFPC advisory board and task force members represent diverse sectors in the community impacted by substance abuse to ensure that their programming meets the needs of the community. |
<p>| Routt      | Steamboat Springs | Routt County Alcohol Council                  | Ann E. Cropper                  | <a href="mailto:rac4321@gmail.com">rac4321@gmail.com</a>           |                          | 810 Lincoln Ave. Suite 200 Steamboat Springs, CO 80487 | 970-879-7708 | Routt County Alcohol council provides alcohol and drug education to the communities of Routt County and some alcohol classes available for Moffat County. Provides referrals to useful public service for clients who are sentenced to community service. Classes include DUI education, Minor in Possession and Marijuana education. |</p>
<table>
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<tr>
<th>County</th>
<th>City</th>
<th>Provider</th>
<th>Contact Person</th>
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<th>Website</th>
<th>Address</th>
<th>Phone Number</th>
<th>Programs</th>
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</thead>
<tbody>
<tr>
<td>Eagle, Garfield, Grand, Jackson, Mesa, Moffat, Pitkin, Rio Blanco, Routt and Summit</td>
<td>Grand Junction</td>
<td>The Women's Recovery Center</td>
<td>Eric Moyer</td>
<td><a href="mailto:emoyer@cwrmhc.org">emoyer@cwrmhc.org</a></td>
<td></td>
<td>2800 Riverside Parkway, Building #2, Grand Junction, CO 81501</td>
<td>970-245-4213</td>
<td>A structured 90 day intensive residential treatment program and transitional living program for women and women with infants. A client can graduate earlier depending on progress in the program and treatment needs and issues. Our staff are substance abuse professionals who utilize evidence-based therapeutic practices and receive ongoing education and training. A weekly multifamily group and opportunities for on site visits are offered and primary counselors are available to meet individually for additional family and/or couple counseling.</td>
</tr>
<tr>
<td>Routt</td>
<td>Steamboat Springs</td>
<td>The 437 Club</td>
<td></td>
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<td>437 Oak Street (upstairs), Steamboat Springs, CO 80477</td>
<td>970-879-4882</td>
<td>Support groups for AA, Al-Anon, and NA (Narcotics Anonymous).</td>
</tr>
<tr>
<td>Routt</td>
<td>Steamboat Springs</td>
<td>CHP+ - Routt County Department of Human Services</td>
<td>Fran Jenkins, Case Manager</td>
<td><a href="mailto:fjenkins@co.routt.co.us">fjenkins@co.routt.co.us</a></td>
<td>co.routt.co.us</td>
<td>135 6th Street, Steamboat Springs, CO 80477</td>
<td>970-879-1540</td>
<td>CHP+ or Child Health Plan Plus is a full-coverage health plan for uninsured children. Coverage for outpatient and inpatient services including: check-ups and shots, immunizations, medical office visits, teen services, prescriptions, glasses and hearing aids; dental care and mental health care including hospitalization and outpatient substance abuse treatments. If you applied for Baby Care/Kids Care and did not qualify, your application will automatically be forwarded to CHP+.</td>
</tr>
<tr>
<td>Routt</td>
<td>Steamboat Springs</td>
<td>Child Welfare Services - Routt County Department of Human Services</td>
<td>Mike Sidinger, Assistant Director/Child Welfare &amp; Adult Protection Program Manager</td>
<td><a href="mailto:msidinger@co.routt.co.us">msidinger@co.routt.co.us</a></td>
<td>co.routt.co.us</td>
<td>135 6th Street, Steamboat Springs, CO 80477</td>
<td>970-870-5253</td>
<td>Child Welfare Services are intended to strengthen the ability of families to protect and ensure the safety of their own children; minimize harm to children and youth; and ensure Permanency Planning, or a stable, safe, structured environment. The main goal is, when appropriate, to keep the family intact. Persons reporting concerns for the abuse or neglect of a child or children shall be immune from liability, civil or criminal, if the reporting is done in good faith. The names and the identification of persons who report shall be kept confidential unless the court orders such a disclosure. Reporting parties may be called upon to testify in court proceedings if needed to safeguard the well being of a reported child.</td>
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<td>County</td>
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<tr>
<td>Routt</td>
<td>Steamboat</td>
<td>Violence Prevention and Peer Education - Advocates Against Battering and Abuse</td>
<td>Diane Moore, Executive Director</td>
<td><a href="mailto:advocate@advocatesaba.org">advocate@advocatesaba.org</a></td>
<td></td>
<td>445 Anglers Dr. Suite 2E Steamboat Springs, Co 80487</td>
<td>970-879-2034</td>
<td>High school students from all three school districts in Routt County volunteer to be trained for 15 hours on issues such as dating violence, sexual harassment, bullying and sexual assault. These students then present this information to their peers and younger students.</td>
</tr>
<tr>
<td>Routt</td>
<td>Steamboat</td>
<td>Youth in Conflict - Routt County Department of Human Services</td>
<td>Mike Sidinger, Assistant Director/Child Welfare &amp; Adult Protection Program Manager</td>
<td><a href="mailto:msidinger@co.routt.co.us">msidinger@co.routt.co.us</a></td>
<td>co.routt.co.us</td>
<td>135 6th Street Steamboat Springs, CO 80477</td>
<td>970-870-5253</td>
<td>Services are provided to reduce conflicts between youth and their family members, or between youth and the community, when those conflicts affect the youth's well-being, the normal functioning of the family, or the well-being of the community. Targets children and youth whose behavior is such that there is a likelihood they may cause harm to themselves or to others or who have committed acts that could cause them to be adjudicated a delinquent by the court. Family preservation programs include: Intensive Family Treatment Team, Sexual Abuse Treatment, Day Treatment, Alternative Program, Alcohol and Mental Health treatment, and provision of Life skills.</td>
</tr>
<tr>
<td>Grand County</td>
<td>Granby</td>
<td>Alcoholics Anonymous (AA) - Grand County</td>
<td><a href="mailto:groupservice@aa.org">groupservice@aa.org</a></td>
<td><a href="http://www.alcoholics-anonymous.org">www.alcoholics-anonymous.org</a></td>
<td>148 2nd Street Granby, CO 80446</td>
<td>970-887-2918</td>
<td>Alcoholics Anonymous is a worldwide, 12-step program whose primary purpose is to help participants stay sober and help other alcoholics to achieve sobriety. The only requirement for membership is a desire to stop drinking. There are no dues or fees for AA membership; they are self-supporting through contributions. The General Service office does not maintain information about local groups. Alcoholics Anonymous meetings available in the Grand County area by calling number listed below.</td>
<td></td>
</tr>
<tr>
<td>Grand County</td>
<td>Fraser</td>
<td>Rangeview Counseling Center</td>
<td>Jean Gehring, Operation &amp; Clinical Director</td>
<td><a href="mailto:jgehring@rangeviewcounselingcenter.com">jgehring@rangeviewcounselingcenter.com</a></td>
<td><a href="http://www.rangeviewcounselingcenter.com">www.rangeviewcounselingcenter.com</a></td>
<td>Meadow Ridge Clubhouse Fraser, Co 80442 1790 30TH ST STE 305 Boulder, CO 80301</td>
<td>303-447-2038</td>
<td>State licensed, outpatient substance abuse treatment program. Offers counseling and DUI education and treatment program.</td>
</tr>
<tr>
<td>County</td>
<td>City</td>
<td>Provider</td>
<td>Contact Person</td>
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</tr>
<tr>
<td>Grand County</td>
<td>Granby</td>
<td>Resource Clearinghouse - Grand Futures</td>
<td>Suzie Baird, Managing</td>
<td><a href="mailto:suzie@grandfutures.org">suzie@grandfutures.org</a></td>
<td><a href="http://www.grandfutures.org">www.grandfutures.org</a></td>
<td>195 3rd Street Granby, CO 80446</td>
<td>970-819-7805</td>
<td>A library of books, pamphlets, brochures, videos that are available free of charge to rent or keep on alcohol, tobacco, other drug, parenting, and more.</td>
</tr>
<tr>
<td>Grand County</td>
<td>Granby</td>
<td>Granby Outpatient Clinic - Colorado West</td>
<td>Kathy Davis, Division</td>
<td><a href="mailto:kmcwilliams@cwrmhc.org">kmcwilliams@cwrmhc.org</a></td>
<td><a href="http://www.cwrmhc.org">www.cwrmhc.org</a></td>
<td>1023 County Rd. 610 Granby, CO 80446</td>
<td>970-668-3478</td>
<td>Provides counseling to those who have a mental health or substance problem. Offers DUI classes. Staff is qualified to deal with any type of disorder. Telephone screening determines what paperwork will be needed for outpatient treatment. Inpatient care is available at facility in Mesa County.</td>
</tr>
<tr>
<td>Jackson County</td>
<td>Walden</td>
<td>Substance Abuse - Walden Outpatient Clinic - Colorado West Regional Mental Health Center</td>
<td>Jane D. Bingham, Program Coordinator</td>
<td><a href="mailto:jbingham@cwrmhc.org">jbingham@cwrmhc.org</a></td>
<td><a href="mailto:jbingham@cwrmhc.org">jbingham@cwrmhc.org</a></td>
<td>350 McKinley St Walden, CO 80480</td>
<td>970-723-0055</td>
<td>General mental health services to Jackson County which include substance abuse counseling. Substance abuse counseling includes DUI Level I and II therapy and Minor in Possession classes.</td>
</tr>
<tr>
<td>Rio Blanco County</td>
<td>Meeker</td>
<td>Domestic Violence Education / High School Family Living Program - Safehouse Inc</td>
<td>Nancy Richardson</td>
<td>Safehouse Inc. PO Box 223 Meeker, Co 81641</td>
<td><a href="http://www.cwrmhc.org">www.cwrmhc.org</a></td>
<td>Colorado West Regional Mental Health 267 6th St Meeker, CO 81641</td>
<td>970-878-4846</td>
<td>Safehouse Inc. provides domestic violence education through the Family Living Program at the local high school. Programs are also available for elementary and middle schools.</td>
</tr>
<tr>
<td>Rio Blanco County</td>
<td>Meeker</td>
<td>Meeker Outpatient Clinic - Colorado West Regional Mental Health Center</td>
<td>Michelle Huber</td>
<td><a href="http://www.cwrmhc.org">www.cwrmhc.org</a></td>
<td>Colorado West Regional Mental Health 267 6th St Meeker, CO 81641</td>
<td>970-878-5112</td>
<td>Provides counseling to those who have a mental health or substance problem. Offers DUI classes. Staff is highly qualified to deal with any type of disorder. Telephone screening determines what paperwork will be needed for outpatient treatment. Inpatient care is available at facility in Mesa County.</td>
<td></td>
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<td>County</td>
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<tr>
<td>Rio Blanco</td>
<td>Rangely</td>
<td>Rangely Outpatient Clinic - Colorado West Regional Mental Health Center</td>
<td>Phyllis Zdra or Michelle Huber</td>
<td><a href="http://www.cwrhmhc.org">www.cwrhmhc.org</a></td>
<td>Colorado West Regional Mental Health 17497 Hwy 64 County Annex Building Rangely, CO 81648</td>
<td>970-675-8411</td>
<td>Mental Health Counseling, Individual, Family, Marital, Children and Adolescents, Psychiatric Services, Employee Assistance Programs, Crisis Intervention and Emergency Services, Community Education, substance Abuse Education and Treatment and DUI Education and Therapy Groups for Levels I and II and Consultation. Issues include: Anger, Depression, Grief, ADHD, Bipolar, Substance Abuse Assessment, Blended Family Issues, Play Therapy Communication, Families in transition and tobacco prevention</td>
<td></td>
</tr>
<tr>
<td>Moffat</td>
<td>Craig</td>
<td>Craig Outpatient Clinic - Colorado West Regional Mental Health Center</td>
<td>Gina Toothaker, Program Director</td>
<td><a href="mailto:gtoothak@cwrhmhc.org">gtoothak@cwrhmhc.org</a></td>
<td>439 Breeze St. Suite 200 Craig, CO 81625</td>
<td>970-824-6541</td>
<td>Provides mental health and substance abuse services including evaluations, individual, couples, family and group therapy, case management services, 24/7 emergency coverage. Does not provide domestic violence evaluations or perpetrator treatment.</td>
<td></td>
</tr>
<tr>
<td>Moffat</td>
<td>Craig</td>
<td>Craig Group 1 AA - Alcoholics Anonymous (AA)</td>
<td>Bud Nelson</td>
<td><a href="mailto:budnpenny@hotmail.com">budnpenny@hotmail.com</a></td>
<td>First Congregational Church 630 Green Street Craig, CO 81625</td>
<td>970-824-1793</td>
<td>Craig Group 1 is a program of Alcoholics Anonymous.</td>
<td></td>
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</tbody>
</table>
Tobacco
Yampa Valley Medical Center
COMMUNITY HEALTH NEEDS ASSESSMENT

Center for Health Administration
University of Colorado Denver
The Surgeon General’s report on tobacco in 1964 was the beginning of a wealth of research that subsequently followed the dangers of tobacco use. Tobacco’s links to cancer, heart disease, and respiratory disease are well documented in the literature. Even second-hand smoke has been linked to these same diseases, as well as to asthma, respiratory illnesses and ear infections in children. Furthermore, smokeless tobacco has been linked to cancer of the mouth and gums, periodontitis and tooth loss.1

Colorado spends $1.3 billion a year on tobacco related health care costs.2 In addition, employers lose about $1 billion a year in lost productivity due to smoking-related losses in productivity.3

The good news is that “tobacco use is the single most preventable cause of death and disease in the United States.”4 Over 45 years of research has shown that tobacco use can be reduced through a variety of programs, such as reducing tobacco advertising, increasing the price of tobacco products, and funding tobacco control programs.5 6 7

---

1 Healthy People 2020.
3 Ibid.
CIGARETTE USE

BRFSS Survey Question: Do you currently smoke cigarettes?

Moffat County’s smoking rate is higher than the state average, while Routt County’s rate is below the state average, the HP 2020 target and the Colorado Winnable Battles goals of 12%.

Figure 2 Smoking Rates

---

SMOKING TRENDS

The trend for cigarette smoking in the state and nation is down, with 16.5% of the population smoking in Colorado in 2010. Colorado’s smoking rates are consistently lower than the nation’s.

Figure 3 Cigarette Smokers

DEMOGRAPHICS OF SMOKERS

Smoking rates are significantly higher among youth age 18-34, and decrease with age. People who are married or part of a couple are significantly less likely to smoke than those who have never married or are divorced/separated/widowed. Males are more likely to smoke than females.

**Figure 4 Smoking by Gender**

**Figure 5 Smoking by Age**

**Figure 6 Smoking by Marital Status**

---

12 Ibid.
13 Ibid.
The tobacco industry spends up to $140 million in advertising each year just in Colorado. The tobacco industry targets communities with a high percentage of minorities, Hispanics, and multiracial residents, as well as lower socioeconomic neighborhoods.

The chart on this page shows that their advertising efforts are largely successful, as 27.5% of people in poverty smoke tobacco compared to 16% in the state. Many lower-income communities also lack cessation programs or adequate secondhand smoke restrictions in multiunit housing areas.

### Smoking Rates by Federal Poverty Level, 2010

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Lower Limit</th>
<th>Upper Limit</th>
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</thead>
<tbody>
<tr>
<td>&lt;150% FPL</td>
<td>27.5</td>
<td>23.8</td>
</tr>
<tr>
<td>&gt;=150% FPL</td>
<td>13.2</td>
<td>12.1</td>
</tr>
<tr>
<td>All</td>
<td>16.0</td>
<td>14.9</td>
</tr>
</tbody>
</table>

Figure 7 Smoking Rates by Federal Poverty Level

Smoking significantly decreases with income. People who make $50,000 and above were significantly less likely to smoke; their current smoking rate of 11% was below the state average of 16%.

Differences among racial and ethnic groups in Colorado were not significant.

---

14 Colorado Winnable Battles. Colorado Department of Public Health and Environment.
15 Ibid.
16 Ibid.
17 Chart Source: Colorado Winnable Battles.
Lower education levels are also associated with higher smoking rates, and the rate significantly decreases with more education.

Figure 9 Smoking by Education Level

TOBACCO USE AMONG YOUTH

YRBS Survey Question: Percentage of students who smoked cigarettes or cigars or used chewing tobacco, snuff, or dip on one or more of the past 30 days. (Answered 1 or more)

The nearby chart shows the increase in tobacco use with each grade in high school.

![Figure 10 Tobacco Use Among High School Students](image1)

On a positive note, the smoking trend among high school students is decreasing over the past 15 years and is closely approaching the adult rate. The adult rate has steadily decreased since 1996.

![Figure 11 Trends in Current Cigarette Smoking Among High School Students and Adults, United States, 1965-2009](image2)

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The Colorado Winnable Battles Goal for 2016 is a 16% smoking rate among youth in high school. Reducing smoking rates in youth is paramount to reducing rates in adults since 80% of all adults start smoking when they are young. Adolescents are more susceptible to developing smoking habits since they are more sensitive to nicotine’s effects. They are also more easily influenced by their peers and more likely to respond to discounts for tobacco products. Unfortunately, 60% of youth who tried to buy tobacco products were successful, despite prohibitive state laws. If a community can reduce its smoking rates among youth, the addiction rates in the general population will eventually decrease, thus reducing the 4,300 tobacco-related deaths a year.\textsuperscript{22}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure12.png}
\caption{9-12th Graders Who Smoke\textsuperscript{23,24}}
\end{figure}

\textsuperscript{22} Colorado Winnable Battles. Colorado Department of Health and Environment.
\textsuperscript{23} Ibid.
\textsuperscript{24} Chart Source: Youth Risk Behavior Survey, Colorado Department of Public Health and Environment.
CHILDREN’S EXPOSURE TO SECONDHAND SMOKE

The percent of children ages 1-14 in Colorado who live with a smoker in the home and are exposed to secondhand tobacco smoke decreased overall since 2004, with a minor increase in the last two recorded years. The goal of the Colorado Winnable Battles is to have only 28% of children exposed to secondhand smoke in 2016.\textsuperscript{25}

Exposure to secondhand smoke is a concern because it is linked to heart disease, stroke, cancer, and lung disease. Children exposed to tobacco smoke are more likely to have learning disabilities, behavioral disorders and loss of hearing. The likelihood of them smoking when they are older increases, too.\textsuperscript{26}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure13.png}
\caption{Colorado Children Who Are Exposed to Secondhand Tobacco Smoke at Home\textsuperscript{27}}
\end{figure}

\textsuperscript{25} Colorado’s Winnable Battles. Colorado Department of Health and Environment.
\textsuperscript{26} Ibid.
\textsuperscript{27} Ibid.
INTERVENTIONS

Colorado is using several strategies to combat youth tobacco use including the following:

• “supporting state and local initiatives to reduce youth exposure to tobacco;
• communicating public health messages that counteract pro-tobacco marketing;
• increasing and enforcing restrictions on tobacco sales to minors;
• actively enforce the Family Smoking Prevention and Tobacco Control Act;
• supporting proven school-based, youth-friendly programs such as “N-O-T (Not on Tobacco)” and “Second Chance”;
• finding and sustaining adequate funding for evidence-based comprehensive tobacco control initiatives.”

Other initiatives in Colorado are described in the following section.

“The voter-approved tobacco tax (2005), Colorado Clean Indoor Air Act’s public smoking ban (2006), and public health interventions resulted in at least 100,000 fewer Colorado smokers. The Colorado Department of Public Health and Environment is working with state and local, public and private partnerships to eliminate loopholes in current law, expand smoke-free housing options and reduce the illegal sales of tobacco to minors at the local level to reduce tobacco use and related death and disease rates. Current statewide collaborative efforts include

• disseminating information about secondhand smoke and tobacco-free policies;
• developing, expanding and enforcing state and local tobacco-free policies;
• expanding public smoking bans in multiunit housing;
• reducing illegal sales of tobacco to minors;
• increasing availability of and promoting tobacco cessation programs, such as the Colorado QuitLine, and targeting at-risk populations;
• increasing insurance coverage for tobacco cessation interventions and all FDA-approved medications;
• assessing tobacco use trends and evaluating interventions.

Such strategies are recommended by the U.S. Centers for Disease Control and Prevention, partially funded by a voter-approved tobacco tax.”

28 Colorado Winnable Battles, Colorado Department of Health and Environment.
29 Ibid.
The Centers for Disease Control and Prevention (CDC) has compiled the following list of evidence-based community interventions. More information on specific interventions can be found from links to their website, http://www.healthypeople.gov/2020/topicsobjectives2020/ebr.aspx?topicId=41#inter.

**DECREASING TOBACCO USE AMONG WORKERS: INCENTIVES AND COMPETITIONS TO INCREASE SMOKING CESSION**

Worksite-based incentives and competitions to reduce tobacco use among workers offer rewards to individual workers and to teams as a motivation to participate in a cessation program or effort.

**DECREASING TOBACCO USE AMONG WORKERS: SMOKE-FREE POLICIES TO REDUCE TOBACCO USE**

Smoke-free policies include private-sector rules and public-sector regulations that prohibit smoking in indoor workplaces and designated public areas.

**HEALTH COMMUNICATION & SOCIAL MARKETING: HEALTH COMMUNICATION CAMPAIGNS THAT INCLUDE MASS MEDIA & HEALTH-RELATED PRODUCT DISTRIBUTION**

Health communication campaigns can increase the use of health-related products when they use mass media messaging and distribute the products at free or reduced prices.

**INCREASING TOBACCO USE CESSION: INCREASING THE UNIT PRICE FOR TOBACCO PRODUCTS**

These interventions increase the unit price for tobacco products through municipal, state, or federal legislation that raises the excise tax on these products.

**INCREASING TOBACCO USE CESSION: MASS MEDIA CAMPAIGNS WHEN COMBINED WITH ADDITIONAL INTERVENTIONS**

Campaigns, as evaluated for this review, are mass media interventions that use brief, recurring messages to inform and motivate tobacco users to quit.
INCREASING TOBACCO USE CESSATION: MASS MEDIA CAMPAIGNS WHEN COMBINED WITH OTHER INTERVENTIONS

These mass media campaigns use brief, recurring messages to inform and motivate tobacco users to quit, and they are often combined with other interventions.

INCREASING TOBACCO USE CESSATION: MULTICOMPONENT INTERVENTIONS THAT INCLUDE TELEPHONE SUPPORT

These interventions provide people who use tobacco products with cessation counseling or assistance in initiating or maintaining abstinence via telephone. They may be combined with other interventions, such as client education materials, individual or group cessation counseling, or nicotine-replacement therapies.

INCREASING TOBACCO USE CESSATION: PROVIDER REMINDERS WHEN USED ALONE

Provider reminder systems for tobacco cessation include efforts to identify clients who use tobacco products and to prompt providers to discuss and/or to advise clients about quitting.

INCREASING TOBACCO USE CESSATION: PROVIDER REMINDERS WITH PROVIDER EDUCATION

These multicomponent efforts to increase tobacco use cessation include implementation of provider reminders and efforts to educate providers to identify and intervene with tobacco-using patients, as well as provide supplementary educational materials.

INCREASING TOBACCO USE CESSATION: REDUCING CLIENT OUT-OF-POCKET COSTS FOR CESSATION THERAPIES

These interventions include efforts to reduce the financial barriers that may keep people from using cessation therapies such as nicotine replacement, other pharmacologic therapies, or behavioral therapies such as cessation groups.
REDUCING EXPOSURE TO ENVIRONMENTAL TOBACCO SMOKE: SMOKING BANS AND RESTRICTIONS

Smoking bans and restrictions are policies, regulations, and laws that limit smoking in workplaces and other public areas.

REDUCING TOBACCO USE INITIATION: INCREASING THE UNIT PRICE OF TOBACCO PRODUCTS

This intervention includes an assessment of personal health habits and risk factors; an estimation or assessment of risk of death and other adverse health outcomes; and provision of feedback in the form of educational messages and counseling.

RESTRICTING MINORS’ ACCESS TO TOBACCO PRODUCTS: COMMUNITY MOBILIZATION WITH ADDITIONAL INTERVENTIONS

These are community-wide interventions aimed at focusing public attention on the issue of youth access to tobacco products and mobilizing community support for additional efforts to reduce that access.

WORKSITE HEALTH PROMOTION: ASSESSMENT OF HEALTH RISKS WITH FEEDBACK TO CHANGE EMPLOYEES’ HEALTH

This intervention includes an assessment of personal health habits and risk factors; an estimation or assessment of risk of death and other adverse health outcomes; and provision of feedback in the form of educational messages and counseling.  

30 Healthy People 2020.  
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<th>County or Statewide</th>
<th>City</th>
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<tr>
<td>Colorado</td>
<td></td>
<td>American Lung Organization: N-O-T Program</td>
<td>Diane Draper</td>
<td><a href="mailto:tobacco@lungcolorado.org">tobacco@lungcolorado.org</a>*</td>
<td><a href="http://www.lung.org/associations/states/colorado/not-on-tobacco/">http://www.lung.org/associations/states/colorado/not-on-tobacco/</a></td>
<td>5600 Greenwood Plaza Blvd. Suite 100, Greenwood Village, CO, 80111-2316</td>
<td>(303)-388-4327</td>
<td>Ten-week program that helps participants learn to identify their reasons for smoking, healthy alternatives to tobacco use</td>
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<tr>
<td>Colorado</td>
<td></td>
<td>Colorado Breath/GASP Colorado</td>
<td></td>
<td>*</td>
<td><a href="http://www.breathcolorado.org/breath/index.html">http://www.breathcolorado.org/breath/index.html</a></td>
<td>2885 Aurora Avenue Suite 37, Boulder, CO 80303</td>
<td>(303)-444-9799</td>
<td>Education and resource services regarding health issues of second hand smoke, prevention and awareness</td>
</tr>
<tr>
<td>Colorado</td>
<td></td>
<td>Colorado Quit line</td>
<td>Christopher E. Urbina</td>
<td>*</td>
<td><a href="https://colorado.quitlogix.org">https://colorado.quitlogix.org</a></td>
<td>Colorado Department of Public Health and Environment 4300 Cherry Creek Drive South Denver, Colorado 80246-1530</td>
<td>1800-QUIT-NOW</td>
<td>Toll-free telephone counseling service that connects people who want to quit smoking with trained counselors who can guide and support them through the quitting process.</td>
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<tr>
<td>Routt</td>
<td>Steamboat Springs</td>
<td>Grand Futures Prevention Coalition Routt</td>
<td>Kate Elkins, Routt County Director</td>
<td>Kate@g randfutures.org</td>
<td><a href="http://www.grandfutures.org">www.grandfutures.org</a></td>
<td>445 Angler's Drive Steamboat Springs, CO 80477</td>
<td>970-879-6188</td>
<td>The mission of Grand Futures Prevention Coalition is to engage our community in the creation and promotion of healthy, positive lifestyle choices as alternatives to substance abuse. Programs and activities include</td>
</tr>
</tbody>
</table>

Yampa Valley Medical Center | Tobacco
- Alcohol and tobacco compliance checks
- Youth leadership and advocacy activities
- Teen Council
- Parent and community substance abuse prevention education and awareness
- Policy change, including social host ordinances, athletic code revisions, medical marijuana dispensary regulation, parent, student and community data collection,
- Healthy Kids Colorado survey, prevention media campaigns, social norms and marketing campaigns, tailored alcohol, tobacco and other drug prevention, presentation and curricula for schools and community organizations. The Excellence Project, TIPS trainings for servers, and substance free events for youth and teens.

Grand Futures also has a lending library of books, videos and education materials related to substance abuse prevention.

Grand Futures Prevention Coalition works collaboratively with schools, governmental agencies, nonprofit organizations, and businesses within communities to make most of limited resources. GFPC advisory board and task force members represent
| Routt | Steamboat Springs | Adult health (Routt County) - northwest Colorado Visiting Nurse Association Inc. (VNA) | Stephanie Anderson | Sanders o@nwcova.org | 940 Central Park Drive Suite 101 Steamboat Springs, CO 80487 | (970) 879-1632 | Programs for Adults & Seniors include: | - Women's Health Clinic 970-879-3738 | - Adult Immunizations | - Travel Immunizations | - Senior Wellness Services | - Communicable Disease Control | - Cancer Awareness and Screening | - Cardiovascular and Diabetes Screening | - Medical eligibility and enrollment | - Tobacco Prevention and Education Services | - Adult Day services | - Hospice and palliative care services | - Emergency Preparedness |

<p>| Rio Blanco | Rangely | Rangely Outpatient Clinic - Colorado West Regional Mental Health Center | Phyllis Zadra or Michelle Huber | <a href="http://www.cwrmhc.org">www.cwrmhc.org</a> | 17497 Hwy 64 County Annex Building Rangely, Co 81648 | 970-675-8411 | Mental health counseling, individual, family, marital, children and adolescents, psychiatric services, employee assistance programs, crisis intervention and emergency services, community education, substance abuse education and treatment and DUI education and therapy groups for levels I and II and consultation. Issues include: anger, depression, grief, ADHD, bipolar, substance abuse assessment, blended family issues, play |</p>
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<th>Location</th>
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<th>Services</th>
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</thead>
<tbody>
<tr>
<td>Moffat</td>
<td>Craig</td>
<td>Community health (Moffat county) - northwest Colorado Visiting Nurse Association Inc. (VNA)</td>
<td>Stephanie Anderson</td>
<td>745 Russell Street, Craig, CO 81625</td>
<td>(970) 871-7636</td>
<td>Programs for Residents include: -Community Health Clinic -Women's Health Clinic -Immunizations -Senior Wellness Services -Communicable Disease Control -Cancer Awareness and Screening -Tobacco Prevention and Education Services -Emergency Preparedness -Bereavement Support Group</td>
</tr>
<tr>
<td>Grand County</td>
<td>Granby</td>
<td>Resource clearinghouse - Grand Futures Prevention Coalition - Grand County</td>
<td>Suzie Baird, Managing Director</td>
<td>195 3rd street, Granby, CO 80446</td>
<td>970-819-7805</td>
<td>A library of books, pamphlets, brochures, videos that are available free of charge to rent or keep on alcohol, tobacco, other drug, parenting, and more.</td>
</tr>
</tbody>
</table>