Application

FY26 Iowa Cancer Plan Implementation Grant Cycle

Iowa Cancer Consortium
www.canceriowa.org

Applicant Information:

Name of Project Lead: Amanda Rickard
Project Lead Email Address: arickard@promisechc.org
Project Lead Phone Number: 712-722-1700
Organization: Promise Community Health Center
Street Address: 33 4th St NW
City: Sioux Center, IA
Zip Code: 51250

Project Details:

Project Title: Improving Lung & Oral Cancer Prevention in Northwest Iowa
Total Amount of Funds Requested for FY26 (up to $25,000): $25,000

Provide a brief description of your intended project and any relevant background information about your organization. *(Suggested: 1,000 words or less.)*
Promise Community Health Center, located in Sioux Center, Iowa, is the only Federally Qualified Health Center (FQHC) in rural northwest Iowa. Founded in 2008, Promise CHC received New Access Point funding from HRSA in June 2012. Promise provides primary medical care, prenatal, dental, vision, and mental health services, as well as transportation, social work, and health coaching.

Promise's project will address rising rates of lung and oral cancer in Northwest Iowa, with a priority of reducing health disparities for populations who are uninsured, low-income, minorities, non-English speaking, and recent immigrants. We will focus on the areas of smoking, vaping, and chewing tobacco for strategies of improved screening, education, referrals, HPV vaccination, low-dose CT screening, and collaboration in the community.

The project will utilize the staff time and strengths of Promise's Population Health staff: Nurse Health Coach, Population Health Interpreter, and Population Health Manager. These are existing staff who worked on the project in Year 1 of the grant workplan who continue to be very excited and engaged in the work for Year 2. Staff such as Quality Coordinator, COO, Director of Clinical Services, and Data & Quality Specialist will continue to support the grant activities, alongside project staff. Promise has had many successful clinical quality improvements in the last several years, including clinical quality

measures in the top 10% of U.S. health centers. Promise learned from successes and challenges in Year 1 which has helped shaped Year 2 activities.

The first focus of the grant will be continued strategies for tobacco and vaping to prevent initiation and strengthen cessation support. The Project staff evaluated current practices, screening, and referrals primarily in the medical/prenatal department in Year 1 and we plan to advance this into the Dental and Mental Health departments in Year 2. These departments have gone through many changes in the last year which presented a challenge in fully integrating the workplan activities into these departments in the first year of the workplan. The Nurse Health Coach and Population Health Manager will evaluate, train staff on these topics and best practices, monitor, and adjust. Project staff will also continue to support best practices for the medical/prenatal department.

Cessation support is the area that Promise has found very impactful to patients during Year 1. The project will continue to utilize the Nurse Health Coach who is trained in Motivational Interviewing, Health Coaching, and Tobacco Cessation Counseling and who is supported by a Spanish-language interpreter who can also help manage and track patient needs and communication. Of the 23 patients who received direct Nurse Health Coach support in Year 1, 16 continue to be engaged in cessation support, 8 have decreased their tobacco use, and 2 have quit completely. Minority or low-income patients who are vaping or smoking or using chewing tobacco have many barriers to receiving support. 12 of the 23 patients who received Health Coach cessation support were uninsured, low-income patients and 9 of the 12 accessed nicotine-replacement products (NRT) through our program. The two individuals who fully quit were uninsured and low-income. Due to not previously tracking tobacco cessation success, it is difficult to compare our Year 1 numbers to any previous baseline; however clinical staff shared that our referrals to Quitline and other resources were often not acted upon and no change in patient tobacco use. We hope to increase the number of patients who reduce or quit tobacco in Year 2 as we build on the success and initial implementation in Year 1.

Promise is offering both choices of in-house health coach cessation counseling or Quitline or a combination, leaving it to patient choice. We feel patients will have good results with this support for several reasons:

- Team-based approach with Promise health coach, interpreter, pharmacist, PCP, therapist
- Health coach is also supporting overall health/lifestyle changes related to chronic conditions such as diabetes and hypertension
- Assisting with potential barriers accessing Quitline for patients with technology barriers such as navigating websites, literacy issues, or phone barriers.
- Utilizing text messaging to check in with patients or have a quick telehealth video visit
- Catching patient when they are in-office for other visits to follow up on cessation support

All this creative and flexible support helps build trust and support for the patient. This is in contrast to quickly mentioning Quitline during a doctor's visit which may work for a highly motivated patient with no barriers to accessing this service but may not work for many underserved patients.

One addition to our Year 1 workplan was providing nicotine-replacement products (NRT) directly to patients through our medication repository program. This was originally planned for Year 2 or 3 of the work plan, but our team found that it was an essential component to patient engagement in cessation to ensure that they had quick, affordable access to these products as well as support from our team in the best use of the products. The team developed protocols for NRT and will continue to utilize and adapt these as needed during Year 2.

Promise will also continue work for two clinical care items that impact oral and lung cancer: HPV vaccination and low-dose CT screening.

Promise serves many young children and adolescents and would like to improve the rate of adolescents getting HPV vaccination. Promise's HPV vaccination rate in 2024 was 51% and after grant improvement activities is now 59%. The Population Health staff, alongside Quality Coordinator, will continue evaluation of current workflows, improve screening and communication to patients in order to increase rates.

Low-dose CT screening is an important intervention for lung cancer screening. Promise started evaluation in Year 1 to determine if we are catching all patients who need this screening. We found that there are additional questions that need to be asked of the patient and documented in the EHR to capture those who need to be screened (ie. # pack years and quit time). The denominator for this EHR quality measure only has 9 patients and so we know many are most likely being missed. The next workplan steps for this include improvements to EHR workflow, education to teams, and monitoring and adjusting processes. This will help expand the number of patients identified as needing screening (measure denominator). From there we can also plan improvement steps for referring and connecting patients to a low dose CT scan – with scheduling, referring, affordability and insurance, or any other barriers. In the past, the local hospital has been willing to help provide important cancer screenings at reduced rates for patients referred from the health center and so Promise can evaluate if this might be needed. If a patient is diagnosed with lung cancer, the patient will be supported by their Promise medical provider and team. We frequently help patients in ensuring they have good support in specialty care and so we would help with cancer care in the same way: referring, helping with any transportation or language barriers, assisting with paperwork or financial assistance programs, and ensuring good follow up.

For many of these steps, EHR workflows are an integral piece. Promise utilizes athenaOne which has capability for custom templates and workflows to standardize processes. We can also run custom reports to monitor activities. The activities related to tobacco, HPV, and low-dose CT screening will impact both the patients being seen in the health center and patients who meet the qualifications who have not been seen in a while. Through EHR reports, we can find patients who are due for screening/vaccination or have previously reported using tobacco products. The EHR allows staff to pull addresses for mailings, create lists for staff to call, and can also send out custom text message campaigns. The strategy of reaching out to both patients in the clinic and outside the clinic can help broaden the reach.

Promise staff will collaborate with Community Health Partners (CHP), the public health entity for Sioux County. Promise has partnered with CHP for many years for health improvement planning, community events, and overall population health work. This is a great extension of this partnership as CHP is the recipient of the Tobacco Use Prevention Grant through state funding. CHP focuses on broad education and support to area organizations and workplaces. Promise will talk with CHP staff at least a couple times per year to hear updates from their grant work, give updates on our grant work, and evaluate for any partnership or joint awareness opportunities. Promise already collaborates with CHP on the Healthy Sioux County team that addresses health initiatives and will incorporate oral and lung cancer interventions. Promise will also work with CHP on any opportunities for improved HPV vaccination in the community.

The other partner on this project will be the Iowa Primary Care Association. Promise will utilize this partner as a source of support and opportunity for collaboration with other Iowa health centers. Promise staff engage in IA PCA committees such as Clinical Quality Committee, Value-Based Care Task Force, and Consumer Advisory Committee. They also host Transformation Collaboratives 2-3 times per year which engages CHCs from across the state in learning about improvement strategies and sharing ideas and best practices. Promise can share lessons learned from this project during these committee meetings or Transformation Collaboratives.

How many individuals in Iowa do you expect to reach through your project?
1,200

In which Iowa counties do you expect to reach people through your project?
Sioux County

Please describe how your project addresses one or more of these priority areas: *(Suggested: 1,000 words or less.)*

- Addressing cancer disparities across the cancer continuum.
- Addressing cancer prevention and/or early detection.
- Expanding successful local projects statewide in Iowa.
- Formalizing lasting and broad change in cancer control through policy and systems change within organizations, systems, and communities. (Funds may not be used for lobbying.)

The mission of Promise Community Health Center is to provide accessible, holistic health care that adapts to the needs of the community to improve the wellbeing of all persons. The core principle is that everyone is welcome at Promise, no matter their income or background.

The project will address issues of cancer disparities, prevention, and early detection related to rural population in Sioux County, race and ethnicity, language barriers, insurance status, immigration status, and socioeconomic status.

Many of the patients served by Promise are considered vulnerable populations due to poverty, insurance status, and language barriers. In 2024, 29% of patients reported an income at or below 100% Federal Poverty Level, 41% were uninsured, and 58% reported identifying as Hispanic/Latino ethnicity. Promise served 6344 patients in 2024 for 20,000 visits. Over 60% of Promise visits require interpreting services for patients who do not speak English. Many aspects of the project are related to being responsive to issues of reducing disparities for underserved populations. Linking patients with more creative support through health coaching can be impactful for patients with barriers. All aspects of the grant will be monitored utilizing analysis of patient demographics such as race, ethnicity, and language to see if project initiatives are positively impacting all patient groups. Any disparities found will trigger changes in strategies.

The project will address the cancer types of oral and lung cancer which are especially high and rising in Iowa. Lung cancer is the leading cause of cancer death in Iowa and oral cancer rates are rising rapidly.

Please indicate which type of funding you are applying for (choose one):

☐ **Single Year** (applying for one year of funding only)

☐ **Multi-Year: Year 1** (applying for the first year of a two- or three-year project with the intention of applying for Year 2 in FY27, if awarded)

☒ **Multi-Year: Year 2** (FY25 Year 1 awardees only) *

☐ **Multi-Year: Year 3** (FY25 Year 2 awardees only) *

If you are applying for continued funding (funded last year for the same multi-year project), please describe your success and challenges in previous years of funding. *(Suggested: 250 words or less.)*
In the first year of funding, our projects have made strong progress toward improving preventive care of oral cavity and lung cancers. We successfully increased adolescent vaccination rates from 51% to 59% through re-education, workflow changes, and regular audits. Our tobacco cessation efforts have also expanded significantly. We streamlined screening processes, trained nurse health coaches in evidence-based cessation counseling and NRT use, and began offering in-house cessation support. We established acquisition of NRT through our SafeNet Rx Drug Repository program, allowing us to provide nicotine replacement therapy onsite to low-income patients. We have found that patients who use NRT are more likely to continue with cessation coaching than those who do not. We also implemented a new tracking system focused on patient engagement frequency in cessation counseling to more accurately monitor impact, and received positive feedback from both patients and providers.

Challenges included initial difficulty defining and tracking “quit attempts,” which led us to shift toward measuring engagement in coaching. Efforts to expand cessation counseling to our dental department were limited by staffing constraints and scheduling demands in the dental department. Additionally, we identified gaps in the information needed to effectively flag patients who may be

eligible for low-dose CT lung cancer screening. An added challenge is that NRT availability through the repository is not always steady, at times limiting patient access. Despite these challenges, the groundwork laid this year has set us up for sustained growth and impact.

We enjoy sharing patient success stories when possible, to highlight the impact on the lives of those we serve. Below are two wonderful examples of early program success:

1. 54-year-old, who started smoking at age 13, was smoking 5-6 pipes a day (equivalent to 2 packs per day) when he started cessation counseling with Promise Nurse Health Coach and team. Over the last year, he progressively decreased his smoking, no longer smoking pipes and now smokes only 3 cigarettes per day. He continues to work with Nurse Health Coach and has a goal to quit completely.
2. Patient was vaping daily. Nurse Health Coach provided individual coaching and support and dispensed nicotine gum through SafeNetRx Drug Repository. Patient uses 1-2 pieces per day. Patient read handouts from Health Coach that recommended replacing a negative habit with positive one. Patient now does Pilates in the morning when she used to vape. She is no longer vaping at all.

Which goal(s) and strategy(ies) from the Iowa Cancer Plan will your project support/help to implement? (*Suggested: 100 words or less.)*

Our first major link to the Iowa Cancer Plan strategies relates to **addressing smoking, vaping, and smokeless tobacco** (Chapter 2: Prevention and Risk Reduction, Priority 1: Reduce exposure to tobacco and secondhand smoke, Strategy A: Prevent initiation of tobacco and nicotine use, especially among youth and young adults and Strategy C: Increase access to and use of evidence-based nicotine addiction treatment). Informing our patients about the dangers associated with nicotine products and providing support for tobacco cessation will help to decrease their likelihood of developing oral, lung, esophageal, and other cancers.

Another major link to the Cancer Plan is promoting **HPV vaccinations** (Chapter 2: Prevention and Risk Reduction, Priority 4: Increase immunization rates for vaccines shown to reduce the risk of cancer and protect cancer patients from preventable diseases, Strategy C: Reduce missed clinical opportunities to recommend and administer vaccinations) and **low-dose CT screening** (Chapter 3: Early Detection and Screening, Priority 2: Empower health care systems to strengthen cancer screening and diagnostic services, Strategy A Encourage health systems to identify or develop quality improvement metrics and processes to improve cancer screening rates and diagnostic care). We plan to inform patients of the importance and create better workflows linking patients to these services. We will work with other medical establishments in our local area in order to ensure our programs reach maximum impact.

Project Objectives:

These objectives will serve as the grant deliverables for your project, if awarded. The Iowa Cancer Consortium Board of Directors may request to change, add, or remove objectives with your agreement prior to funding. Where applicable, please include baseline (current) data. Please add additional objectives, if desired.

Objectives should be SMARTIE goals: **Specific, **M**easurable, **A**ttainable, **R**elevant, **T**ime-Based, **I**nclusive, and **E**quitable. The CDC's National Breast and Cervical Cancer Early Detection Program put together a helpful resource for SMARTIE objectives. (This and additional resources can be accessed at https://canceriowa.org/grants/ifp)*

***Objective #1: By May 31, 2026, increase the percentage of patients receiving cessation support (counseling and/or medications) from 58% of eligible patients to 75% of eligible patients, ensuring inclusive and equitable outcomes by comparing percentages based on patient demographics and adjusting for any disparities found.**

- Deadline *(funding period is July 1, 2025-May 31, 2026):* May 31, 2026
- Baseline data: 58%
- Target by deadline: 75%

***Objective #2: By May 31, 2026, increase number of patients engaged in Nurse Health Coach tobacco cessation support from 16 to 26 and increase average number of cessation support visits per patient from 2.5 to 3.5, ensuring inclusive and equitable outcomes by comparing the objective data based on patient demographics and adjusting for any disparities found.**

- Deadline *(funding period is July 1, 2025-May 31, 2026):* May 31, 2026
- Baseline data: 16 patients, average of 2.5 cessation support visits per patient
- Target by deadline: 26 patients, average of 3.5 cessation support visits per patient

***Objective #3: By May 31, 2026, increase number (#) of patients captured as eligible for low-dose CT screen for lung cancer from 9 to 15 and evaluate baseline screening rate for this increased denominator, ensuring inclusive and equitable outcomes by comparing the objective data based on patient demographics and adjusting for any disparities found.**

- Deadline *(funding period is July 1, 2025-May 31, 2026):* May 31, 2026
- Baseline data: 9 patients
- Target by deadline: 15 patients

Project Collaborators:

The Iowa Cancer Consortium seeks to fund collaborative proposals. **At least one collaborator is required per project.** A letter of support is required for each listed collaborator.

Collaborator #1 (required)

Name: Teri Bos
Organization: Community Health Partners
Mailing Address: 705 State Hwy 10, Orange City, IA 51041
Phone: 712-737-2971
Email: chp@siouxcountychp.org
Please describe the collaborator's proposed responsibilities/role in the project. *(Suggested: 100 words or less)*
Collaborate on assessing community needs for oral and lung cancer.
Share project updates on tobacco use prevention and HPV vaccination .
Attend Health Improvement planning committees (Healthy Sioux County) and incorporate oral and lung cancer intervention strategies.
Align efforts with broader public health goals.

Collaborator #2 (optional)

Name: Aaron Todd
Organization: Iowa Primary Care Association
Mailing Address: 500 SW 7th St, Des Moines, IA 50309
Phone: 515-244-9610
Email: info@iowapca.org
Please describe the collaborator's proposed responsibilities/role in the project. *(Suggested: 100 words or less)*
Collaborate on assessing health center patient needs for oral and lung cancer.
Organize committees such as Clinical Quality, Value-Based Care, and others which can include topics of oral and lung cancer intervention strategies and opportunities for Promise to ask for input and share best practices with other health centers.
Align efforts with broader Iowa Primary Care Association goals and value-based care programs.

Collaborator #3 (optional)

Name: Click or tap here to enter text.
Organization: Click or tap here to enter text.
Mailing Address: Click or tap here to enter text.
Phone: Click or tap here to enter text.
Email: Click or tap here to enter text.
Please describe the collaborator's proposed responsibilities/role in the project. *(Suggested: 100 words or less)*
Click or tap here to enter text.

Evidence & Evaluation:

Resources for Evidence-Based Interventions and Evaluation: (This and additional resources can be accessed at https://canceriowa.org/grants/ifp)

- *The Iowa Cancer Consortium has put together a blog post, A Public Health Professionals Guide to Evidence-Based Cancer Control Interventions (EBIs), which contains state and national resources for public health professionals to visit when selecting interventions.*
- *CDC's Program Evaluation Framework guides public health professionals in conducting program evaluation. It is a practical, nonprescriptive tool, designed to summarize and organize essential elements of program evaluation.*

What scientific evidence is there that your project will be effective? (*Suggested: 500 words or less.)*
Our project will reflect our existing commitment to and investment in cross-cultural and multilingual healthcare. For example, many of our patients are children, about half of whom are Hispanic/Latino Spanish-speakers. Because broader community awareness about the dangers and negative consequences of vaping and e-cigarettes may not have reached this population yet, and because vape ads are targeted primarily at tween/teenage audiences, we have a unique opportunity, capability, and responsibility to educate these patients about nicotine products and the associated health risks of nicotine use. According to an article by Paul Tchounwou in the International Journal of Environmental Research and Public Health, "Tobacco use remains the leading preventable cause of disease and death among Latinos, the largest racial and ethnic minority group in the United States." The article goes on to state that Hispanic/Latino Americans are less likely than other groups to use smoking cessation programs or pharmacotherapy to stop smoking.

Promise is in an ideal position to combat this problem. We plan to make our patients aware of the quitting options available to them, such as nicotine replacement therapy, the Iowa Quitline, and our counseling-trained nurse health coaches. Our interpretation services, as well as secure messaging platforms such as Klara, will allow us to overcome communication barriers. Staff will do much more than hand out Quitline brochures to our patients or simply tell them to quit. After examining eighteen studies, a systematic review carried out by the Community Preventive Services Task Force found that policies and programs meant to reduce tobacco users' out-of-pocket costs for evidence-based cessation treatments increase the number of tobacco users who quit. Based on the results of this study, it is highly likely that our many low-income and/or minority patients will benefit from easier access to the aforementioned quitting options, not to mention easier access to life-saving tools such as CT screening and HPV vaccines.

According to the National Center for Health Statistics (HPV vaccination coverage in children 9-17 years: 2024), Hispanic children (34.4%) are less likely than White Non-Hispanic children (39.9%) to receive one or more HPV vaccine doses. HPV vaccination rate was lowest among children without health insurance. Oral cancer risk is significantly higher for those with low socioeconomic status

(Significant oral cancer risk associated with low socioeconomic status, 2009) and low-income adults have the lowest prevalence of oral cancer screenings (Oral cancer screening prevalence in low-income adults before and after the ACA, 2022). Lung cancer is also associated as higher risk for those with lower income. People with annual family incomes of less than $12,500 have higher lung cancer incidence than those with family incomes of $50,000 or more (Impact of socioeconomic status on cancer incidence and stage at diagnosis: NMLS Study, 2008). Tobacco use is also higher for those with Medicaid (28.6%) and who are uninsured (27.3%) compared with those with private insurance (16.4%) (Tobacco Product Use Among Adults – United States, 2020, MMWR).

How will you evaluate your project? How will you know if you have been successful? (*Suggested: 250 words or less.)*

At the start of the project, our team will establish a work plan for the year which will include set interval for implementation meetings and immediate first steps. The Population Health Manager (Project Lead) will supervise the Nurse Health Coach and Population Health Interpreter, providing oversight and evaluating their activities. The steps being taken and the outcomes recorded will be shared with the Promise leadership team and the board of directors for external oversight. We plan to evaluate the program's outcomes by setting clearly outlined and testable objectives. For example, in evaluating our impact on nicotine addiction, we would monitor patient engagement in cessation support. We evaluate program and outcome data broken down by patient demographics (age, sex, language, race, ethnicity, income, etc) in order to find any disparities, which allows us to know if an intervention is not reaching a certain population or not having the same level of positive outcomes. We have been doing this for many years, especially in our Quality Improvement Committee, to make sure our quality outcomes are being evaluated from the health equity perspective.

How will you modify your project to meet the unique needs of certain populations? *(Suggested: 500 words or less.)*

Promise is dedicated to serving the underprivileged, and a large portion of our patients are immigrants and/or Hispanic/Latino. During the grant period, we will be upholding this commitment however we can. Because of our FQHC status, the makeup of our board of directors must be at least 51% composed of current patients, and these must also be representative of the patient population in general. This not only gives patients a direct say in how Promise is run, but also greatly increases the diversity of voices giving their input, voices that would otherwise not be heard or included in the decision-making.

Project engagement and outcomes will be compared by patient demographics such as language, race, ethnicity, and insurance status to determine any disparities or barriers for specific patient populations.

We will also embed staff input into the implementation of the program. Staff who work directly with patients are often able to share about the unique needs of populations and ensure the needs are considered in program development. Promise staff are already used to giving this input in department meetings, strategic planning sessions, and other workgroups.

Budget:

Allowable budget categories have been identified below. If funding is requested within a specific category, a brief explanation or funding justification is required.

Staff Support

- Applicants may request funds for key personnel. Funds may not be requested to supplant existing job responsibilities.
- For any staff support requests through this grant mechanism, a copy of staff resume/CV, estimate of project hours, and list of staff project-related responsibilities must be included along with the budget request. Resumes should be included as an attachment.

Travel

- Travel essential to the proposed project may be funded under this proposal.
- Travel reimbursement is allowed at the following rates: $0.50/mile; in-state travel reimbursements follow Iowa Department of Administrative Services (DAS) guidelines, which is $37/day for meals ($27.75/day for first and last day of travel); out-of-state travel reimbursements follow Iowa DAS guidelines, which varies by destination. Maximum lodging reimbursement for in-state hotels is $80 plus taxes per night (see the Iowa DAS travel webpage for more information and resources).

Printing and Copying

- Estimate the total number of document pages that will be copied or printed. Use $0.06/page for calculating costs. Example: 500 pages X $.06/page =$30.00

Supplies

- Estimate the unit cost for each item to be purchased and the total number of items needed. Example: 200 brochures X $1.25/brochure = $250.00

Indirect/Administrative Costs

- Applicants for whom the Iowa Cancer Consortium is not serving as a fiscal agent may charge an indirect rate limited to 8% of the direct costs proposed in the budget.
- The total budget, including indirect or administrative costs, may not exceed the total requested funds (maximum of $25,000).
- Administrative costs are those incurred for common or joint objectives and cannot be identified readily and specifically with a sponsored program but are still necessary to the organization's operations.
- For example, the costs of operating and maintaining facilities, depreciation and administrative salaries are generally treated as indirect/administrative costs.
- If there is a need for indirect funding beyond 8% of direct program costs, requests should be written into the applicant's budget and justified heavily.
- The applicant shall maintain documentation to support the administrative cost allocation. The Consortium reserves the right to request the documentation at any time.

Other:

- Equipment
    - Describe equipment needed for project implementation.
    - Equipment costs must be justified, and an explanation provided for equipment use after the grant period ends.
    - Items that cost $5,000 or more are not routinely funded but will be considered on an individual basis.
- Incentives
    - Incentives are an allowable expense only if proven to be effective as part of an evidence-based intervention. The research or evidence case must be outlined.

- Clinical Care/Service Delivery
    - Clinical care, including the provision of medication, vaccinations and/or treatment, is not an allowable expense. Service delivery, including radon mitigation and cancer screening test purchases, will be reviewed individually.
    - Community organizations and collaborators are encouraged to provide financial support for service delivery components.

Please explain your budget in words: *(Suggested: 100 words or less)*

Grant funds will support three Promise Community Health Center employees: Nurse Health Coach, Population Health Interpreter, and Population Health Manager. They will evaluate current processes, create new ones, educate staff, collaborate with partners, and provide patient education and support. The Nurse Health Coach, a Registered Nurse trained in Motivational Interviewing, Health Coaching, and Tobacco Cessation Counseling will lead the project and support patients. The Spanish-bilingual interpreter will assist with interpreting and patient navigation. The Population Health Manager will oversee program implementation, new processes, and community collaboration.

Use the table below to complete your proposed budget:

Reminder: Funding period is July 1, 2025, to May 31, 2026. This is an 11-month period, not a full year.

Budget Items and Explanation	Grant Funds Requested	Other Funding	Total Funds for Project
If possible, please divide them into categories. Examples include staff support, travel, supplies, equipment, etc. If service delivery or incentives are included within the budget, please include a statement of need along with each budget item.	*Funds being requested from the Iowa Cancer Consortium.*	*Include in-kind support, volunteer hours, collaborator financial support, and other types of financial support.*	*Include requested Iowa Cancer Consortium funds + items outlined in the Other Funding category.*
Staff Support			
Nurse Health Coach ($35.63/hr. x 5 hours x 48 weeks + taxes/benefits)	$10,228.21		$10,228.21
Population Health Manager ($40.51/hr. x 4 hours x 48 weeks + taxes/benefits)	$10,144.79		$10,144.79
Population Health Interpreter/Navigator ($28.02/hr. x 3 hours x 48 weeks + taxes/benefits)	$4,627.00		$4,627.00
Travel			
Printing			
Supplies			
Shipping			
Other			
Totals:	$25,000	$ 0	$25,000

Submit your completed application, along with letters of support from all collaborators and resumes/CVs for anyone whose salary will be supported by requested funds, to orton@canceriowa.org by 11:59pm (CDT) on May 14, 2025.

May 8, 2025

Iowa Cancer Consortium
PO Box 859
North Liberty, Iowa 52317

Dear Iowa Cancer Consortium Board of Directors,

The Iowa Primary Care Association (Iowa PCA) enthusiastically supports Promise Community Health Center's (Promise CHC) project "Improving Lung & Oral Cancer Prevention in Northwest Iowa" proposed to the Iowa Cancer Consortium as part of the FY26 Iowa Cancer Plan Implementation Grant, Invitation for Proposals.

The Iowa PCA is a nonprofit association comprised of fourteen community health centers and is recognized as a trusted voice on healthcare, particularly concerning under-resourced populations. The Iowa PCA provides technical assistance, training, health information technology services and other direct services to Iowa's community health centers to support their commitment to provide quality, affordable primary, behavioral and oral health care services to meet community needs. Iowa's community health centers serve nearly 250,000 Iowans annually at over 100 clinic sites across the state.

The Iowa PCA will fulfill the following roles in this partnership:

- Collaborate on assessments of community health center patient needs for oral and lung cancer.
- Leverage existing Iowa PCA committees and work groups to bring forward oral and lung cancer intervention strategies and opportunities for Promise to ask for input and share best practices with other Iowa community health centers.
- Seek alignment with broader Iowa PCA goals and value-based care programs

Promise Community CHC is an engaged member of the Iowa PCA and actively collaborates with other health centers in Iowa to ensure delivery of quality health care services to under-resourced communities across the state. Thank you for the opportunity to express our strong support for Promise CHC's impactful project and thank you for long-standing efforts to reduce the burden of cancer in Iowa!

Sincerely,

Aaron L. Todd, MPP, MHCDS
CEO

SIOUX COUNTY Community Health Partners

May 2, 2025

Iowa Cancer Consortium
PO Box 859
North Liberty, Iowa 52317

Dear Iowa Cancer Consortium Board of Directors,

I write on behalf of Community Health Partners in support of Promise Community Health Center's project " Improving Lung & Oral Cancer Prevention in Northwest Iowa" proposed to the Iowa Cancer Consortium as part of the FY26 Iowa Cancer Plan Implementation Grant, Invitation for Proposals.

Community Health Partners is the Local Public Health Department for Sioux County, and provides essential public health services to all who live, learn, work and play in Sioux County. Community Health Partners has worked collaboratively with Promise CHC on communicable disease follow-up, health improvement planning, and community events like health fairs, immunization clinics, and targeted population health work. Community Health Partners will continue to collaborate with Promise CHC in this work, especially related to population health and social determinants of health strategies that are most impactful for the community.

We are pleased to support that work that Promise CHC is doing to improve lung and oral cancer prevention in Northwest Iowa. Their initiatives, especially as related to tobacco cessation support, are a wonderful complement to the tobacco prevention and education activities that we provide in a nine-county area in Northwest Iowa through our Tobacco Community Partnership with Iowa HHS.

Community Health Partners will fulfill the following roles in this partnership:

- Collaborate on assessing community needs for oral and lung cancer
- Share project updates on tobacco use prevention and HPV vaccination
- Attend Health Improvement planning committees (Healthy Sioux County) and incorporate oral and lung cancer intervention strategies
- Align efforts with broader public health goals

Sincerely,

Teri Bos
Director of Community Health Services
Community Health Partners of Sioux County

AMANDA M. RICKARD

Sioux Center, IA
m: 801.389.4370
missmandalousugar@gmail.com

PROFESSIONAL SUMMARY

Versatile and collaborative professional with the ability to build and lead high-performing teams, oversee departmental operations, and develop impactful strategies

Highly effective and well-rounded leader with diverse experience in healthcare services, team building, policy development, and change management. Reliable, with verifiable year-after-year success in team building and development. Recognized for supporting business development and expansion, and ensuring the achievement of cross-organizational goals and objectives. Strong interpersonal communication, decision-making, and relationship management skills. Skilled at delivering feedback that results in performance improvement, enhancing quality, and cultivating collaborative work environments conducive to success.

CORE COMPETENCIES

- Health Administrative Services
- Policy Development
- Quality Improvement
- Customer Service
- Staff Training & Development
- Cross-Functional Collaboration
- Strategy Development
- Relationship Management
- Team Building
- Decision-Making
- Change Implementation and Management

PROFESSIONAL EXPERIENCE

PROMISE COMMUNITY HEALTH CENTER, SIOUX CENTER, IA

POPULATION HEALTH MANAGER

- Supervise, coach, and provide training and continuous education to direct reports.
- Provide safe, supportive, and encouraging environment for staff growth and development.
- Collaborate across departments for evaluation, assessment and data collection of quality metrics, social determinants of health, and other needs of the patient population to provide innovative approaches to wholistic patient care.
- Ensure adherence to best practices and guidelines for care management of chronic disease patients.
- Pursue collaboration and relationship with community entities to promote health and wellness throughout the community.

NURSE HEALTH COACH

- Provide patient driven health coaching across a large variety of health conditions.
- Provide safe, supportive spaces to explore patients' goals and intentions.
- Empower patients to understand their motivations, and create behavior change.
- Skill in eliciting and supporting patients in behavior change.
- Collaborate with providers, pharmacist, and patients to improve patient health outcomes.
- Effective online and in-person communication.
- Consistent effort to improve personal knowledge and skills to better serve patients.

OGDEN CLINIC, OGDEN, UT, JULY 2010 – JULY 2019

RN QUALITY COORDINATOR

- Assisted in developing and implementing Transitional Care Management (TCM) program for the clinic.
- Established and maintained collaborative partnerships in the community to increase quality of care and decrease medical costs.
- Worked closely with ACO partners to meet CMS standards and improve quality outcomes.
- Oversaw and coordinated team members to ensure optimal productivity and quality.

CLINICAL SKILLS LEAD

- Responsible for standardizing best practices in skills and charting throughout 16 clinic locations – focused mainly in family practice and pediatrics.
- Developed and implemented new employee skills training courses.
- Collaborated with physicians, practice administrators, and clinical staff in providing skills training as needed clinic wide.

- Served as the OSHA Compliance Officer and Employee Immunization Nurse for the clinic.

RN – CLINIC NURSE

- Provided excellent patient care in the fields of family practice, urgent care, pediatrics and urology in various physical locations clinic wide.

WEBER MORGAN HEALTH DEPARTMENT, OGDEN, UT, JULY 2005 – JULY 2010

PUBLIC HEALTH NURSE/HIV PROGRAM COORDINATOR

- Oversaw case management, counseling, and coordination of care for newly diagnosed HIV patients in the community.
- Trained in other specialties including immunizations, STD testing and treatment, breast and cervical cancer screening, family planning, and epidemiological disease investigation and prevention.
- Specialized in providing education on various health topics to help individuals understand and implement positive preventative health changes.

MCKAY DEE HOSPITAL, OGDEN, UT, OCTOBER 2003 – JULY 2005

REGISTERED NURSE (FLOAT POOL AND POSTPARTUM)

- Provided competent care to a variety of patients in the hospital using nursing skills and critical thinking.
- Selected to be the charge nurse on postpartum, responsible for overseeing care given by other nurse and staff on the floor by assigning patients, being attentive to the workload of each nurse, and being cognizant of the needs of staff.
- Cross-trained to care for high risk antenatal patients and became one of the few lactation experts on the floor.

EDUCATION AND CREDENTIALS

ASSOCIATES OF SCIENCE IN NURSING, 2003

Weber State University, Ogden, UT

NATIONAL BOARD CERTIFIED HEALTH AND WELLNESS COACH, 2022

Precision Nutrition

AWARDS AND HONORS

- Leadership Sioux Center Graduate
- Employee of the Year, Ogden Clinic
- Nominee Best of Northwest Iowa for Best Nutritionist
- Young Womanhood Medallion

VOLUNTEERISM

- Sioux Center Hockey Association, Social Marketing Contributor
- Heart of a Woman Retreats
- Treehouse Children's Museum
- Ogden Marathon

ADDITIONAL INFORMATION

Technical Proficiencies: Windows, ECW, Microsoft Office Suite, Microsoft Project, Athena, Canva

Interests: Spending time with my family and friends, weight lifting, pod casts, nutrition, literature, camping, hiking, true crime, traveling

TARA VYN

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Telephone: (712) 449-6203
Email: taravyn@hotmail.com

Profile

Registered Nurse with a Master of Science degree in Nursing and 23 years of experience in the health care field. Passionate about improving people's health and wellbeing. Excellent interpersonal and negotiation skills. Excellent planning and organizational skills. Strong writing and analytical skills. Able to work well independently and within a team environment. Adept at operating Microsoft Office. Enjoy learning and possess good internal motivation to search out and take advantage of additional learning opportunities.

Education

Master of Science in Nursing
University of Western Ontario, 2009

Bachelor of Science in Nursing
University of Alberta, 2001

Employment History

Nurse Health Coach 2023- Present
Promise Community Health Center, Sioux Center, IA

- Provide nurse health coaching for patients diagnosed with chronic medications conditions such as hypertension, hyperlipidemia and diabetes.
- Promote health by utilizing motivational interviewing and SMART goal planning to coach patients with weight management, tobacco cessation, nutrition and physical activity recommendations.

Research Nurse 2021 – 2022
Unity Health, Toronto, ON

- Utilized coaching strategies such as motivational interviewing and SMART goal planning to ensure clients who were planning a second pregnancy could reach optimal health before conceiving.
- Contacted study participants via telephone and used motivational interviewing techniques to establish health goals for clients. Followed up with clients at regular study intervals to assess clients' health goal achievements. Documented coaching session in study database post-visit.

Public Health Nurse 2006 – 2021
Middlesex London Health Unit, London, ON

- Counseled clients using motivational interviewing techniques and provided nicotine replacement products to clients who attended the Quit Clinic with the goal of quitting tobacco.
- Responded to communicable disease questions from the community through the triage phone line and followed up on communicable disease cases in the community.
- Managed clients in the community diagnosed with latent tuberculosis (TB) through the latent TB clinic which included providing TB medications, home visits and tuberculin skin tests.
- Provided infectious disease on-call coverage during weekends, responding to and managing all community-related infectious disease calls.

Infection Control Practitioner 2008 – 2012
London Health Sciences Centre, London, ON

- Provided infection control information to acute care staff when they had infection control questions or concerns.
- Managed outbreaks within the hospital, which included assessing and implementing infection control protocols to ensure communicable diseases were contained and outbreaks were resolved quickly.
- Reviewed charts and lab results daily to ensure patients diagnosed with communicable diseases were placed on appropriate precautions and infection control precautions were maintained.
- Collaborated with public health to ensure they were notified of communicable diseases within the community that were diagnosed and treated in acute care.

Public Health Nurse 2004 – 2006
Brant County Health Unit, Brantford, ON

- Promoted health through a population-based strategy aimed at Healthy Weights within the community.
- Educated clients through a car seat program, which included checking infant car seat usage and performing car seat presentations within the community.

Research Assistant 2002 – 2004
Alberta Health and Wellness, Edmonton, AB

- Assisted the provincial government with research projects concerning the health of Albertans.

Staff Registered Nurse 2001 – 2002
University of Alberta Hospital, Edmonton, AB

- Staff nurse providing nursing care to medicine patients. Worked as a float nurse on pulmonary medicine, nephrology medicine and general medicine floors.

Professional Development

- Obtained Certification in Infection Control (CIC), 2012
- Completed TEACH tobacco cessation certification, 2019
- Completed GCP Research Ethics Course, 2021
- Completed CORE-2022-Course on Research Ethics, 2021

RUTH HERNANDEZ

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rhernandez @promisechc.org

I am a long-term employee and have seen this Organization grow and expand over the past 15 years. Speaking Spanish and helping others has always been a passion of mine, so I am grateful that I can do both things as a Certified Medical Interpreter.

EXPERIENCE

08/15/2008 – CURRENT

PT NAVIGATOR-POPULATION HEALTH TEAM, SPANISH INTERPRETER, PROMISE COMMUNITY HEALTH CENTER

Reach out to patients who are referred to health coaching and make sure they are following up with health coach and PCP. Interpret for health coaches and for other departments as well (Medical, Dental, Mental Health, OB and Vision). Became Certified in February of 2021 as Spanish Interpreter for NBCMI. Completed Clinical Health Coach training June of 2021. Also had role of Medical Assistant January of 2013-October of 2020

AUGUST OF 2002 – JUNE 2017

BAKERY/DELI WORKER, CASEY'S BAKERY

Packaging Bread and pastries. Cashier & deli worker. Complete orders for surrounding stores/businesses. Helped Interpret and translate when needed.

2005-2009

WIC INTERPRETER, MID SIOUX OPPORTUNITIES

Interpreter for clients (Spanish)

EDUCATION

AUG 2005 - MAY 2007

SPANISH, IOWA STATE UNIVERSITY

Degree in Spanish - Literature, History, and Business of Latin America. Interned/Job Shadowed at Broadlawns Medical Center for Medical Interpreting Course

AUG 2002- MAY 2004

GENERAL CLASSES, NCC AND DORDT COLLEGE

SKILLS

- Great team player
- Great auditory listener
- Great work ethic
- Passionate about what I do