

ARTICLE 1

Cultural Aspects of Death and Dying

Written by Marcia Carteret
(Copyright © 2010. All Rights Reserved.)

While the end of life experience is universal, the behaviors associated with expressing grief are very much culturally bound. Death and grief being normal life events, all cultures have developed ways to cope with death in a respectful manner, and interfering with these practices can disrupt people's ability to cope during the grieving process. While health care providers cannot be expected to know the mourning ceremonies and traditions of each family's culture, understanding some basics about how different cultures may prepare for and respond to death is important. Though difficult to ask, there are crucial questions that need to be part of conversations between doctors and nurses and families. For example:

- What are the cultural rituals for coping with dying, the deceased person's body, the final arrangements for the body and honoring the death?
- What are the family's beliefs about what happens after death?
- What does the family consider to be the roles of each family member in handling the death?
- Who should the doctor talk to about test results or diagnosis?
- Are certain types of death less acceptable (for example, suicide) or are certain types of death especially hard to handle for that culture (for example, the death of a child – this example may seem too obvious, but in countries with high infant mortality, there are indeed different attitudes about the loss of children.)³

This list of questions is so important because patients and families should be viewed as a source of knowledge about their special/cultural needs and norms – but health care professionals sometimes are at a loss about what to ask under such trying circumstances. There is perhaps no area where reliance on cultural reference books is less useful. The degree of acculturation is absolutely paramount in determining the beliefs and traditions a family will follow when coping with impending death, post-death arrangements and mourning. While we can find many similarities across cultures, such as wearing black as a sign of mourning, there are always exceptions. In China, for example, white is the color of death and mourning. Part of why the degree of acculturation is highly significant is that blending belief systems becomes more pronounced in highly acculturated persons. There are places in the world where accommodation is made for multiple faiths. For example, in Nigeria there is a triple heritage of Christianity, Islam, and ancestor worship². Similar blending can be found in Caribbean nations and Mexico where Catholicism can be mixed with indigenous folk beliefs like Voodoo and Curanderismo. Another layer of expectation comes with living in the United States culture and relying on the Western medical culture. The mix of cultural/religious attitudes and behaviors surrounding death and dying can become very complex indeed. And when a death actually occurs, some individuals suddenly choose to break with tradition entirely, often creating chaos within families.

What follows in this article are some important points of consideration, but the list is introductory in nature at best. The on-line version found at www.dimensionsofculture.com provides active links for more in-depth exploration. There is a strong focus on religions because religion can be thought of as a cultural system of meaning that helps to solve problems of uncertainty, powerlessness, and scarcity that death creates. In placing death within a religious perspective, bereaved persons find meaning for an event that for many is inexplicable.¹

Monotheistic Religions: Especially since the events of 9/11 changed many people's views of Muslims, it is important to be aware that Christians and Muslims both believe death is a transition to a more glorious place and both believe in the sovereignty of a God (Allah) in matters of loss and take consolation in phrases such as "Allah giveth and Allah taketh away." Both are also faiths springing from a single scripture, founder or sacred place. Readings from the Koran or Bible are important parts of the recognizing the departure of a loved one from this life. Similarly, in the Jewish faith, there is the expression mourners recite a few minutes before a funeral begins: "The Lord has given and the Lord has taken, blessed be the name of the Lord." Both Muslims and Christians believe in the afterlife and view worldly life much in terms of preparing for eternal life. In the Jewish tradition, the focus is on the purpose of earthly life, which is to fulfill one's duties to God and one's fellow man. Succeeding at this brings reward, failing at it brings punishment.

The traditions around death and dying differ greatly across all three major monotheistic religious systems (as well as within different branches of each faith, i.e. Jehovah's Witnesses and Mormonism in Christianity). They are highly nuanced and very hard for outsiders to understand thoroughly. Key rituals and practices that differ widely between religions include the preparation of the deceased person's body, the permissibility of organ donation, and the choosing of cremation vs. burial.

Ancestor Worship: The premise of ancestor worship is based on understanding that the course of life is cyclical not linear. Those who are dead may not be seen physically, but are alive in a different world and/or can reincarnate in new births. Ancestor worship in various forms can be found in many parts of the world and is very strong in parts of Africa and Asia. Many Native Americans and Buddhists alike believe that the living co-exist with the dead. A central theme in all ancestor worship is that the lives of the dead may have supernatural powers over those in the living world – the ability to bless, curse, give or take life. In some cultures, worship of the dead is important, and includes making offerings of food, money, clothing, and blessings. In China there is the annual observance of "sweeping the graves" and as its name denotes, it is a time for people to tend the graves of the departed ones. In Mexico, there is The Day of the Dead (Dia de los Muertos), a holiday that focuses on gatherings of family and friends to pray for and remember those who have died. The Day of the Dead is also celebrated by many Latin Americans living in the U.S. and Canada. The intent of the celebration is to encourage visits by the souls of the departed so that those souls will hear the prayers and the comments of the living directed at them. It makes sense that in cultures where ancestor worship is common, the acceptance of organ donation and cremation may be low.

Buddhism and Hinduism: Hinduism does not have roots springing from a single scripture, founder or sacred place. It is more like an umbrella term describing a set of philosophies and ways of life. Buddhism has a single founder, but the Buddha is not prayed to in the same sense as a God or Allah. Buddhism is also a set of philosophies for living. There are marked differences between the two, of course, but in both death is not seen as the end of life; it is merely the end of the body we inhabit in this life. The spirit remains and will seek attachment to a new body and a new “life” – in Buddhism it is called a “*kulpa*,” which is a unit of time. Where a given person will be born again is a result of the past and the accumulation of positive and negative action, and the result of karma. Followers of both traditions keep in mind the impermanence of life. The transition of a soul to a new life is very important so both traditions observe specific rituals at the time of dying and the handling of the body. The corpse of a Buddhist should not be touched for 3-8 hours after breathing ceases as the spirit lingers on for some time. Hindus believe the body of the dead must be bathed, massaged in oils, dressed in new clothes, and then cremated before the next sunrise. It follows that cremation would be acceptable in a faith where the soul will be released to find another body to inhabit.

Truth-telling to Patients: In collectivist cultures, the good of the individual is often so enmeshed with the good of the family or in-group that family members may have a greater say in health care decisions than the patient does in some circumstances. In many countries, family members may become very upset if a physician reveals bad news directly to the patient. Families and patients may place great value on the right NOT to know! This is completely at odds with the standards set forth in the Patient Self Determination Act http://en.wikipedia.org/wiki/Patient_Self-Determination_Act which secures certain rights legally for all patients in the U.S. The health care system needs to be flexible enough to accommodate communication patterns that look different from those within the informed-consent tradition which insists doctors and nurses tell patients everything. So, a key question in cross-cultural health care situations would be: *Who do you want me to talk to about test results or diagnosis?*

Expressions of Grief: In some cultures, showing grief, including wailing, is expected of mourners because the more torment displayed and the more people crying, the more the person was loved. In other cultures, restraint is expected. Rules in Egypt and Bali, both Islamic countries, are opposite; in Bali women may be strongly discouraged from crying, while in Egypt women are considered abnormal if they don't nearly incapacitate themselves with demonstrative weeping. In Japan, it is extremely important not to show one's grief for a number of reasons. Death should be seen as a time of liberation and not sorrow, and one should bear up under misfortune with strength and acceptance. One never does anything to make someone else uncomfortable. In Latino cultures, it may be appropriate for women to wail, but men are not expected to show overt emotion due to “*machismo*.” In China, hiring professional wailers may be customary in funerals, which may sound odd, but this was also a common practice in Victorian England.

Conclusion: For health care professionals, providing culturally sensitive bereavement/end of life care is understandably an issue of discomfort. Language and cultural barriers obviously compound the challenges of being professionally appropriate and compassionate. Patients and families may be in need of compassion, advice, and

guidance from doctors and nurses, but often the realities of a given situation include a press for time and both physical and emotional exhaustion among providers and families. It happens - sometimes we simply fail, in the moment, to express sufficient sensitivity and warmth when critical decisions must be made. The clinical facts are immediate and demand logical linear thinking which is natural for those trained in the Western medical tradition. For many cultures, such a direct approach may seem harsh, and decisions about something like organ donation might be experienced as inhumane immediately upon death. The questions suggested in this article can be used to ease some of the communication challenges and facilitate more openness between health care professionals and families around death and dying. Of course they should be tailored to the context of a given situation.

Resources

1. Gire, J. T. (2002). How Death Imitates Life: Cultural Influences on Conceptions of Death and Dying *The University of Washington*. Retrieved April 16, 2010 from <http://www.ac.wvu.edu/~culture/gire.htm>.
 2. Eyetsemitan, F. (2002) Cultural Interpretations of Dying and Death in a Non-Western Society: The Case of Nigeria. *The University of Washington*. Retrieved April 17, 2010 from www.ac.wvu.edu/~culture/Eyetsemitan.htm.
 3. *Culture and Response to Grief and Mourning* (2009, Sept. 3) Retrieved Apr. 12, 2009 from The National Cancer Institute Site at <http://www.cancer.gov/cancertopics/pdq/supportivecare/bereavement/Patient/page10>
- Lobar, Sandra L., Youngblut, JoAnne M., Brooten, Dorothy (2006). Cross-Cultural Beliefs, Ceremonies, and Rituals Surrounding Death of a Loved One. *Pediatr Nurs* 32(1), 44-50.

ARTICLE 2

Practice Manager's Corner

CORRECTION!

The information regarding Third Party Insurance related to Medicaid that appeared in CCHAP Newsletter 37, Article 4 contained inaccurate information in regards to the correct contact for these issues.

To expedite Medicaid provider's requests to end commercial health insurance for Medicaid clients and to get assistance with billing issues, please call Medicaid Provider Services (ACS) at 303-534-0146 or 1-800-237-0757. Medicaid Provider Services has the capability to end commercial health insurance for Medicaid clients and also instruct providers how to properly submit claims when Medicaid has denied claims due to inaccurate insurance information in our billing system. If a provider is not satisfied with the service of ACS, they may then contact Pete Garcia and he will make sure the issue gets resolved.

We apologize for the incorrect information that was previously communicated.

MEDICAID and CHP+ Eligibility Expansion Effective May 1, 2010

Almost 70,000 more Coloradans will be eligible for Medicaid and CHP+ as of May 1, 2010. This is the first expansion as a result of the Colorado Health Care Affordability Act provider fee.

An estimated 44,000 parents who have a child on Medicaid and 24,000 children and pregnant women will be eligible for health care coverage as a result of the hospital provider fee, at no cost to the taxpayer.

CHP+ eligibility is increasing from 205% of the FPL, or \$45,000 per year for a family of four, to 250% FPL, or about \$55,000 per year for a family of four. Eligibility for parents with a child on Medicaid can now make up to 100 percent of the federal poverty level - \$22,056 per year for a family of four. This is up from 60%, or \$13,234.

More information is available at:

www.colorado.gov/hcpf > Partners & Researchers > At a Glance > April 2010

HEADS UP!

MEDICAID FEE SCHEDULE Updated April 15, 2010

www.colorado.gov/hcpf > Providers > Provider Services (scroll down on page)

One change of note: Outpatient Consultation as well as Hospital Consultation codes are no longer a covered benefit (99241 – 99245 and 99251 - 99255). Please use an applicable alternate E/M code.

Early Periodic Screening, Diagnosis & Testing (EPSDT)

EPSDT and Medicaid Lead Testing Requirement for Children

All children enrolled in EPSDT/Medicaid must be tested for lead poisoning at 12 and 24 months of age.

If these children are not tested at these intervals, testing for lead levels in EPSDT/Medicaid children must be conducted between 36 and 72 months of age. Section 1905(r)(5) of the Social Security Act requires that any medically necessary service be provided to EPSDT clients. The Colorado Medical Assistance Program would like to remind providers of the Centers for Medicare and Medicaid Services (CMS) blood lead testing requirement and that it is a medically necessary service because all EPSDT/Medicaid children are considered to be at risk for lead poisoning.

A finger-stick blood lead test which generates a result greater than 10 micrograms/deciliter must be confirmed using a venous blood sample. Providers may defer blood level testing at the above intervals only if previous lead testing is documented in the child's health record.

While recent guidelines from the Centers for Disease Control suggest alternative methods of risk assessment for lead exposure, CMS blood lead testing requirements remain in effect.

For more information, please visit <http://www.cdphe.state.co.us/ap/down/leadservices.pdf> or contact George deCurnou at 303-866-6010 or George.deCurnou@state.co.us

Medicaid Provider Bulletins

Reminder: Don't forget to review the monthly bulletins which are available on the HCPF website at:

www.colorado.gov/hcpf > Providers > Provider Services > Provider bulletins

ARTICLE 3

CCHAP Quality Improvement Resources Now Available!

CCHAP now has a variety of QI educational tools and resources available for practices wishing to implement QI projects and/or beef up their quality improvement IQ. We hope that these tools will increase your QI confidence, and provide a roadmap for how to get QI started in your practice!

- QI Chapter
 - We've recently added a Quality Improvement Chapter to our CCHAP Orientation Manual. Please use this chapter as a quick reference guide. [Click here](#) to be taken directly to the QI Chapter.
- QI Video Training Session
 - This video is from our March 11, 2010 Practice Manager's meeting. This training quickly highlights the Do's and Don't of QI. [Click here](#) to view the video and/or download meeting handouts.
- Quality Improvement Coach
 - Remember, QI coaching is available – for FREE – to CCHAP affiliated practices wishing to improve their Medical Home. Call or email today!

Angie Goodger, MPH, MHA
Quality Improvement Coach
720-346-4903 Cell
720-777-7338 Fax
angela@cchap.org

Great things are not done by impulse,
but by a series of small things brought together.
~Vincent Van Gogh

ARTICLE 4




New Look for Medical Identification Cards June 1, 2010

Beginning June 1, 2010 the Department will begin issuing Medical Identification Cards with a new look. The new cards will be bilingual – English and Spanish – and more informative. A sample of the new card is below.

These new cards do not replace cards issued before June 1, 2010, therefore, please accept both versions. Please contact Roberta Lopez at 303-866-6114 or Roberta.Lopez@state.co.us if you have any questions.

Card Front – Sample

	Sample A Sample A123456	Department of Health Care Policy and Financing
Present this card every time you receive medical services.		
Questions?		
<ul style="list-style-type: none">• Call Customer Service at 303-866-3513 within Metro Denver or 1-800-221-3943 outside Metro Denver, Monday - Friday, 8 - 5, excluding holidays.• Call 1-800-QUIT.NOW (1-800-784-8669) for help to quit smoking.• Call 1-800-283-3221 (24 Hour Nurse Advice Line) for help deciding what to do when you are sick and cannot call your doctor or other health provider.		
In a life threatening emergency, dial 911 or go to the nearest emergency room. This card does not guarantee eligibility or payment for services		
Providers:		
<ul style="list-style-type: none">• Verify the identity and eligibility of the cardholder.• Request prior authorization when pre-approval of services is required.		

ARTICLE 5

Colorado Department of Health Care Policy and Financing Efficiencies and Cost-Containment Initiatives March 2010

The mission of the Department of Health Care Policy and Financing is to improve access to cost-effective, quality health care services for Coloradans. Since 2007, Governor Ritter, the Department and the General Assembly have implemented an approach to health care reform that is strategic, incremental and system-wide so that every Coloradan can access high-quality, affordable health care. The results of this approach are the implementation of many strategies that improved access to health care; created efficiencies; defined consumer value for the dollar; and promoted transparency to the taxpayer.

- **Preferred Drug List** established by Executive Order to better manage the pharmaceutical benefits for Medicaid clients, using objective, scientific evidence to determine the efficacy of medications and to create a rational formulary for Medicaid clients. The use of the list and the aggressive negotiation of rebates from pharmaceutical companies are saving the state over \$9 million per year.
- **Long-Term Care Partnership** launched to ensure older Coloradans have access to long-term care services when they need them, and provides an alternative to using Medicaid as their only resource for long-term care. The program has helped more than 6,000 middle-income Colorado families purchase affordable, quality long-term care insurance.
- **Medical Homes for Children** established standards for providers to ensure children have access to preventative care, coordination of services, and 24/7 phone consultation. The state is saving money and improving care for children by avoiding unnecessary use of emergency departments for services that should be provided in primary care settings. Currently, 236,000 children are served in medical homes.
- **Colorado Regional Integrated Care Collaborative** is a program designed to better serve high-need/high-cost Medicaid clients. Health plans provide robust care-coordination and manage the utilization of services. Savings are found through avoiding unnecessary hospitalizations and better coordinated care that reduces duplication of services.
- **PACE** programs that coordinate services between Medicare and Medicaid were expanded to eight sites, allowing 2,000 elders to live at home and in their communities instead of in nursing facilities. An expansion is planned for 2010.
- **Emergency Room Diversion** projects were funded in two communities with a federal grant. The projects are designed to educate Medicaid clients regarding inappropriate use of emergency rooms when primary care providers are available to serve them. Thousands of individuals in these two communities have since scheduled visits with primary care clinics.

- **The Benefits Collaborative** is a Department-led initiative for defining the amount, scope and duration of each Medicaid benefit. This effort will save the state money by ensuring that all benefits offered are medically necessary and consistent with current evidence and medical standards.
- **Colorado Health Care Affordability Act (HB09-1293)** expands coverage to more than 100,000 Coloradans without General Fund by using the hospital fees to draw down federal Medicaid matching funds. The combined \$1.2 billion will support Medicaid and CHP+ expansions and will be used to improve hospital reimbursement. Covering more of the uninsured reduces the amount of uncompensated care in the health care system, and reduces the amount of cost-shifting of that care that is passed on to individuals with insurance.
- **Program Integrity** activities identify potentially excessive or improper utilization, or improper billing to Medicaid by providers. These efforts recover approximately \$8 million per year.
- **Benefits Coordination** is designed to recover costs for medical care paid for by Medicaid from other insurance plans, trusts, estate recoveries, and recovering any payments to clients who were discovered to be ineligible for Medicaid. The Department recovered \$45 million of Medicaid payments from estate recovery efforts.
- **Health Information Technology** is a key tool in improving health outcomes and reducing unnecessary expenditures in the health care system. The Department is partnering with CORHIO, the statewide entity establishing guidelines and developing health information exchanges, to develop the tools for providers to exchange data and information about Medicaid clients. This will save the state money by allowing providers to talk with one another through secure internet or email capabilities, sharing information about client tests and treatments that will avoid duplication of services, repeated tests, and the use of inaccurate information that leads to medical errors.
- **Smoking Cessation** is an important tool for improving health outcomes and reducing Medicaid costs associated with tobacco-related illnesses. Medicaid coverage was expanded to provide clients access to additional medications to help them quit smoking successfully.
- **Medical Errors**, or serious reportable events, will no longer be covered by Medicaid as a result of Executive Order D 006 09. This policy results in improved patient safety, decreased Medicaid costs and saves taxpayers money.
- **Avoidable Hospital Readmissions** that occur within 24 hours of discharge for a related condition will no longer be reimbursed by Medicaid. This policy will encourage better patient support during and after a hospital discharge and save taxpayers money.
- **Quality Incentive Payment Programs** were adopted to provide financial incentives to nursing homes to provide higher quality services, and will be implemented with hospitals as well. A certain portion of the payment will be directly related to the achievement of quality and outcome goals. Page 2 of 4

- **Prior Authorization** is an important tool in managing the utilization of high cost benefits. Medicaid now requests all outpatient clinics obtain prior authorization for non-emergent CT, non-emergent MRI and all PET scans. Justifying these non-emergent services ensures necessity and saves taxpayers money.
- **The Nurse Advice Line** is being aggressively marketed to Medicaid clients as a way to reduce unnecessary use of emergency rooms. The toll-free number is now on Medicaid identification cards, in enrollment packets, and in client correspondence. The Department sent letters to clients who visited ERs more than six times, giving them the toll-free number and scheduling many of them for visits with primary care providers. The number of calls to the line increased by 300% in 2009.
- **The Accountable Care Collaborative** will save the state approximately \$14 million per year by holding regional organizations accountable for delivering high-quality, patient-centered, coordinated care to Medicaid clients using community-based care coordinators.
- **CHP+ at Work** will be expanded, allowing the Department to provide coverage to more children through their parents' insurance. This keeps families in the same plan, and allows the Department to pay premiums for children instead of enrolling them in a public plan.
- **Three-Share Community Projects** are health coverage programs that bring together employers and workers without coverage, with community providers offering direct services to those workers. Everyone shares in the cost – the employer, the employee and the community so individuals get good, basic primary care services. The Department will support the expansion of the project in Pueblo and expand to the San Luis Valley. This expansion will be accomplished with \$761,000 from a five-year federal grant.
- **The Center for Improving Value in Health Care** will establish an all-payer claims data based, giving providers and consumers' information about the costs and quality of health care provided throughout Colorado. Consumers will have transparency into the costs of services, and be able to plan for out-of-pocket expenses associated with their health care.
- **Public Health and Population Health Initiatives** can save the state and other payers' money by focusing on keeping the overall population healthy. The Department will be partnering with *Baby and Me - Tobacco Free* – a program that combines smoking cessation support specific to pregnant women with the incentive of free diapers to help motivate the women to stay smoke-free during the first months of the baby's life. The Department will be promoting *5 Alive!* – a collaborative, community-wide initiative to provide a supervised wellness program to Colorado 5th graders who have limited access to healthy lifestyle choices for fitness and nutrition. The Colorado Behavioral Healthcare Council will assist the Department to survey behavioral health providers on their current health promotion activities and interventions; identify improvement areas; and implement and evaluate needed health promotion and wellness interventions.
- **Veterans in the Veterans Affairs Health Care System** connects eligible Colorado veterans with benefits for which they are eligible but of which they have not yet taken advantage. By working with Veterans Affairs to establish regular care for Colorado's veterans, the high costs of emergency care can be avoided while maximizing the federal dollars contributed to the VA program.

- **Health Insurance Buy-In Program** will enroll an additional 100 new clients for FY 2009-10. The program generates savings by paying the premiums, deductibles, and co-insurance for clients who would otherwise be utilizing higher cost services. The clients can continue seeing their physicians of choice thus maintaining continuity of care.
- **Fluoride Varnish Treatments** allow the Department to avoid costly dental and medical procedures by providing children up to age 6 with effective, preventive dental care through fluoride varnishing.
- **Manual Pricing of DME, Injectibles, and Medical Services** removal allowed the Department to automatically set reimbursements a percentage of Medicare while ensuring that for goods and services where no Medicare rate information exists, rates were set using the Department's average paid, other states' Medicaid average paid, or the commercial average paid rate. By developing an automated reimbursement rate setting methodology, the Department ensures that it is always generating value for medical goods and services by reimbursing at appropriate prices.
- **Evidence-Guided Utilization Review** will divert clients away from inappropriate medical care by providing reviews of services received and reimbursing only those services that are medically necessary. The Department's designated Quality Improvement Organization (QIO) will expand the scope of services currently reviewed, providing additional savings while also identifying situations and allowing for intervention where utilization patterns are not in the best interest of our clients.
- **Coordinated Payment and Payment Reform** will streamline payment processes, enhance recovery efforts and provide for proactive integration of care while expanding the application of performance-based payment structures which incentivize desired outcomes. Physician Payment Reform and Waiver Rate Reform will create payment plans based upon health outcomes, allowing the Department to purchase better health rather than to simply purchase medical services.

ARTICLE 6



We are pleased to announce a cooperative project between National Jewish Health and Northeast Denver Housing Center sponsored by HUD that will help identify and fix or remediate asthma triggers in the homes of children living in Northeast Denver. In addition to helping families this project examines the efficacy of a low-cost, sustainable home assessment and intervention system for indoor asthma triggers. Past research has shown that environmental factors within homes can significantly impact the asthma symptoms of the people who live within those homes. The purpose of this study is to evaluate home environmental factors and to determine if knowledge of potential hazards, combined with educational intervention and possible remediation will reduce the impact of the home environment upon children with asthma.

We are looking for:

- **Families who speak English or Spanish and have a child under the age of 12 with asthma or recurrent wheezing;**
- **Families who live in one of the following neighborhoods:
Globeville, Elyria Swansea, Five Points, North Capital Hill, Cole, Whittier, Skyland, Northeast Park Hill, City Park West, City Park North and Clayton**

For participating, families receive:

- **A detailed report about any problems we find and what you can do to improve these.**
- **A free vacuum cleaner and other household cleaning and safety supplies.**
- **The possibility of free professional assistance in repairing problems.**

Each family enrolled in the project will receive 2 home visits, approximately 9 to 12 months apart. During the initial home visit the project staff will ask the participant some questions about their home environment and their child's asthma. They will also conduct a visual survey of the participants home and will collect dust and air samples. This visit will last about 3 hours and the participant will be given approximately \$150.00 worth of cleaning supplies, including a vacuum cleaner.

Shortly after the first visit we will mail the parent the results of what we found including recommendations for how conditions in the home might be changed in order to improve your child's asthma. **If the parent agrees, the results of these tests will also be sent to you and the child's health care provider.** Project Staff will also speak with the parent over the phone in order to go over the results and the recommendations made. Depending on the problems identified, families may be offered up to \$5000 in professional remediation provided through the Northeast Denver Housing Center.

We hope that you will consider sharing information about this project with eligible families within your practice.

For more information please call Mike Vandyke, PhD at 303-398-1034 or Andres Diaz at 303-398-1447.

Visit <http://www.cchap.org/nl38/#6> for flyers in English and Spanish