

Table of Contents

Executive Summary	3
Introduction	4
Methodology	5
Findings	
Program & Operations	5
Partnerships	9
Needs Assessment	13
Recommendation	17
Appendices	
Works Cited & Consulted	18
Sufficiency Model Concepts	20
Confidence Instrument	21
Staff Resumes	22
Example of English/Spanish Materials	27



Executive Summary

Overall, the program is running quite smoothly. Outreach efforts are successful and result in more individuals and families receiving assistance in accessing the health care system. Because the need is great –and growing due to economic conditions and high unemployment in the Latino community –The ENTRA Program is essential to maintaining health for those individuals and their families who are unable to gain access to the health care system.

Findings: The ENTRA Program has been able to expand their profile and clientele through a grant from the Colorado Health Foundation. With this grant, SDLR was able to hire, train, and deploy three professionals with over 46 years of experience in case management and health care assistance combined. While these professionals have distinct skills and are assigned separate and essential tasks, all three are dedicated to improving access to the health care system for Latinos overcoming financial, employment, or language barriers. To date, the program has reached households in all parts of the Denver area and outreach sessions or workshops have been scheduled at least twice each week. Materials –including intake forms – have been developed in both English and Spanish, and tracking processes have been implemented.

Partnerships have also been established. The ENTRA Program has three identified partners. Of these, one is a Supportive Partnership and two are Collaborative Partnerships. Examining the partners and the partnership concepts, SDLR indicates that they are a greater contributor of resources than their three partners. SDLR also feels that they share a common vision for the partnership goals with one of their collaborative partners and their supportive partner – namely, Clinica Tepeyac and CHS Commerce City. The final collaborative partnership –Focus Points –is fairly weak. Furthermore, there is an opportunity to partner with some existing service competitors in order to provide better service for the Latino community.

Finally, a Needs Assessment for SDLR included research, data from national data-bases, and from residents in the SDLR catchment area. All data indicate that Latinos:

- Are in need of assistance in overcoming financial, language, and educational barriers so that they can access the health care system
- Do not have access to the same level of health care as whites, as our health insurance system is employment-based. Furthermore, government programs are complicated and require full proficiency with the English Language
- Require an advocate in order assist with the completion of forms and adhering to complicated regulation.

Recommendations for improvement: The program is working as designed. The two areas of worth attention include striving for a balance of partnership types so that the program can achieve economic and political resiliency; and the consolidation of data requests and better data management processes.

Introduction

In 2010 Servicios de La Raza (SDLR) was awarded a three-year grant from the Colorado Health Foundation to operate the ENTRA Program.¹ This grant enabled SDLR to continue its mission of providing and advocating comprehensive and culturally relevant human services to the Spanish speaking population of Denver. The ENTRA program serves to educate potential recipients and participants accessing the health care in the following ways:

- Provide culturally specific information sessions that are open to the community and partnering agencies,
- Ensure that SDLR clients and participants have access to and can complete the required forms necessary to obtain public healthcare coverage,
- Develop communication between individuals, their families and various health care providers,
- Provide effective and comprehensive case management for clients to gain complete public healthcare coverage enrollment and to identify gaps in health care services,
- Provide information at public events about accessing the healthcare system.

In order to coordinate these activities with existing SDLR programs, three funded positions are dedicated to program administration, client management, coordinating the program with existing SDLR programs, implementing a culturally specific marketing plan complete with bilingual materials, apply for applicable funding, and other general operations related to the program. Along with the SDLR management, these individuals are also responsible for developing a long-term strategy for sustainability of the ENTRA-Enter Public Family Healthcare Coverage Program.

Grant activities and reporting are divided into a Planning Phase (0-6 months), an Implementation Phase (1-3 years), and a Needs Assessment Phase (first three months following the end of the grant period). During the Planning Phase SDLR will hire and train the HealthCare Advocate (HCA), create culturally specific programming and associated materials, and coordinate activities with other SDLR programs. Additionally, the HCA will facilitate and conduct information sessions, and establish beneficial and viable partnerships to assist with reaching as many individuals within the target population as possible.

During the Implementation Phase, the HCA will continue to coordinate healthcare access information with other SDLR programming, seek new partnerships with health care providers, and identify and apply for funding. Finally, the Needs Assessment Phase will measure local need against program delivery. Data will indicate the extent to which SDLR was successful in reaching individuals and families and building capacity within the Latino population to access health care.

¹ Everyone Needs Tender, Respectful Attention

Methodology

Research on existing access to the health care system by urban Latino individuals were gained by examining local data from the United States Census (2010), the National Institute of Health Survey (NHIS 2009), the Pew Foundation Study on Hispanics, Health Insurance and Health Care Access (2008), various monthly supplements from Current Population Survey (2010 and 2011), the American Community Survey (2007-2009), and data from the Centers of Disease Control (CDC 2006-2009). Information specific to this grant was obtained from personnel employed by SDLR.

Individual data were gathered through the SDLR ENTRA Program Intake form, the ENTRA In-House Reporting Form, and qualitative statements from the ENTRA Program staff. The Confidence Instrument was under development, tested and is ready to deploy for the next grant cycle. Organizational and group data were gathered using the Sufficiency Partnership Model instrumentation² and the corresponding Competitors Analyses.

All quantitative data were analyzed using SPSS V.18 statistical software, ESRI shapefiles printed in Microsoft Map 2010, and graphed using 2010 Microsoft Excel and Smartdraw VP 2010. Qualitative data were analyzed using AtlasTi software.

All data were gathered, stored, analyzed and reported according to the ethical and professional standards maintained by the American Evaluation Association and guidelines adapted for Human Subjects Research. All private (non-public access) data remain the possession and responsibility of SDLR.

Findings – Program & Operations

Three positions were created as the result of the grant. The Health Coverage Advocate and the Planning Development Coordinator were hired within the first 60 days of receiving the grant. It was soon determined that more complete staffing was needed in order to deliver the necessary support; as such, the Case Manager position was staffed in early March of 2011. All three individuals hired possess strong backgrounds in health care community outreach and client management (See Appendix for resumes).

1. HealthCare Advocate provides wrap-around services to SDLR clients. The HCA attends to and supports each client's health care issues and links the individual or family to the local health care community.
2. Planning Development Coordinator works to build sustainability by bolstering the funding base for the ENTRA Program. This entails thorough research of all applicable RFP's, material dissemination to potential funders, and strengthening the relationship with community partners.
3. Case Manager makes every effort possible to ensure that clients have accessed the health care system. In addition to supporting the activities of the HCA in outreach and building family awareness, the Case Manager is responsible for tracking clients, recording relevant data, and reporting the progress of the program.

² As Developed by the Ohio State University P-12 Project; Nestor-Baker, Fahey, Kerka, and Overly (2007).

Together, the individuals in these positions have developed materials, forms, and flyers in both Spanish and English (See Appendix), and work to provide workshops information sessions. In the first 5 months of 2011, 20 separate information sessions and outreach workshops were held for 115 households. Walk-in sessions were also arranged; however on a less frequent basis, for those individuals presenting at the SDLR offices with immediate needs.

While community outreach and family education are critical aspects, financial concerns are cited as the primary barrier preventing Latino families from accessing the health care system. Asked about the issues faced when obtaining health insurance, over 58% indicated that financial cost was indeed a barrier to obtaining insurance.

Furthermore, in review of work, the HCA indicated that finances needed to be considered for obtaining health care. As most of the clientele are unemployed, employer-based health care is out of the realm of possibilities.

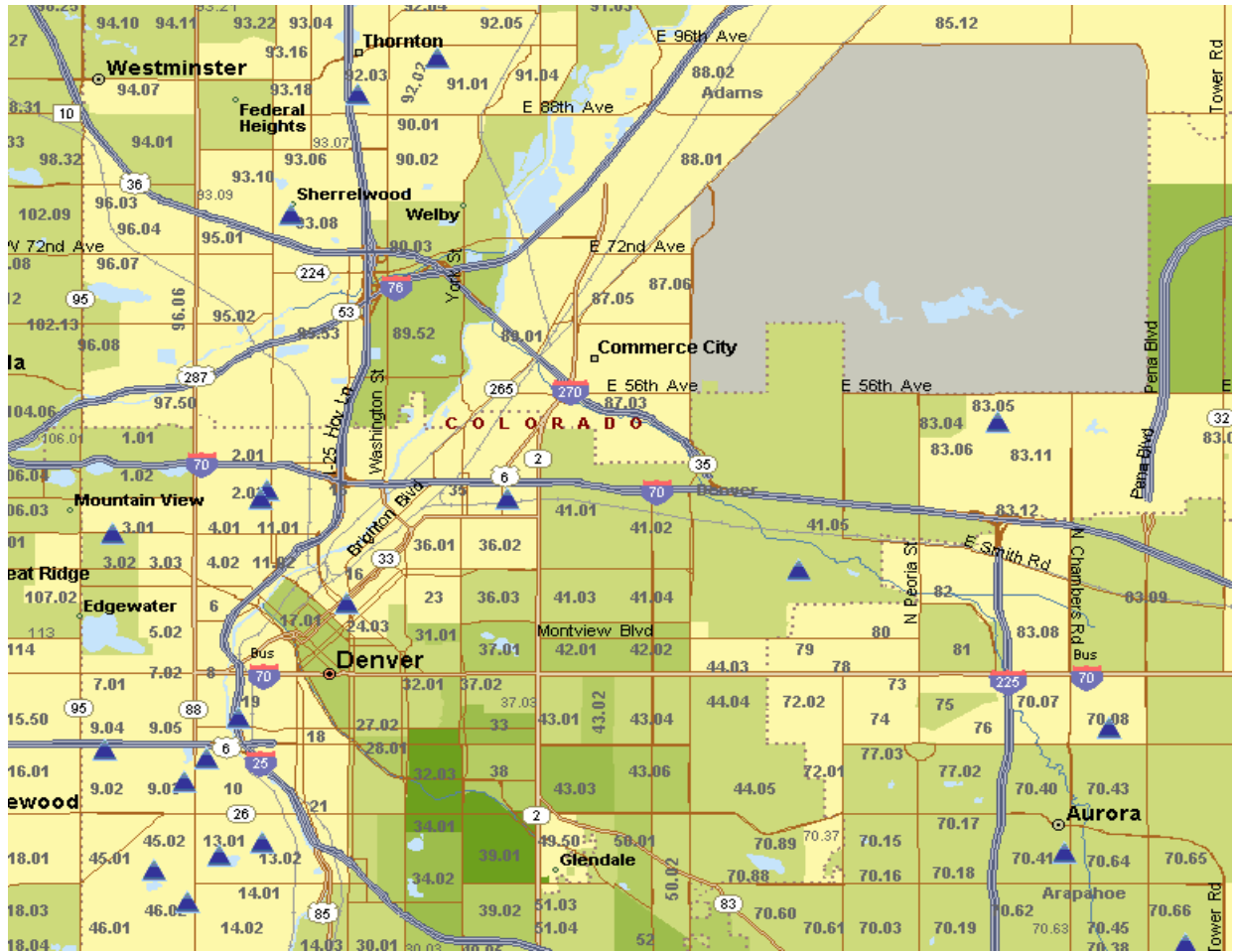
“Each client will benefit from the peace of mind that comes with knowing that they and /or their loved ones are successfully enrolled in health care coverage. Health care is such a critical piece of overall wellness and being covered can help alleviate the financial burden that often leads to stress and other problems within the family. “

This is echoed throughout the region. In 2008, the PEW Hispanic Center conducted a national survey. Data for the individuals living the Denver Metropolitan Area³ show that nearly 20% of Hispanics do not have insurance because of the cost.

<i>What is the main reason why you do/DID not have health insurance?</i>	<i>Is it...?</i>
It's too expensive	19.5
Employer offers plan, but not eligible (Wait pd/PT work)	5.0
You don't think you need insurance	2.3
Can't get it due to poor health, illness, or age	.5
Other family member has insurance, but it doesn't cover you	1.5
You don't know how to get insurance	3.9
Your immigration status prevents you from getting insurance	5.2
Some other reason	6.9
Don't know	2.1

³ Data were downloaded and sorted for specific region using SPSS V.18

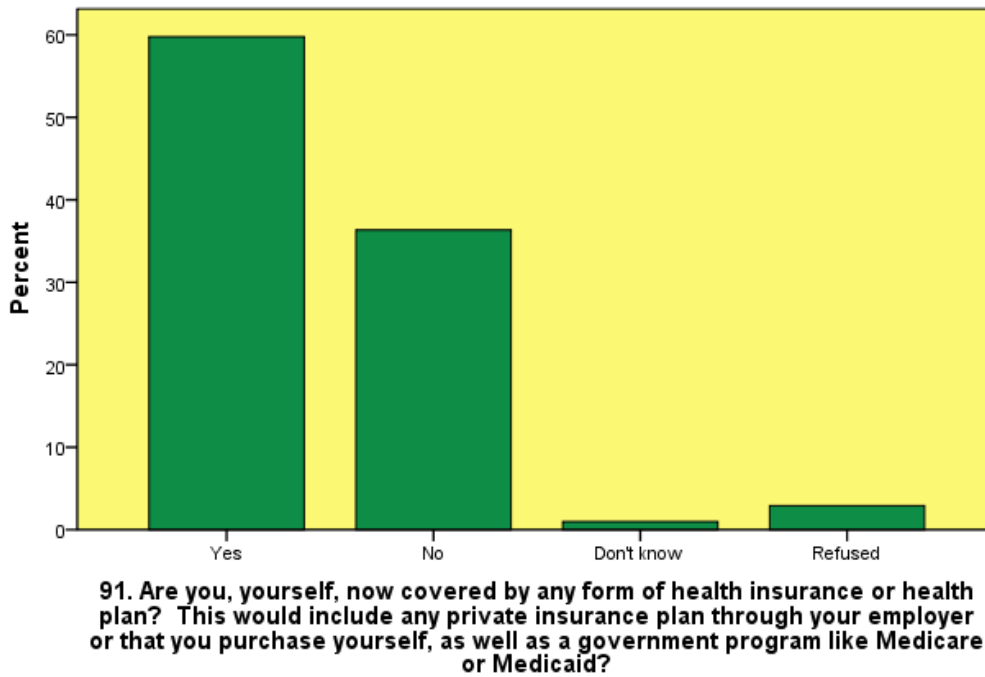
The map below shows the level at which Latinos spend money on health care. The lighter or more yellow the census block, the less money is spent. Conversely, the darker or more green the area, the more money is being spent on healthcare per household. Mapping the locations of individuals who received assistance from SCLR program staff, it is easy to see that the ENTRA Program is reaching those individuals and families living in areas where health care spending is at a minimum.



In the previous year, the SCLR ENTRA program has worked to engage those neighborhoods and households where accessing the health care system is either too expensive or too complicated. The majority (82%) were Medicaid eligible and the rest were evenly split (9% each) between CHP+ and Medicare. Most (57%) were Spanish speakers and 43% spoke English. Also, slightly more than 64% were citizens or legal residents, and 36% were undocumented. Of those who were undocumented, all were Spanish speakers with children living in the household.

While they may be covered, there is still much work to be done in understanding. Barriers to access are also related to education and English literacy. When the PEW study asked respondents about their confidence in completing medical forms or being educated about their condition, over 51% of the Latinos in the Denver area indicated that they were somewhat to

not-at-all confident about how they completed their medical forms, and 33.4% indicated that they needed some assistance in reading materials distributed by hospitals.



In addition to poor education, the crux of the problem lies in cultural and language barriers that prevent members of the Latino community from fully utilizing health care facilities and health insurance (Flores et. al., 2002). Language barriers prevent many Latino families from applying for health care from private or public insurance systems. Flores et. al. found that “Latinos are more likely to be uninsured (27%) than any other ethnic group of US children. In comparison, 9% of white, 18% of black, and 17% of Asian/ Pacific Islander children are uninsured,” (2002). In a comprehensive literature review, Flores et. al. identified 22 access barriers to health care encountered by Latino children – and thus their primary caregivers – which include poverty, low parent education levels, transportation issues, long waiting time in clinics, lower levels of preventative screening, fewer drugs prescribed, language barriers, cultural differences, no health insurance, and no regular care (primary physicians) (2002). They also found that when Latino children do receive care, the quality of their care is decidedly lower than care of youth in other racial/ethnic groups including fewer medical tests and less time with physicians (Flores et. al., 2002). Additionally, Latinos are extremely underrepresented in all types of health care professions. Whereas 16% of youth under 18 are Latino, Latinos make up only 3% of medical school faculty, 5% of pediatricians, 2.8% of dentists and 2% of nurses. Flores et. al. state, “the Latino pediatrician-to-child ratio is expected to decrease from 17 Latino pediatricians per 100,000 Latino children in 1996 to 9 per 100,000 by 2025,” (2002).

This holds for SDLR ENTRA program clients -- 46.4% indicated that at some previous time, they had health insurance. A majority of SDLR clientele (53%) indicated that they looked to the ENTRA program for assistance as other programs were not as helpful as the client needed.

Findings – Partnerships

In communities across the country, partnerships are viewed as a means to share resources in order to expand services that could not be accomplished by separate organizations individually. What one group does well, another may do poorly, or not at all (Fahey, 2010).

There is an assumption that all partnerships are somehow homogenous in design, practice, structure, and desired outcome. This is not the case. Some partnerships are true collaborations with the participating groups sharing costs, decision-making, and taking responsibility for the outcomes. Others are partnerships in name, purpose, or location only (Edens and Gilsinen, 2005; Acar and Robertson, 2004).

In brief, there is no right or wrong type of partnership, but some partnerships may be less sufficient than others. Researchers at the P-12 Project at Ohio State University have identified three different types of partnerships and some of their characteristics. The table represents the research to date on the various types of educational partnerships (Fahey, 2010; Nestor-Baker, et. al., 2008).

Partnership Types and Characteristics

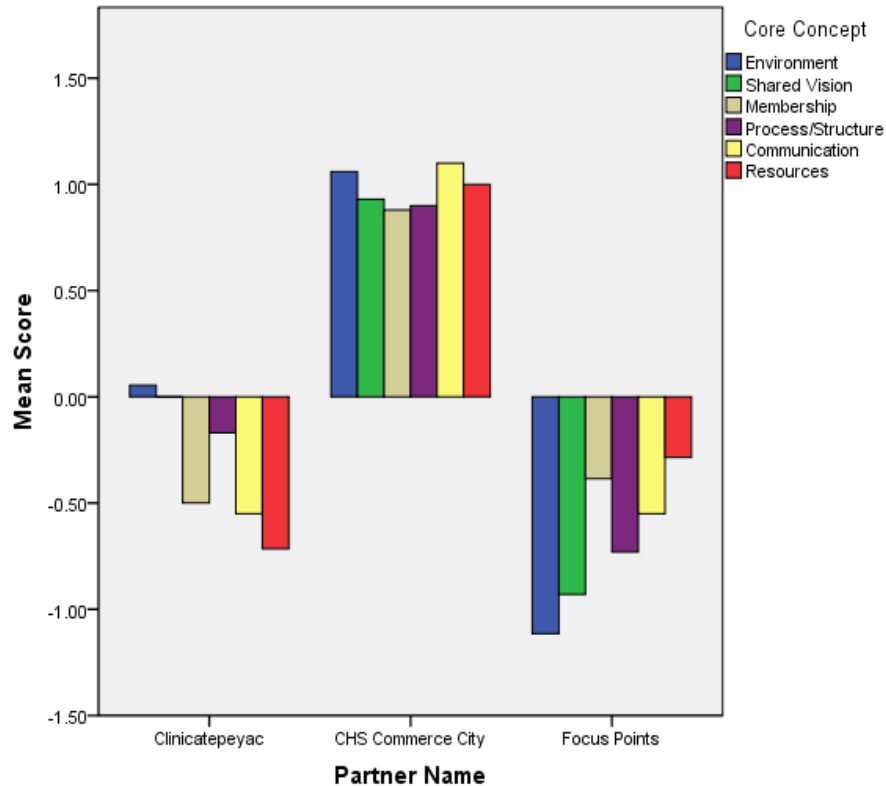
Characteristic*	Supportive Partnership	Competitive Partnership	Collaborative Partnership
Environment	One dominant culture and leadership style	Multiple cultures, leadership styles	Multiple cultures, Shared leadership
Shared Vision	Possible Shared Vision	Shared Needs	Shared Mission
Membership	Participants embrace project, but are neither engaged nor committed to anything beyond the project. Partners embrace stakeholder role, but engagement limited to specific task	Partners are willing to commit resources. Partners are engaged with a shared mission.	Partners embrace stakeholder role and are willing to commit resources.
Process/Structure	Independent operations and governance, Reactive decision making	Independent governance, Project-dependent operations, Some shared decision making	Governance equity, Formal operational structures, Shared decision making
Communication	Very limited communication	Strong communication at institutional level, Communication at staff level limited to project or operation	Strong communication at institutional and staffing levels
Resources	Lopsided resource commitment	Equity in resource commitment	Equity and transparency in resource commitment
Examples	PTO at an elementary school	Colleges and universities in the same general region in a partnership to encourage young people to go to college	Local hospitals and senior citizen associations sponsoring health fairs

*Mattessich, Murray-Close, & Monsey, 2001

Essentially, a Supportive Partnership exists to benefit the mission and operations of only one of the partners. A good example would be a county health department and a school. As long as the health department program adheres to the school’s mission and rules of operation, the department can maintain access to the children.

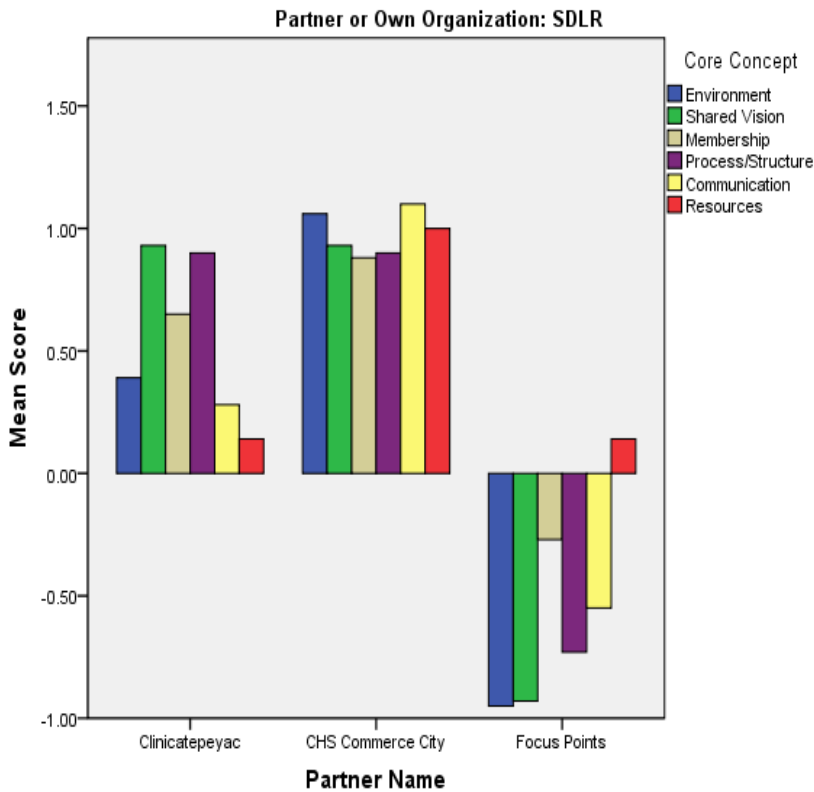
A Competitive Partnership may seem to be little more than an oxymoron; however, these partnerships tend to be extremely effective over a narrow range of issues. Many institutions engage in competitive partnerships to encourage such things as greater penetration for immunizations, safer parks, or blood pressure screenings.

True Collaborative Partnerships in education are both rare and even more specific than a competitive partnership. Collaborations require both an organizational and a resource commitment from all partners in an equitable fashion. Furthermore, collaborations share the decision making about the program, at times including supportive functions extending beyond the program.



When examining the combined scores⁴, the best partner for SDLR ENTRA Program delivery is CHS Commerce City. Showing uniform moderate strength on all six core concepts, this collaborative partnership is the strongest for the ENTRA program. The other two partners Clinica Tepeyac (Supportive) and Focus Points (Collaborative) are much weaker.

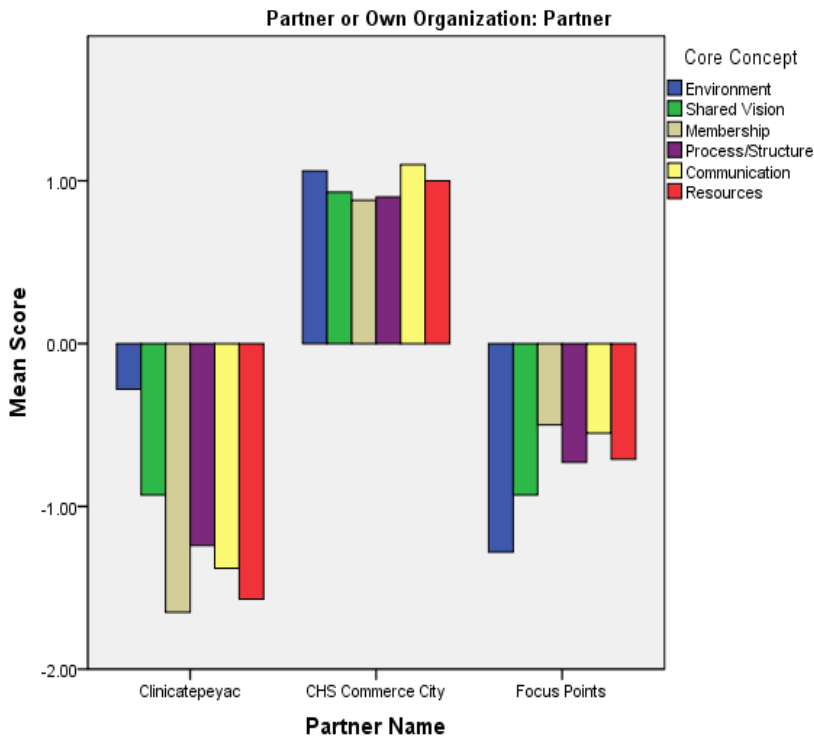
⁴ Data were standardized on the mean of each concept, then smoothed using a Log10 transformation. Concept means are reported in standardized format.



Examining the partners and concepts separately, SDLR indicates that they are a greater contributor of resources than their three partners.

SDLR also feels that they share a common vision for the partnership goals with Clinica Tepeyac and CHS; but not with Focus Points.

Comparing those concepts to the chart below, the Clinica fails to reciprocate on all but one concept – the Environment. Since this is a Supportive Partnership, the disparities between the scores indicates that the culture of the partnership is likely to be one more resembles Clinica rather than SDLR.



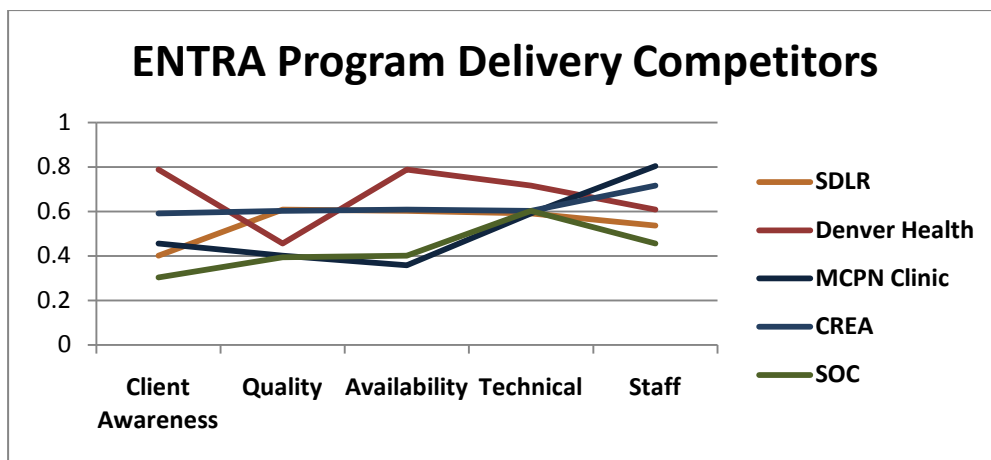
Another interesting finding rests with Membership⁵. It is anticipated that a Supportive partnership (Clinica) would show a negative relationship with the home partner (SDLR); however, it is unexpected that a collaborative partnership would also have a negative relationship.

⁵ Statistically significant differences using one-way ANOVA (P <.05) were found on Membership, Resources, and Culture. Because of the limited number of partnership types, no tests were run on those data.

Plotting the standardized, aggregate scores from the Sufficiency Partnership Model, the SCLR ENTRA Program has few partners, shows no Competitive Partnerships and only one moderately strong Collaborative Partnership. The remaining partnerships are weak⁶. Because the ENTRA Program relies on referrals and community outreach, more work should be done to strengthen existing partnerships and forge new ones, with the idea of building a strong, lasting relationship.



Possible partners could come from competitors⁷. As there are currently no Competitive Partnerships, some of the natural competitors for area service delivery hold the potential for engaging in a strong partnership. The chart below shows that several (MCPN Clinic and SOC) have complementary strengths when compared to SCLR.



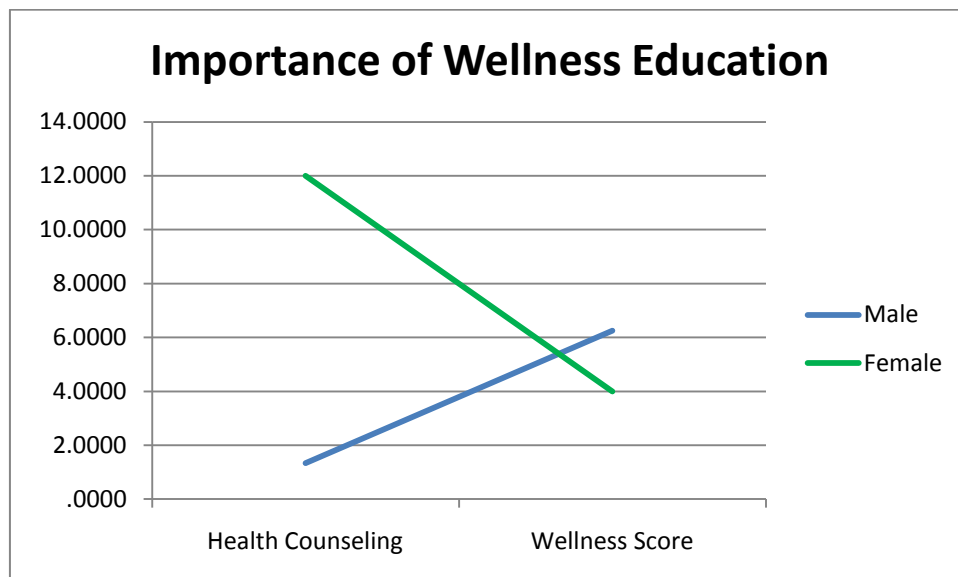
⁶ Location on the horizontal axis indicates degree to which the partnership is Supportive or Collaborative. Position on the vertical axis denotes strength. Circle size denotes benefit to SCLR.

⁷ Competitors analyses was performed as part a Needs Assessment for all programs at SCLR.

Access to the health care system and its benefits (counseling, family health awareness, nutrition, etc.) are desperately needed. Compared to the national average, Latinos in the United States have lower mortality rates than non-Latino whites and non-Latino blacks (Lara et. al., 2005); however, as demonstrated in Latino youth, there are disproportionate disparities between Latinos and non-Latino ethnic groups in many areas of health care (Flores et. al., 2002). Flores et. al. found that Latino youth, controlling for family income and parental education, are more likely than their non-Latino peers to “have suboptimal health status, spend more days in bed for illness, and make fewer physician visits,” (2002). This is likely to be learned behavior. According to the US Department of HHS, Office of Minority Health, Latino adults are 24-37% less likely than white adults to receive flu shots, HEP-B, and pneumonia shots (CDC, 2002).

Wood et. al., in 1995 completed a study on immunization status for 3 month and 24 month-old urban Latinos and African Americans. They found that at 3 months old 70% of Latino children are up-to-date on their immunizations; this drops to 42% of Latino children being up-to-date on their immunizations at 24 months old (Wood et. al., 2005). Their study compared types of health care plans and found that Latino children were less likely to be up-to-date on their immunizations at 24 months of age using private health care providers or health maintenance organizations than if they used public clinics (Wood et. al., 1995).

This phenomenon holds true for individuals in the SDLR service catchment area. A Needs Assessment Survey conducted in late summer of 2010 shows that as women receive less Health Counseling, their overall Wellness (concern about nutrition, insurance, exercise) diminishes. Since women are more often than not responsible for getting their children immunized, those children of mothers without access to health counseling are less likely to receive the full immunization slate.

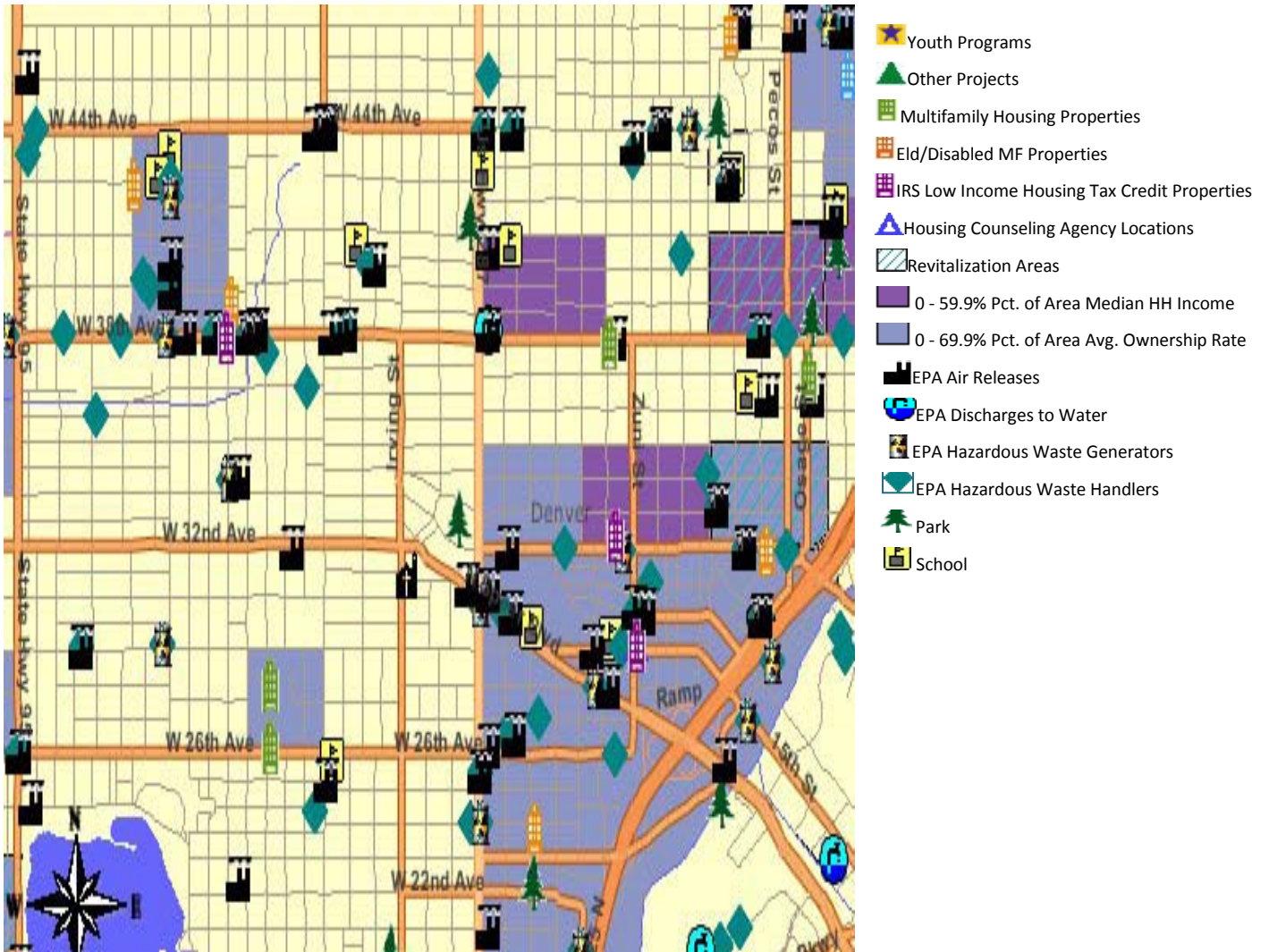


Counseling and access to health care also has impacts on individual behavior and choices. Obesity and being overweight are common health problems for Latinos. Research has found that “Latino boys are the most overweight and Latino girls the second most overweight racial/ethnic groups of US children,” (Flores, et. al., 2002). Part of this disparity comes from cultural differences where diet (Lara et. al., 2005) and cultural acceptability of being overweight (Barroso et. al. 2010) encourage more full-figured body-types. Barroso et. al. conducted a focus group study in Houston at the University of Texas Health Science Center where they found, “Of particular interest was the salient belief attached to the acceptance and tolerance of overweight, sexual attraction of overweight, preference of overweight by elders, and barriers to healthy eating and active living,” (2010). Both men and women expressed preferences for more full-figured individuals than skinny individuals in terms of sexual and (assumed) personality attraction, citing that men who are bigger are more protective and women who are full-figured are more confident (Barroso et. al., 2010). Additionally, the study cited cultural-economic shifts, where the Mexican-American diet has become more fatty and unhealthy due to the increased availability of foods that were once considered to be special occasion foods, and now are daily fare (Barroso et. al., 2010).

Acculturation can have both negative and positive impacts on individual health. Lara et. al. found that acculturation has a negative impact on substance abuse, dietary practices, and birth outcomes (which are heavily related to substance abuse and diet), whereas acculturation has positive impacts on health care services use and self-perceptions of health (2005). Changes in community structure, values, and family-unit behavior before and after immigration influence the acculturation process. Generally, Lara et. al. found that some level of community fracturing takes place where substance abuse (smoking, alcohol abuse, and drug use) become more acceptable in the US community compared to the community of origin (2005). Additionally, the relative abundance of fatty, high-sodium, and nutrient-poor foods in American urban communities enables poor nutrition. The negative impact of acculturation on birth outcomes comes from a combination of lack of access to health facilities and health care, poor prenatal nutrition, and increased substance-use during pregnancy (Lara et. al., 2005).

Another concern specific to urban Latino populations deals with environmental health impacts. Unhealthy urban planning can lead to greater levels of obesity, asthma, and mental health problems in urban populations (Corburn, 2004). Urban environments can limit access to green spaces and ecosystem benefits associated with natural landscapes (Bolund and Hunhammar, 1999). Although more extreme in Latinos of Puerto Rican descent than other Latinos, more than 500,000 Latino children suffer from asthma (Flores, et. al., 2002). Blame rests solely on environmental issues. A large percentage (34%) of Latinos, as compared to 17% of blacks and 15% of whites, live in areas with greater exposure to particulate matter. Overall, Latinos are exposed to more outdoor and indoor air pollutants including hazardous waste, pesticides, lead, and mercury (Flores et. al., 2002).

Urban environments that incorporate parks and natural elements, including trees and gardens, facilitate cleaner air and cleaner water (Bolund and Hunhammar, 1999). Additionally, cities designed to allow for more exercise – including walking, biking and running – encourage healthier populations (Frank and Engelke, 2001). Furthermore, as Martens, Gutscher, and Bauer found, there are psychological benefits associated with green spaces in cities, regardless of the type of natural landscape (wilderness or tended) (2011). Overall, increasing access to green spaces – like parks, walking trails, or even trees and gardens – can improve the health of a community.



Mapping the SDLR service area shows a disparity between high-density housing and available green space. Combined with the environmental concerns, as listed on the map, the ratio indicates a serious lack of green space, or public recreational options for area residents. The largest available green space reserved for recreation is under administration of the Denver Public Schools, and is reserved for school-aged children or school-sponsored activities.

Recommendations for Improvement

Overall, the program is running quite smoothly. Outreach efforts are successful and result in more individuals and families receiving assistance in accessing the health care system. Because the need is great –and growing due to economic conditions and high unemployment in the Latino community –The ENTRA Program is essential to maintaining health for those individuals and their families who are unable to gain access to the health care system.

Information and Data: Currently, the information on the ENTRA program is recorded in multiple steps on different forms. Because these data are inter-related and can affect service delivery, there needs to be a tighter process recording the information. The data for the ENTRA Program should be consolidated onto one or two forms, for ease of program review, record keeping, and obtaining periodic updates and reports. Once these tracking forms have been completed and the data entered, they can be filed for use by the case manager or HCA.

The complete data should include:

- Current information from the in-take and confidence reporting forms
- Partnership and referral forms
- Competitors forms

Once consolidation has occurred and a process has been established, SDLR will be able to evaluate gaps in services, identify new locations in need of outreach, and increase their client-list and program's public profile.

Partnerships: Because SDLR ENTRA Program uses outreach events and referrals as a key method to disseminating information and getting clients into the health care system, the partnerships established through this program need to be strong and consistent. While the program was operating for only a portion of the year, good progress has been made in securing partners. More work is needed, however. The existing partnerships need to become more equal –especially as it concerns application of resources, communications, and membership-stake in the partnership itself.

Additionally, because only two types of partnerships are represented, a greater balance in partnerships types is needed. Strong programs –resilient to funding and political ebbs and flows, enjoy the full complement of partnership types, so partnering efforts should be concentrated on securing all three types of partnerships --Supportive, Collaborative and Competitive. Furthermore, organizational outreach to competitive entities should be made where possible. The most likely groups are the MCPN Clinic and Sisters of Color.

Appendices - Works Cited and Consulted

- Acar, M. & Robertson, P. (2004) Accountability challenges in networks and partnerships: evidence from educational partnerships in the United States. *International Review of Administrative Sciences*, 70, 331-344.
- Bainer, B. L. (1997). A comparison of four models of group efforts and their implications for establishing educational partnerships. *Journal of Research in Rural Education*, 13(3), 143-152.
- Barrio, C. et. al.. (2008). *Unmet needs for mental health services for Latino older adults: Perspectives from consumers, family members, advocates, and service providers*. *Community Mental Health Journal*, 44, 57-74.
- Barroso, C.S. et. al.. (2010). *Beliefs and perceived norms concerning body image among African-American and Latino teenagers*. *Journal of Health Psychology*, 15 (6), 858-870.
- Bolund, P. and Hunhammar, S. (1999). *Ecosystem services in urban areas*. *Ecological Economics*, 29 (2), 293-301.
- Catsambis, S. (2002). Expanding knowledge of parental involvement in children's secondary education: Connections with high school seniors' academic success. *Social Psychology of Education*, 5, 149-177.
- Chávez, N., Telleen, S. and Kim, Y.O.R. (2007). *Food insufficiency in urban Latino families*. *Journal of Immigrant Minority Health*, 9, 197-204.
- Corburn, J. (2004). *Confronting the challenges in reconnecting urban planning and public health*. *American Journal of Public Health*, 94 (4), 541-546.
- Coulson, A. (2005). A plague on all your partnerships: Theory and practice in regeneration. *International Journal of Public Sector Management*, 18(2), 151-163.
- Edens, R., & Gilsinan, J. E. (2005, February). Rethinking school partnerships. *Education & Urban Society*, 37(2), 123-138.
- Epstein J. L. (2001). *School and family partnerships: Preparing educators and improving schools*. Boulder, CO: Westview Press.
- Epstein, J. L. (2008, February). Improving family and community involvement in secondary schools. *Education Digest*, 73(6), 9-12.
- Fahey, D. (2010). Are all partnerships created equal? An example of the sufficiency model. P-12 Principal's Office, October 2010.
- Flores, G. (2002). *The health of Latino children: Urgent priorities, unanswered questions, and a research agenda*. *Journal of the American Medical Association*, 228 (1), 82-90.

- Frank, L.D., and Engelke, P.O. (2001). *The built environment and human activity patterns: Exploring the impacts of urban form on public health*. *Journal of Planning Literature*, 15 (2), 202-218.
- Garcia, C. et. al.. (2008). *Family and racial factors associated with suicide and emotional distress among Latino students*. *Journal of School Health*, 78 (9), 487-495.
- Leistyna, P. (2002). *Defining and designing multiculturalism: One school system's efforts*. Albany: State University of New York Press.
- Lara, M. et. al.. (2005). *Acculturation and Latino health in the United States: A review of the literature and its Sociopolitical Context*. *Annual Review of Public Health*, 26, 367-397.
- Martens, D., Gutscher, H. and Bauer, N. (2011). *Walking in "wild" and "tended" urban forests: The impact on psychological well-being*. *Journal of Environmental Psychology*, 31, 36-44.
- Nestor-Baker, N., Fahey, D., Overly, C. & Kerka, S. (2007). *The sufficient model: an exploration into partnership, organizational needs assessment, and partnership evaluation*. Outreach Conference, 2007.
- Rowland, A.L. (2008). *The health challenges of urban Latino college students as revealed through student journaling*. *Journal of Hispanic Higher Education*, 7 (2), 131-143.
- Sanders, A.E. (2010). *A Latino advantage in oral health-related quality of life is modified by nativity status*. *Social Sciences and Medicine*, 71, 205-211.
- Wood, D. et. al.. (1995). *Factors related to immunization status among inner-city Latino and African American preschoolers*. *Pediatrics*, 96 (2), 295-301.

Appendices – Sufficiency Model Concepts & Structure

Partnership Concept	Best Practices
1. Environment	
Culture	Clearly recognize, acknowledge, and work to understand differences in the cultures of partner organizations
Equity	Acknowledge, value, and respect the different perspectives, talents, and unique contributions of the stakeholder; ensure parity in resources and decision making
Leadership	Share power among formal and informal leaders who span organizational boundaries
2. Shared Vision	
A shared sense of critical needs as the catalyst for the partnership’s vision, which is focused on a clearly defined mission	
3. Membership	
Diversity	Include depth and breadth of membership with complementary strengths and diverse perspectives
Commitment	Demonstrate commitment by devoting time, allocating resources, and attending to the attainment of partnership goals
Relationships	Build productive working relationships characterized by respect, understanding, openness, accountability, and trust
Trust	Build trust by understanding each partner’s perspectives, valuing partners’ needs, managing conflict, and designing a program with shared goals and mutual benefits
Self-Interest/Benefit	Provide tangible, equitable (not equal) benefits for all partners involved
4. Process/Structure	
Decision Making	Aim for democratic situations in which the decision-making process is group majority or group consensus
Organization	Structure the partnership with written documents that clearly define roles, responsibilities, and policies
Adaptability/Flexibility	Evolve in response to changing conditions while remaining focused on the shared vision and adjusting strategies to accomplish goals
Evaluation	Uses ongoing, cyclical processes for measuring outcomes and determining whether strategies are supporting goals
Continuity/Sustainability	Periodically reassess the mission and vision, secure funding, and institutionalize collaboration
5. Communication	
Use multiple communication tools and channels to ensure that partners are well informed and members feel free to share opinions and perspectives	
6. Resources	
Make significant investments of human, fiscal, and other resources including time	