THE COLORADO TRUST

DEDICATED TO ACHIEVING HEALTH EQUITY FOR ALL COLORADANS | FEBRUARY 2014

2013 *Health Equity* LEARNING SERIES

CREATING *Health Equity for all Coloradans*

Prepared for The Colorado Trust by Sherry Freeland Walker

VISION OF THE COLORADO TRUST:

All Coloradans have fair and equal opportunities to lead healthy, productive lives regardless of race, ethnicity, income or where we live.

INTRODUCTION

Every aspect of an individual's life is affected by whether or not he or she has good health. Part of being healthy is having access to health care, but good health goes far beyond being able to see a doctor. It goes to the heart of where one lives, works, plays and learns. For many people, health disparities caused by lack of political, social or economic power – not individual lifestyles and actions – are the greatest obstacles to becoming as healthy as they can be.

Health disparities vary dramatically by state, county, community and even neighborhood, and are closely linked with economic or social disadvantage. People in groups with a history of discrimination or social exclusion because of race, ethnicity, gender, sexual orientation, age, disability or geography are most likely to suffer health disparities.

A groundbreaking 2002 report from the Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, showed that racial and ethnic minorities receive lower quality health services and are less likely to get routine medical procedures than predominantly white Americans, even when factors such as insurance, income, age and condition are equal.

In Colorado, the Office of Health Equity has found similar inequities throughout the state and across racial/ethnic groups. Colorado has significant differences in health and wellness that have persisted or worsened, even as the state continues to be recognized as one of the healthiest states in the nation. Illness, infant mortality and reduced life expectancy disproportionately affect different racial/ethnic groups, people with low incomes and other vulnerable populations.

To increase awareness and understanding of health equity, The Colorado Trust sponsored its first Health Equity Learning Series in 2013. Eight national experts at five events discussed the problems of health disparities and the obstacles to achieving health equity. More than 500 people attended the luncheon meetings in Denver. To expand the reach and audience beyond those able to physically attend the events, The Trust offered live-streaming, allowing more than 1,000 individuals across the state to participate. Additionally, The Trust provided funds to 18 organizations to host "viewing parties" of the live-stream broadcast in their own communities.

Throughout the events, several recurring themes became apparent.

- Everyone should have the opportunity to be healthy.
- Social, economic, and political factors and policies shape these opportunities.
- Organizations and communities must work together to create opportunities that lead to health equity.

Presenters in the learning series discussed ways in which lives could be saved each year by addressing the environmental and social factors that affect health. Neighborhoods that have high unemployment, poor transportation, crime, pollution, lack of medical facilities, inadequate schools or other deficits limit opportunities for the people who live there to be healthy. These conditions can also lead to chronic stress which in itself causes poorer health. Neighborhood segregation is one such factor that negatively affects health, not only through increasing chronic stress but through concentrating poverty as well. Children raised in poverty have lower levels of educational attainment, lower earnings as adults and shorter life expectancies.

Presenters also illuminated the ways that health care providers, community organizations and foundations can do a better job of serving their clients by viewing them within the context of these community conditions. Health equity is a complex issue that must be addressed at multiple levels. While some organizations seek to address health equity through targeting health care access needs, others look beyond health care to social determinants of health, racial equity or advocacy for policy changes that can lead to better health equity. Regardless, it takes multiple entities working toward the same goal to achieve health equity for all.

This publication summarizes the knowledge and advice gleaned from the national experts who were a part of the Health Equity Learning Series. The speakers came from varied backgrounds and experiences, and included health care practitioners, foundation and organizational leaders, academics and public health experts. They addressed the subject of health equity from different angles and through their different experiences, but all agreed that achieving health equity is vital to the health of the nation and state, as well as the individuals affected by health disparities. The publication also features stories of Colorado organizations working toward achieving health equity and Coloradans impacted by a lack of health equity.

LETTER FROM THE PRESIDENT AND CEO

We know that good health depends on more than health care. It is affected by where we live, the education we receive, the work we do and the wages we earn. We also know that certain groups consistently experience greater challenges in accessing quality care and coverage and therefore have worse health outcomes than other groups. As a result, The Colorado Trust set out to discover the root cause of these disparities in our state and how we can help eliminate them.

In 2013, we launched an initiative to learn and share information about health equity from individuals across the country who are committed to working toward its achievement. The Trust sponsored the Health Equity Learning Series at which national experts with varying perspectives and ideas discussed factors that lead to health disparities and solutions to advance health equity. Five learning lunches were held in Denver, and "viewing parties" were hosted across Colorado to allow individuals to take part via live online streaming. We were pleased to welcome participants from Alamosa, Colorado Springs, Durango, Eagle, Fort Collins, Frisco, Grand Junction, Gunnison, Lamar, Leadville, Monte Vista, Montrose, Pueblo, Rifle, Steamboat Springs, Telluride and Yuma.

As a result of all we are learning, The Trust has shifted its focus to achieving health equity. Partnering with communities, nonprofit organizations and others, we want to advance fair opportunities for all Coloradans to be healthy. As part of this new vision, the Health Equity Learning Series will continue in 2014 and 2015, and we are developing new grant strategies and funding opportunities focused on advancing health equity in our state. I invite you to join us as we move forward to create health equity for all Coloradans.

Ned Calonge, MD
President and CEO, The Colorado Trust

2013 HEALTH EQUITY LEARNING SERIES – WHAT WE LEARNED

What is Health Equity?

The series began by grappling with the question of how to define health equity and health disparities. Paula Braveman, MD, Director of the Center on Social Disparities in Health at the University of California, San Francisco, asked why these definitions matter. While differences in health status exist, when are they more than just a difference? When are they considered a health disparity or a health inequity?

The distinguishing factor between a health difference and a health disparity, Dr. Braveman said, is in whether or not it can be considered "unfair, avoidable and unjust." Not all differences in health are unfair. For example, skiers have more arm or leg fractures than non-skiers, and young adults are generally healthier than the elderly, but those are not health disparities.

Dr. Braveman sees health equity as part of social justice. International human rights agreements provide guidance because they go beyond the civil and political rights that most people think of to economic, cultural and social rights. Among those is "the right to achieve the highest attainable standard of health," defined as the health experienced by the most privileged group in society. She also noted that there is an obligation to address the "non-medical determinants" of health, which are "the most powerful determinants of who gets sick."

While health equity represents an ethical principle, health disparities are one metric by which health equity is measured. To effectively address health disparities, the focus must be on people in groups with a history of discrimination, marginalization or social exclusion. According to the human rights literature, such vulnerable groups include those that are marginalized due to race, ethnicity, skin color, religion, language, nationality, socioeconomic status, gender, sexual orientation, gender identity, age, disability, geography or political affiliation. To Dr. Braveman, then, health equity means pursuing the highest possible standard of health for everyone while focusing on those with the greatest obstacles.

PAULA BRAVEMAN, MD, *Director, Center on Social Disparities in Health, University of California, San Francisco*

Importantly, Dr. Braveman also cautioned against focusing too much on the cause of health disparities. There are health disparities for which the causes are complex – for example, in the United States blacks are at least twice as likely to deliver premature and low birth weight babies as whites, but the reason for this is not fully understood. Not fully understanding the cause of a disparity, however, does not mean that the disparity should not be addressed.

Pursuing health equity is difficult, long-term work, akin to "swimming upstream," said Dr. Braveman. To those working on achieving health equity, she recommended focusing efforts on problems that disproportionately affect disadvantaged groups and are "plausibly avoidable," then taking small steps to address these problems and focus on intermediate outcomes.

Health equity means pursuing the highest possible standard of health for everyone while focusing on those individuals with more obstacles.

~ Paula Braveman, MD

ACCESS DR. BRAVEMAN'S PRESENTATION ONLINE:

http://www.coloradotrust.org/health-equity-learning-series/paula-braveman

Health is More than Health Care

Adewale Troutman, MD, Director of the Public Health Practice Program at the University of South Florida, and President of the American Public Health Association, expanded on Dr. Braveman's views by addressing the social determinants of health – the overlapping social and economic systems that are responsible for most health inequities.

In his presentation, Dr. Troutman stressed that health is more than just health care, and is affected by factors such as education, income and occupation – with poverty at the core. Many lives could be saved each year by addressing these social determinants of health, as opposed to addressing the poor health that results many years down the road. Children raised in poverty, for example, have lower levels of educational attainment, lower earnings as adults and shorter life expectancies. Improving education improves people's health knowledge and job opportunities, and is linked to social and psychological factors that affect health. Dr. Troutman suggested, then, that spending resources on primary education would likely be more cost effective than hiring or training more doctors or opening more clinics – a focus on prevention rather than treatment.

To address health equity, Dr. Troutman argued that the social determinants of health should be addressed, as well as promoting policy changes that create health equity. While the Affordable Care Act offers several opportunities to improve health equity, truly achieving it requires a focus on health in all policies, he argued, including housing, land use, recreation, transportation and social services. In Louisville, Kentucky, Dr. Troutman established the Center for Health Equity in a predominantly black community to help build capacity and achieve policy change in public health. Focusing on community engagement, the center trains community members how to advocate for and affect political change. It provides staff with training on community organizing, mini-grants to help address policy issues, help with community visioning – asking what are the issues to target – and other tools.

ADEWALE TROUTMAN, MD, *Director, Public Health Practice Program, University of South Florida, and President, American Public Health Association*

Spending resources on primary education might be more cost effective than hiring or training more doctors or opening more clinics.

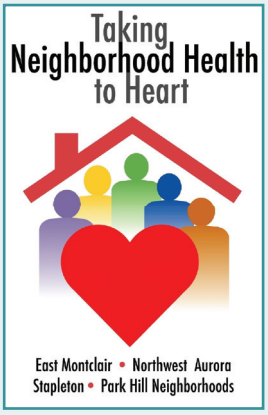
~ Adewale Troutman, MD

Because health equity can be such a daunting issue to tackle, Dr. Troutman discussed the value of effective partnerships as critical to achieving health equity. A variety of community representatives, including those not typically involved in making decisions about health, must be at the table and authentically partner to make decisions about community needs and solutions. In addition to health care entities, necessary community partners include representatives from housing, social services, police, schools, transportation, land use, parks and recreation, and businesses and corporations.

ACCESS DR. TROUTMAN'S PRESENTATION ONLINE:
http://www.coloradotrust.org/health-equity-learning-series/adewale-troutman-md

COMMUNITY-DRIVEN SOLUTIONS LEAD TO BETTER HEALTH

Taking Neighborhood Health to Heart



As Dr. Troutman stressed in his presentation, community partnerships are vital to achieving health equity. Taking Neighborhood Health to Heart (TNH2H), a 2006 research project conducted in five Denver neighborhoods, is doing just that.

TNH2H began as a community-based participatory research (CBPR) project involving the University of Colorado Denver; the Park Hill, Northeast Park Hill, East Montclair, Northwest Aurora and Stapleton neighborhoods; and the Stapleton Foundation. CBPR includes residents, researchers and organizations as equal participants in research efforts, beginning with project conception through data collection and analysis to communication. The National Institutes of Health provided funding for the TNH2H project.

The initial focus of TNH2H was to collect data on the health impacts of the social and built environments. Its mission has since evolved to "provide space and opportunity for people to grow and learn, to realize their vision for healthy neighborhoods and to address challenges," said George Ware, co-chair.

Not surprisingly, said Ware, the research turned up significant disparities by neighborhood. "We didn't want to stigmatize any community, but we couldn't get around the fact that neighborhoods have different health experiences. TNH2H members learned to conduct focus groups in their neighborhoods, took the findings back to the communities and asked residents if the findings reflected what they knew about their neighborhood. We asked, 'What could or should be done?'"

TNH2H's focus on participation and collaboration illustrates the importance of acknowledging the context and realities of neighborhoods to identify issues affecting health equity. Although neighborhoods may be in close proximity to one another, different factors such as safety, access to parks and availability of fresh fruits and vegetables can make significant differences in residents' health.

THE RIGHT PARTNERS AND EARLY WINS CAN HELP ASSURE SUCCESS

Eagle County Public Health

Coming together to achieve health equity is a focus of many public agencies in Colorado. Eagle County Public Health (ECPH) has several programs designed to leverage both the monetary and human resources needed to make a difference in small, rural communities.

Nearly two years ago, ECPH launched the Healthy Communities Coalition with a focus on making healthy eating and active living initiatives succeed in Eagle County. Nearly 20 organizations participate in the coalition, including government organizations, nonprofits, health care entities, businesses, the chamber of commerce, the school district and faith-based community, as well as private citizens.

The coalition chose four "doable" initiatives for its initial focus, said Karen Koenemann, Healthy Communities manager. These included recognizing companies that offer wellness programs; a 5210 campaign directed at children – five vegetables a day, two hours or less of screen time, one hour of exercise and zero sugar-sweetened beverages; foodshed mapping to identify healthy food producers within 100 miles; and universal breakfast for children who qualify for free- and reduced-price school lunches. Koenemann and her team's vision is to have health equity underlie all of the coalition's work.

In addition to the coalition, ¡Estoy Sano!, a Spanish-language multi-faceted program run through ECPH, focuses on health equity through promoting healthy food education and access. A Latino Leadership Council that sprang from the ¡Estoy Sano! initiative is currently being integrated into the Healthy Communities Coalition. "We want all the community voices at the table," Koenemann said. "Using strong partners with a connection to the population is one way to accomplish that."

Advancing Health Equity Through Policy

As other presenters in the learning series noted, good health depends on much more than access to good health care. Brian Smedley, PhD, Vice President and Director of the Health Policy Institute of the Joint Center for Political and Economic Studies, expanded on the ways that where people live, learn, work and play impact health, highlighting racial segregation and its related problems as a chief cause of health inequities.

Primarily, segregation affects health because it concentrates poverty. Many minorities, even middle- and higher-income people of color, live in neighborhoods that lack resources necessary for economic mobility, such as good schools and jobs. The health inequities that result from this segregation affect business, government and society, as well as individuals. According to Dr. Smedley, more than 30 percent of direct medical expenditures between 2003 and 2006 for minorities were excess costs due to health inequities. Eliminating these inequities would have reduced medical expenditures by nearly $230 billion. When direct medical costs and indirect costs such as reduced productivity and premature deaths are included, health inequities cost the United States $1.24 trillion in that time period. That's more than the gross domestic product of India, the world's twelfth largest economy.

More than 30 percent of direct medical expenditures between 2003 and 2006 for minorities were excess costs caused by health inequities – a total of nearly $230 billion.

~ Joint Center for Political and Economic Studies

BRIAN SMEDLEY, PHD, *Vice President and Director, Health Policy Institute of the Joint Center for Political and Economic Studies*

To eliminate these inequities and associated costs, the Affordable Care Act is a step in the right direction, said Dr. Smedley. Its focus on decreasing the number of uninsured Americans through features such as expanding Medicaid eligibility and providing tax credits to help small employers (where most people of color work) purchase health insurance for their employees helps to relieve health inequities.

But Dr. Smedley emphasized that much more is needed. He suggested a number of evidence-based and cost-effective ways to eliminate health inequities and improve impoverished neighborhoods, including:

- Creating incentives to improve neighborhood food options – for example, incentives for grocery stores and farmers' markets to come into a neighborhood
- Increasing early childhood education opportunities in impoverished neighborhoods
- Aggressively addressing environmental degradation
- De-concentrating poverty from the inner city and rural areas through smart housing and transportation policies
- Promoting sustained public and private investment in making communities healthier.

ACCESS DR. SMEDLEY'S PRESENTATION ONLINE:

http://www.coloradotrust.org/health-equity-learning-series/brian-smedley-phd

PERSONAL INVOLVEMENT IS KEY TO BEING HEALTHY

Owetta McNeil knows what it's like to struggle to get health care. Negative experiences with the health care system – including a doctor who would no longer treat her when her insurance coverage ended and another who diagnosed a skin rash without ever entering the examination room – made McNeil realize she had to take responsibility for her own health and help others in her community do the same.

McNeil now serves as a network activist for others who need assistance in getting the health care they need. "How can success be achieved if you're not an active part of the process?" she asks. Among her many activities, McNeil works through the "be well Health and Wellness Initiative" of the Stapleton Foundation. As a block captain, she tries to match resources to individuals who need them.

McNeil is also proud to be part of the TNH2H project and its work to eliminate food deserts and provide Smart Meals guidance in some Denver restaurants. Facing the race issue head-on, she is also involved in

OWETTA MCNEIL, *participant, TNH2H*

Community and Students against Healthcare Racism, a group of local health care professionals, community members and students advocating for policy change.

"Everyone deserves to receive the care they need," said McNeil. She advises others to inform themselves about the Affordable Care Act, work with their legislators for change and do what she has done – take charge of their own health.

Health Care System Needs Better Understanding of Community

Two physicians dedicated to reducing health disparities from different health settings discussed the causes of and possible solutions to some of the obstacles McNeil and other minorities face in obtaining quality health care. Anthony Iton, MD, Senior Vice President of The California Endowment, works to end health disparities by starting in communities. Winston Wong, MD, Medical Director of Kaiser Permanente, believes the health care system can do its part to eliminate disparities by working with communities.

Like other presenters, Dr. Iton noted that people who live in communities with unemployment, crime, lack of access to stores and services, inadequate transportation and housing, low income and poor education face chronic stress that over time results in health problems. Studies of different neighborhoods in various cities found that early deaths were concentrated in certain neighborhoods and differed by as much as 20 years from neighborhoods only a short distance away.

(l. to r.) **WINSTON WONG, MD**, *Medical Director, Kaiser Permanente and* **ANTHONY ITON, MD**, *Senior Vice President, The California Endowment*

"Your ZIP Code is more important than your genetic code," he said.

While medical care is necessary, it's an insufficient tool, Dr. Iton said. Spending $2.8 trillion a year on health care is simply "damage control." Society cannot afford to ignore the conditions that create the risks. Like other presenters, he recommended community interventions to improve conditions that affect health, seeing that health is valued in all policies and realizing that health is not just access to care and/or having a good diet.

In light of the clear importance that communities have in determining health outcomes, Dr. Wong agreed, saying that medical practices must do a better job viewing patients as members of a particular community. He is critical of the energy and time spent on the idea of Patient-centered Medical Homes (PCMHs) and their lack of attention to the social determinants of health. PCMHs are an approach to primary health care that emphasizes care coordination and communication between patients and providers.

Your ZIP Code is more important than your genetic code.

~ Anthony Iton, MD

Currently, however, PCMHs fail to address health at all levels – from individual to society – or treat patients within the context of their environment, Dr. Wong said. They measure success by how well a practice cares for people who are sick or injured rather than on how well it promotes wellness, health and prevention, "much less its success in intervention at the community level." A better approach for PCMHs, he said, would be to work closely with communities to address factors that affect health, such as neighborhood safety.

Dr. Wong added that there is a "third space" between social factors and medical care that includes activating communities and neighborhoods. Medical providers can play a key role in this because they have a special relationship with patients. "As a medical provider myself, I have to ask, 'what am I doing to help patients affected by social determinants?'"

ACCESS DRS. ITON AND WONG'S PRESENTATION ONLINE:

http://www.coloradotrust.org/health-equity-learning-series/solutions-for-health-equity

CLINIC'S FOCUS ON DIGNITY LEADS TO HEALTH EQUITY

Denver's Inner City Health Center (ICHC) works with the uninsured to address their medical issues and reduce health inequities. The center's tagline – "Your doctor. Your dignity" – sums up what Kraig Burleson, ICHC's CEO, wants people to know about the facility he heads.

"Human dignity is a core value in everything we do," Burleson says. "Having your own doctor is part of that." This focus, as well as involving patients as decisionmakers in clinic operations as well as their own health, promotes health equity and strengthens patients' roles in the community.

With its team of three staff and 17 volunteer physicians, the faith-based ICHC hosts about 23,000 patient visits a year. The Patient Advisory Council, comprising 10 patients from different backgrounds, provides input on center operations.

Patients with diabetes participate in group appointments where patients share their experiences with one another, helping to promote health equity. Patients learn from others with the disease, and individuals' personal experiences are on par with the clinicians' input. "The even exchange of individual perspectives lends to building self-esteem and affirmation in the community," Burleson says.

KRAIG BURLESON, *CEO, Inner City Health Center*

ICHC works to achieve health equity in multiple other ways as well. With the help of a grant from The Colorado Trust, center staff participated in dialogues about race and ethnicity, cultural sensitivity and cultural competence and incorporated changes into their daily operations. ICHC sponsors a translation phone line, provides health screenings in local churches and interfaces regularly with individual community members as well as organizations.

Foundations are Working to Achieve Health Equity

As health disparities rob people of their opportunity to live healthy lives, a number of grantmakers are making health equity their focus. Three leaders from foundations across the country spoke about the steps their organizations are taking to eliminate health disparities in their state or communities.

To give clarity to its health equity work, the Connecticut Health Foundation in Hartford, Connecticut focuses on three areas. Elizabeth Myung Sook Krause, Vice President of Policy and Communications, described those issues as: assisting people in finding and enrolling in an affordable health insurance plan; helping individuals navigate the health care system; and making sure providers offer affordable, comprehensive, accountable care, all with a focus on people of color.

On the other side of the country, the Northwest Health Foundation (NWHF) in Portland, Oregon took a hard look at the way it did business. The organization now gives half of its investments directly to communities of color – those most affected by health disparities. The board and staff are becoming majority minority. NWHF is realizing that the communities experiencing the disparities must be the ones to create and implement the solutions. "We learned we must stop having the equity conversation until the right people get in the room, and we need to stop blaming the people who aren't there and hold ourselves accountable for creating a circumstance that may not make them feel welcome," Nichole Maher, President and CEO, said.

(l. to r.) **NICHOLE MAHER**, *Northwest Health Foundation,* **ELIZABETH KRAUSE**, *Connecticut Health Foundation,* **YANIQUE REDWOOD, PHD**, *Consumer Health Foundation*

Public policy, leadership, strategic communications and grantmaking are the incubators of health equity solutions.

~ Elizabeth Krause

In Washington, DC, the Consumer Health Foundation recognizes that people spend most of their time in non-health care settings and has chosen to target its health equity work on funding beyond health care, racial equity and advocacy for systems change, said Yanique Redwood, PhD, President and CEO. One effort establishes cooperative worker-owned businesses in minority areas. These businesses provide anchor institutions such as hospitals, universities and local governments with services they need. Workers have an ownership stake and are paid living wages.

ACCESS THE FOUNDATION LEADERS' PRESENTATION ONLINE:

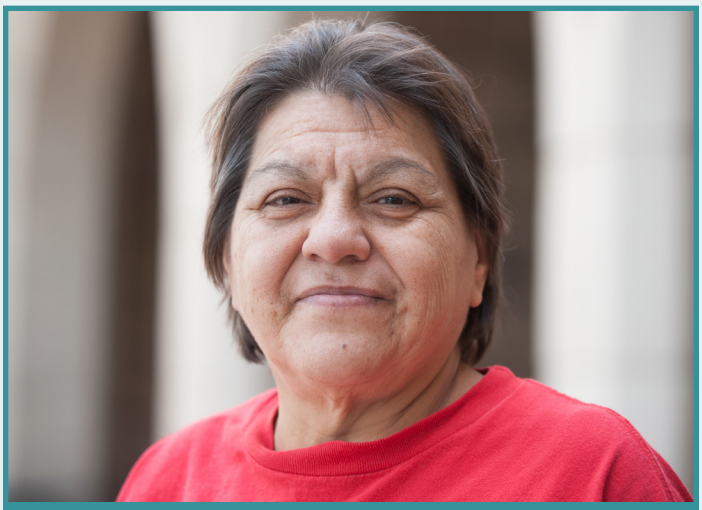
http://www.coloradotrust.org/health-equity-learning-series/elizabeth-krause-nichole-maher-and-yanique-redwood

COMMUNITY PROGRAM HELPS PATIENTS NEGOTIATE HEALTH CARE SYSTEM

Rebecca Yanes knew there was something wrong with her foot late in December 2012. She went to an emergency department where she was told there was no problem and sent home. But on Valentine's Day 2013, after another emergency room visit and a two-week hospital stay, she lost three toes.

Yanes needs another surgery to alleviate the pain she was left with after the amputation. Medicare will pay for part of the surgery, but Yanes and her husband can't afford to pay the rest. Her husband's heart medicine alone costs $290 a month, so sometimes "we either get the medicine or we buy food."

The family was grateful to have assistance from the Bridges to Care program, a joint program of Metro Community Provider Network and Together Colorado. The model sends teams to visit patients in high-need, high-cost neighborhoods to improve their access to health care and manage their chronic conditions. For eight weeks, the program sent a health coach, nurse practitioner, behavioral health care provider, care coordinator and social worker to Yanes' home.



REBECCA YANES, *participant, Bridges to Care*

Eliana Mastrangelo of Together Colorado says access to specialty care is especially difficult to find, and safety-net clinics near Yanes' home have long waiting lists. While the Yaneses have a car, they can't afford the gas to drive to clinics farther away. The Bridges to Care program helps people reduce the number of emergency room visits, get the primary care they need and manage the stress of dealing with and finding help for health problems.

CONCLUSION

In light of the health disparities faced by many Coloradans, The Trust has shifted its vision to achieving health equity, which it defines as "ending inequalities that affect racial, ethnic low-income and other vulnerable populations, so that all Coloradans have fair opportunities to achieve good health." As part of this commitment, The Trust will continue to educate its own staff and the community about health equity issues in Colorado. The Health Equity Learning Series will continue in 2014 and 2015 with additional speakers and learning opportunities. In addition, The Trust will focus on increasing networking and community organizing to advance health equity in communities, enhance leadership, promote actionable solutions, and provide a link to resources from The Trust and other leaders focusing on health equity.

The Colorado Trust also will partner with other foundations, communities, nonprofit organizations, medical practices, state agencies, political leaders and others to monitor inequities and advance health equity solutions. Making progress requires a long-term investment, a policy agenda that considers all the factors that affect health and a commitment by participants to "row in the same direction" if all Coloradans are to have the opportunity to be as healthy as they can be.

Slides and a video of each presentation in the 2013 series are available on The Colorado Trust website (www.coloradotrust.org). Links for other organizations and materials cited appear in Health Equity Resources. The Health Equity Learning Series will recommence in February 2014 as The Colorado Trust expands its efforts to achieve health equity in Colorado.

HEALTH EQUITY RESOURCES

Colorado

Bridges to Care, Together Colorado
http://www.togethercolorado.org/resources/bridges-to-care

Eagle County Public Health
http://www.eaglecounty.us/publichealth

Inner City Health Center
http://www.innercityhealth.com

Metro Community Provider Network
http://www.mcpn.org/en/index.html

Taking Neighborhood Health to Heart
http://www.tnh2h.org

The Colorado Trust
http://www.coloradotrust.org

Health Equity Learning Series Speaker Affiliations

Center on Social Disparities in Health, University of California, San Francisco (Paula Braveman, MD)
http://www.familymedicine.medschool.ucsf.edu/csdh

Connecticut Health Foundation (Elizabeth Myung Sook Krause)
http://www.cthealth.org

Consumer Health Foundation (Yanique Redwood, PhD)
http://consumerhealthfdn.org

Health Policy Institute, Joint Center for Political and Economic Studies (Brian Smedley, PhD)
http://www.jointcenter.org/research/place-matters-ensuring-opportunities-for-good-health-for-all

Kaiser Permanente (Winston Wong, MD)
http://share.kaiserpermanente.org/article/health-disparities-research-highlights

Northwest Health Foundation (Nichole Maher)
http://www.northwesthealth.org

Public Health Practice Program, University of South Florida (Adewale Troutman, MD)
http://health.usf.edu/publichealth/php/home.html

The California Endowment (Anthony Iton, MD)
http://www.calendow.org

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