Eliminating Racial and Ethnic Health Disparities:
What is the Role of Local Philanthropy?
Opportunities for Rose Community Foundation and Colorado

A Briefing Paper for the Health Disparities Forum.
April 10, 2001

EXECUTIVE SUMMARY

Background

Health disparities may be defined as a disproportionate share of negative health outcomes of disease, disability and/or death, affecting specific groups—based on race or ethnicity, sexual orientation, gender, and/or geography—as compared to the general population. This briefing paper and the Health Disparities Forum will focus on racial and ethnic health disparities. It is hoped that in doing so the Health Disparities Forum will build on current health disparities initiatives, supported with public and private funding, and will result in actionable goals that eliminate health disparities that now account for a significant burden of disease and are amenable to targeted improvements.

Despite substantial improvements in the nation's health as a result of medical advances over the last century, disparities in health status persist. The national data is alarming, demonstrating that minorities have poorer health, suffer disproportionately from disease, and have shorter lives than whites. Further, U.S. demographic projections estimate that the minority population is likely to increase from 26.4 percent in 1995 to 47.2 percent by 2050—changes that are only likely to exacerbate these disparities. Because the reasons for these disparities are affected by social, behavioral, genetic, health care, and environmental factors, it will be necessary to address a wide spectrum of issues, including: racism and discrimination, socioeconomic factors, educational issues, systemic problems within health care, environmental influences, and social and cultural factors.

Goal

The goal of the Health Disparities Forum is to determine whether there is a role for local philanthropy in efforts to eliminate racial and ethnic disparities and, if so, to define that role. It is hoped that the Forum conversation proceeds far enough to allow participants to begin discussing ways in which Colorado's philanthropic organizations and nonprofits can work together and along with national foundations, government, and nonprofits to eliminate racial and ethnic health disparities.

The goal of this briefing paper is to identify:

- ♦ Colorado's health statistics and data as they relate to health disparities;
- ♦ national and local initiatives already underway; and
- ♦ questions and issues that need to be addressed to identify local philanthropy's role in eliminating racial and ethnic health disparities and to prepare for the Health Disparities Forum on April 10, 2001.

Colorado Data

When looked at as a whole, Colorado is a healthy state. By almost every measure of death, disability, and quality of life, Coloradans and Denver-area residents experience fewer adverse health outcomes and engage in fewer risky health behaviors than the nation as a whole. Colorado's death rates are *lower than national rates* for chronic diseases such as heart disease, cancer, stroke and diabetes and *higher than national rates* for Chronic Obstructive Pulmonary Disease (COPD), unintentional injuries, suicide, atherosclerosis, and Alzheimer's disease (see Table A). However, while Colorado as a whole has experienced decreases in many of the leading causes of death, when age-adjusted death rates are compared by race and ethnicity, generally, minorities experience higher age-adjusted death rates than whites.

Table A. Top 10 causes of death in Colorado and the Denver-metro area: Comparison of death rates to those of the U.S.

Cause of Death	Colorado Mortality Rate	Denver-metro Mortality Rate	Denver/Adams County Mortality Rate
Heart Disease	Lower	Lower	Higher
Cancer	Lower	Lower	Lower
Stroke	Lower	Lower	Lower

COPD	Higher	Higher	Higher
Unintentional Injury	Higher	Lower	Higher
Pneumonia/Influenza	Lower	*	*
Suicide	Higher	Higher	Higher
Atherosclerosis	Higher	*	*
Diabetes	Lower	Lower	Higher
Alzheimer's Disease	Higher	*	*

Note: County specific mortality rates for pneumonia, atherosclerosis, and Alzheimer's disease were unavailable.

The Denver-metro area has higher self-rated health, longer life expectancy, lower mortality rates from most chronic diseases, and lower rates of health-risk behaviors, than national averages. However, in the two Denver-metro counties—Adams and Denver—where there are a higher percentage of minority and low-income populations, there are consistently higher rates of adverse health outcomes than in the rest of the Denver-metro area, including: higher cancer mortality rates, higher diabetes mortality rate, higher heart disease mortality rate, higher HIV mortality rate (Denver), higher infant mortality rate (Denver), and higher COPD mortality rate (Adams).

Initiatives
Many public and private organizations, nationally and locally, are attempting to address health disparities using a wide range of approaches. While their approaches have varied, they can be grouped into the following categories: ***research and education***, ***collaboration***, ***community development***, ***minority development***, and ***systems improvement.*** Appendix A provides a summary table of how some select national and local organizations are addressing health disparities.

The Health Disparities Forum
The Health Disparities Forum will answer:

- ♦ Should local philanthropy get involved in eliminating health disparities, and why?
- ♦ How can local philanthropy most effectively leverage resources to eliminate racial and ethnic health disparities?

Keeping these questions in mind, please begin to think about a few other questions that we will need to answer as part of the Health Disparities Forum:

- ♦ What are the key antecedents to health disparities?
- ♦ Why is it important for local philanthropic organizations to address health disparities?
- ♦ How are organizations and communities addressing health disparities? Which are successful? Which are not? Why or why not? How can these efforts be better coordinated?
- ♦ What can your experiences teach us?
- ♦ What are some solutions that organizations have missed in addressing health disparities?   What are potentials for success in addressing health disparities? *(Think outside the box!)*
- ♦ How can local philanthropy play a role in addressing health disparities?
- ♦ Who else should philanthropy be working with and what should the roles of the different partners be?
- ♦ What more do we need to know?
- ♦ What strategies can Rose Community Foundation and other organizations in Colorado take to address health disparities?
- ♦ What are the next steps for Colorado? For Rose Community Foundation?

Rose Community Foundation is grateful for your willingness to participate in the Health Disparities Forum on April 10, 2001 and looks forward to learning from you whether and, if so, how to target our grantmaking to address racial and ethnic disparities in health.

BACKGROUND

Defining Health Disparities

Despite substantial improvements in the nation's health as a result of medical advances over the last century, disparities in health status persist. Health disparities may be defined as a disproportionate share of negative health outcomes of disease, disability and/or death, affecting specific groups—based on race or ethnicity, sexual orientation, gender, and/or geography—as compared to the general population. This briefing paper and the Health Disparities Forum will focus on health disparities impacting racial and ethnic minorities—African Americans, Hispanics, Asian & Pacific Islanders, and American Indians or Alaskan Natives—as compared with whites. It is hoped that in doing so the Health Disparities Forum will build on current health disparities initiatives, supported with public and private funding, and will result in actionable goals that eliminate health disparities that now account for a significant burden of disease and are amenable to targeted improvements.

Minorities have poorer health, suffer disproportionately from disease, and have shorter lives than whites. The national evidence is alarming. The research shows that:

♦ Infant mortality rates are twice as high for African Americans as for whites and Hispanics.
♦ African American men are more than twice as likely as white men to have heart disease and about 2.5 times as likely to die of stroke.
♦ The prevalence of diabetes in African Americans is approximately 70 percent higher than whites, for Hispanics it is nearly twice that of whites and for Native Americans nearly triple.
♦ While racial and ethnic groups account for only about 25 percent of the US population, they account for more than 50 percent of all AIDS cases.
♦ African Americans and Hispanics are less likely to receive immunizations than whites.
♦ African Americans have a cancer death rate about 35 percent higher than that for whites.
♦ Vietnamese women have a cervical cancer incidence rate that is five times greater than white women.
♦ Coronary heart disease mortality is 40 percent higher for African Americans than whites.
♦ Consistently, minorities are less likely to receive preventive checkups, be routinely checked for cancer, and less likely to access care overall.

The impact of these disparities becomes even more profound when the projected growth of the population of Americans who are racial and ethnic minorities is taken into account. Though the U.S. population has historically included a rich mix of individuals with different racial, ethnic, and cultural backgrounds, today it is becoming even more dynamic. The U.S. Census Bureau projects that the proportion of the overall population considered to be minority (those persons who are not white and are of non-Hispanic origin) will increase from 26.4 percent in 1995 to 47.2 percent in 2050. By the year 2030, minority children will account for more than one half of the Nations' population under age 18. This rapid change in population patterns has precipitated a serious evaluation of how minority populations access and receive quality health care.

In response to these alarming statistics, in 1999, the federal government launched an initiative to eliminate racial and ethnic disparities in health. The government relied on data on the health status of minorities to identify six key health areas in which disparities exist and affect health across the entire life span. These include:

♦ infant mortality;
♦ child and adult immunizations;
♦ HIV/AIDS;
♦ cardiovascular disease;
♦ diabetes and its complications; and
♦ cancer screening and prevention.

The federal government has encouraged grantmakers and nonprofits to partner with them to eliminate health disparities, focusing on these six key health areas where prevention and outreach are known to make a difference.

Reasons for Health Disparities

The reasons for these disparities are complex, as a variety of factors influence the health of individuals and communities, including:

♦ ***Social factors.*** These include income, education, racism, discrimination, and culture. The evidence related to these factors demonstrates their direct impact on the health of minorities. Income and education are inversely related to health outcomes. For example, often, population groups that suffer the worst health status are also those that have the lowest income and least education. Discrimination and racism have widespread effects both within the health-care system and beyond. For example, discrimination may impact a minority's experience within the health-care system—in the quality of care they receive, treatment of illness, and ability to practice medicine. However, discrimination within the health-care system only mirrors the larger problem of racism and discrimination in society—often seen in substandard housing, education, employment opportunities, and so forth—all of which ultimately affect health status. In addition, cultural beliefs and values play a large role in affecting individual health. For example, different cultural beliefs affect an individual's perception of illness, beliefs about appropriateness of care, and attitudes about death and dying.

♦ ***Behavioral factors.*** These include health practices and risk factors associated with different minority populations. Behavior is important because many diseases and conditions can be prevented or controlled through an individual's behavior. Therefore, behavior and lifestyle can have a direct impact on the health of an individual. For example, there is some data that African Americans are less likely to eat a healthy diet and less likely to routinely and vigorously exercise than whites—likely contributing to some of their negative health outcomes.

♦ ***Genetic factors.*** These include genetic and biological factors which influence predisposition to certain diseases. For example, African Americans are predisposed to sickle-cell anemia.

♦ ***Health care factors.*** These include inadequacies of the current health-care system, such as—health insurance status, access to care, quality and cultural competency in the delivery of services, and shortage of minority health professionals—all of which impact health status. For example, uninsured Americans are less likely to have a regular source of care and to use preventive services and more likely to delay care, seek emergency services, and experience adverse health outcomes and higher mortality rates than insured Americans. In addition, patients with limited English proficiency may encounter obstacles within the system, such as delays in appointments, or more serious misunderstandings about treatment and diagnosis.

♦ ***Environmental factors.*** These include environmental hazards within communities that are deleterious to individual health, such as: quality of housing, exposure to violence within communities, and exposure to other environmental hazards. For example, minorities are more likely than whites to live in such environments where the concentration of poverty is higher, the crime rate is higher, and well-paying, skilled jobs are scarce—all of which impact health status.

These factors interact in complex ways that often result in health disparities and other inequities. The successful elimination of health disparities is likely to involve more than providing access to health services. Rather, a more comprehensive approach, which addresses the roots of these disparities—including racism, discrimination, socioeconomic status, environmental influences, genetics, social and cultural influences, and systemic factors within the health-care system itself—needs to be developed.

GOAL

The goal of the Health Disparities Forum is to determine whether there is a role for local philanthropy in efforts to eliminate racial and ethnic disparities and, if so, to define that role. It is hoped that the Forum will help to identify ways in which Colorado's philanthropic organizations and nonprofits can work together and along with national foundations, government, and nonprofits to eliminate racial and ethnic health disparities.

The goal of this briefing paper is to identify:

♦ Colorado's health statistics and data as they relate to health disparities;
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"You cannot build a strong nation on the backs of sick people. If we are to be strong economically, socially, spiritually, and militarily, all of our citizens – all of our people must be healthy."
- Grantmakers in Health Issue Brief No. 5

COLORADO DATA

Colorado
When looked at as a whole, Colorado is a healthy state. Colorado's population is young, healthy, rapidly growing, and increasingly wealthy, relative to national averages. In Colorado, both the total (8.6%) and child (13.4%) poverty rates are below the national averages, 12.6 percent and 18.7 percent, respectively. In 1999, Colorado's population had a higher percentage of whites and Hispanics, and fewer African Americans and Asian & Pacific Islanders than the national averages (see Table 1).

*Table 1. Colorado and U.S. Population – Percentages by Race/Ethnicity*

Race	Colorado	United States
White – Total	**92.3%**	**82.4%**
White – non-Hispanic	*78.3%*	*71.9%*
White – Hispanic	*13.9%*	*10.5%*
Total African American	**4.3%**	**12.8%**
American Indian & Alaska Native	**0.9%**	**0.9%**
Asian & Pacific Islander	**2.5%**	**4.0%**
Hispanic	**14.9%**	**11.5%**

Source: State Census Bureau, 1999 Data

By almost every measure of death, disability, and quality of life, Coloradans and Denver-area residents experience fewer adverse health outcomes and engage in fewer risky health behaviors than the nation as a whole. In 1998, Colorado's age-adjusted death rate for all causes was 426.7 per 100,000 people, well below the national rate of 470.7 per 100,000 people. Colorado's death rate has been lower than the U.S. rate for the past 15 years. Many of Colorado's health indicators are better than national health indicators, including the leading causes of death. According to 1998 data, the 10 leading causes of death in Colorado are as follows (see Figure 1):
1. Heart disease
2. Cancer
3. Chronic obstructive pulmonary disease (COPD)

4. Stroke
5. Unintentional injuries
6. Pneumonia/influenza
7. Suicide
8. Diabetes
9. Atherosclerosis
10. Alzheimer's disease.
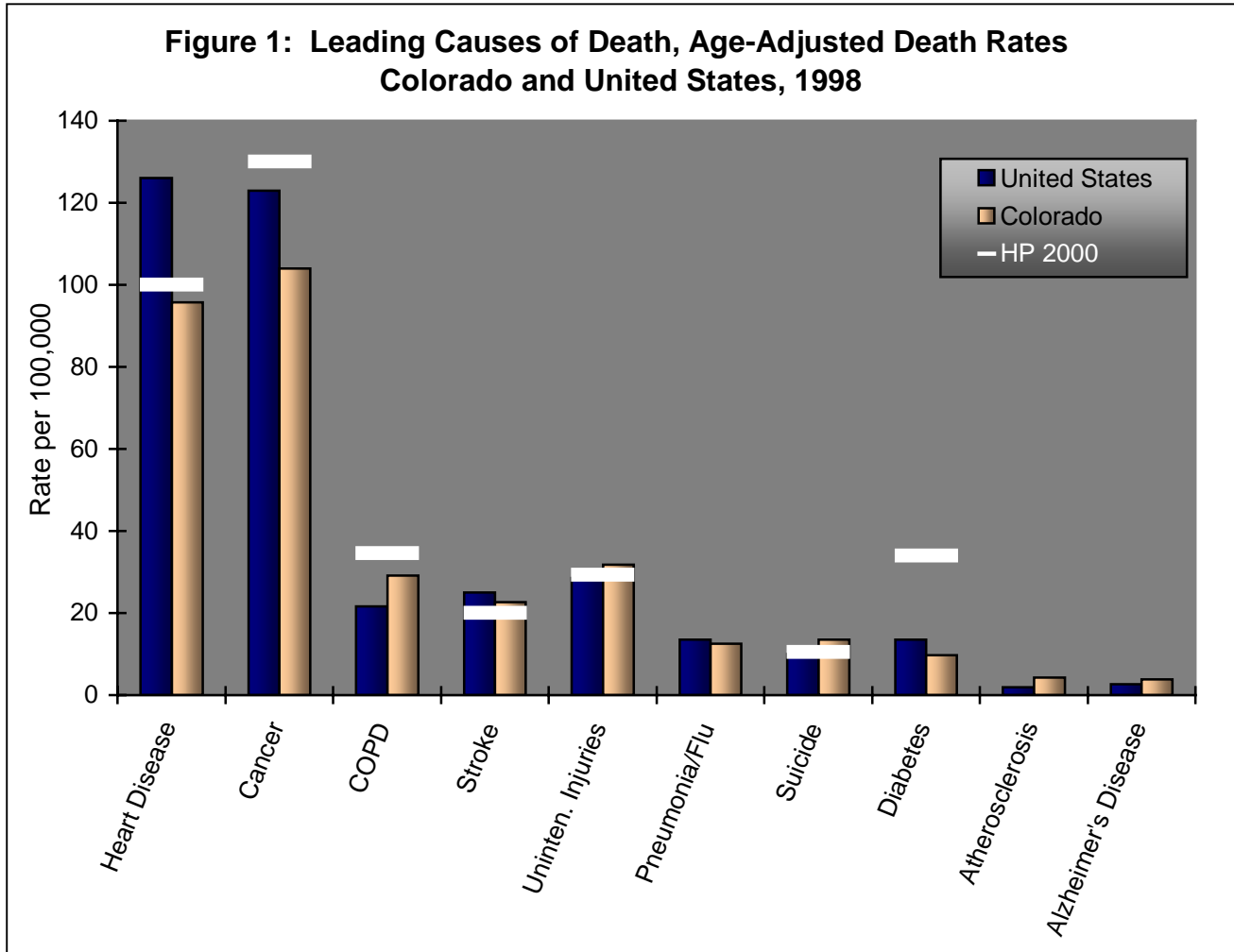
Figure 1: Leading Causes of Death, Age-Adjusted Death Rates Colorado and United States, 1998

Source: Colorado Department of Public Health and Environment (CDPHE) Turning Point Initiative.

Colorado's death rates are ***lower than national rates*** for chronic diseases such as heart disease, cancer, stroke and diabetes (see Table 2 and Figure 1). This may be due to Coloradans having fewer behavioral risk factors. In 1998, only 19.6 percent of Coloradans were physically inactive during leisure time, compared to the national average of 29 percent. Also, Colorado has the lowest prevalence of overweight persons in the U.S., at 23.1 percent of its population. These behaviors probably account for Colorado's 1997 age-adjusted death rate for cardiovascular disease being the second lowest in the nation. Additionally, women in Colorado have exceeded the Healthy People 2000 objective for the percent of women aged 50 or over that have had a clinical breast exam and a mammogram within two years. The age-adjusted death rate for breast cancer in Colorado has been declining since the early 1990's and is currently below the national average and the Healthy People 2000 target.

Colorado does have a few health indicators that are ***higher than national rates***, including COPD, unintentional injuries, suicide, atherosclerosis, and Alzheimer's disease (see Table 2 and Figure 1).

Table 2. Top ten causes of death in Colorado and the Denver-metro area: Comparison of death rates to those of the U.S.

Cause of Death	Colorado Mortality Rate	Denver-metro Mortality Rate	Denver/Adams County Mortality Rate
Heart Disease	Lower	Lower	Higher
Cancer	Lower	Lower	Lower
Stroke	Lower	Lower	Lower
COPD	Higher	Higher	Higher
Unintentional Injury	Higher	Lower	Higher
Pneumonia/Influenza	Lower	*	*
Suicide	Higher	Higher	Higher
Atherosclerosis	Higher	*	*
Diabetes	Lower	Lower	Higher
Alzheimer's Disease	Higher	*	*

* Note: County specific mortality rates for pneumonia, atherosclerosis, and Alzheimer's disease were unavailable.

While Colorado as a whole has experienced decreases in many of the leading causes of death, this is not true for all of its residents. According to Colorado data, when age-adjusted death rates are compared by race and ethnicity, generally, minorities experience higher age-adjusted death rates than whites. Racial and ethnic minority health disparities in Colorado include:

♦ *African Americans* have higher death rates of:
  ▪ heart disease;
  ▪ diabetes;
  ▪ cancer;
  ▪ stroke;
  ▪ homicide/legal intervention; and
  ▪ HIV.

♦ *Hispanics* have higher death rates of:
  ▪ unintentional injuries (including motor vehicle accidents);
  ▪ chronic liver disease;
  ▪ diabetes; and
  ▪ chronic liver disease/cirrhosis.

♦ *American Indians* have higher death rates of:
  ▪ unintentional injuries (including motor vehicle accidents);
  ▪ chronic liver disease/cirrhosis; and
  ▪ diabetes.

♦ *Asian & Pacific Islanders* have higher death rates of:
  ▪ cancer.

♦ *Whites* have consistently higher death rates of
  ▪ chronic obstructive pulmonary disease (COPD); and
  ▪ suicide.

Table 3 illustrates the five leading causes of death (age adjusted), based on percentages within racial and ethnic groups. The leading killers in all five groups are chronic diseases. In 1998, heart disease was the leading cause of death among American Indians, African Americans, Hispanics, and whites, but among Asian & Pacific Islanders, cancer was the primary cause of death. Deaths from unintentional injuries are prevalent and vary by race/ethnicity. In 1998, unintentional injuries were the second leading cause of death for American Indians (accounting for 13.8 percent of deaths within that population), the third leading cause for Hispanics, the fourth leading cause of death for Asian & Pacific Islanders and African Americans, and the fifth leading cause for whites. Among the African American population, homicide/legal intervention was the fifth leading cause of death, accounting for 3.6 percent of deaths within that population.

Table 3: Leading Causes of Death-Percentages by Race/Ethnicity, Colorado 1998

	AMERICAN INDIAN	ASIAN & PACIFIC ISLANDER	AFRICAN AMERICAN	HISPANIC	WHITE
1	Heart Disease 18.5%	Cancer 24.0%	Heart Disease 24.8%	Heart Disease 20.0%	Heart Disease 25.4%
2	Unintentional Injuries 13.8%	Heart Disease 22.2%	Cancer 18.9%	Cancer 18.0%	Cancer 22.3%
3	Cancer 12.3%	Stroke 9.8%	Stroke 6.2%	Unintentional Injuries 9.4%	COPD 7.4%
4	Diabetes Mellitus 5.4%	Unintentional Injuries 8.4%	Unintentional Injuries 6.0%	Stroke 5.5%	Stroke 6.6%
5	Chronic Liver Disease/ Cirrhosis 5.4%	COPD 3.1%	Homicide/Legal Intervention 3.6%	Chronic Liver Disease/ Cirrhosis 4.2%	Unintentional Injuries 5.2%

Source: Colorado Department of Public Health and Environment (CDPHE) Turning Point Initiative.

Deaths due to injury, both intentional and unintentional, also vary by race/ethnicity. For example, suicide is the leading type of injury death for whites, and homicide/legal intervention is the leading type of injury death for African Americans. Suicide is the second leading type of injury death for Asian & Pacific Islanders and American Indians, and homicide is second for Hispanics. Motor vehicle accidents are a leading cause of injury death for all racial and ethnic groups (see Table 4).

Table 4: Leading Types of Injury Deaths by Race/Ethnicity: Colorado 1994 – 1998

	FIRST	SECOND	THIRD
AMERICAN INDIAN	Motor Vehicle/Traffic	Suicide	Homicide/Legal Intervention
ASIAN & PACIFIC ISLANDER	Motor Vehicle/Traffic	Suicide	Homicide/Legal Intervention
AFRICAN AMERICAN	Homicide/Legal Intervention	Motor Vehicle/Traffic	Suicide
HISPANIC	Motor Vehicle/Traffic	Homicide/Legal Intervention	Suicide
WHITE	Suicide	Motor Vehicle/Traffic	Falls

Source: Colorado Department of Public Health and Environment (CDPHE) Turning Point Initiative.

Denver-metro
Compared with the U.S., the six-county Denver metropolitan area (including Adams, Arapahoe, Boulder, Denver, Douglas, and Jefferson counties) reports better measures of quality and years of life. The Denver-metro area has higher self-rated health, longer life expectancy, lower mortality rates from most chronic diseases, and lower rates of health-risk behaviors, than national averages (see Table 2). At the same time, the leading causes of death for the area are the same as those of the U.S.—heart disease, cancer, stroke, and chronic obstructive pulmonary disease.

Overall, the Denver-metro area has significantly *lower rates of diseases* than the U.S. in terms of:

  ♦ cancer mortality (including lung cancer and cervical cancer);

- ♦ Heart disease mortality;
- ♦ stroke mortality;
- ♦ gonorrhea incidence rate; and
- ♦ infant mortality.

However, the Denver-metro area has ***higher rates of death*** than the U.S. in terms of suicide and COPD—both of which disproportionately affect whites. While the exact reasons for this are unclear, it may be attributable to the high percentage of whites in the Denver-metro area (81%, see Table 6) and Colorado as compared with national averages. Because there are more whites than the national averages, it translates to more deaths from diseases that disproportionately affect whites, such as COPD and suicide. In addition to the top 10 causes of death, the Denver-metro area experiences poorer outcomes than the nation regarding low birth weight and improper nutrition.

Table 5. County Population, Race/ethnicity, and Income in the Metro Denver Area

Demographic	Adams	Arapahoe	Boulder	Denver	Douglas	Jefferson	Metro	Colorado
Population in 2000	337,694	486,389	281,428	511,487	160,072	520,712	2,297,782	4,175,003
% of Metro Area	15%	21%	12%	22%	7%	23%	100%	–
Per Capita Income	$21,457	$34,233	$31,393	$33,727	$34,264	$29,497	$30,777	$27,015
White (non-Hispanic)	**75%**	85%	90%	**61%**	95%	90%	81%	81%
Hispanic*	**19%**	6%	7%	**23%**	3%	7%	12%	13%
African American	3%	6%	8%	12%	6%	7%	7%	4%

Source: Colorado Department of Local Affairs – projections based on 1990 census data (not 2000).
*Hispanic may be of any race and accounts for race/ethnicity totals above 100%.

In the two Denver-metro counties—Adams and Denver—where there are a higher percentage of minority and low-income populations (see Table 5), there are consistently higher rates of adverse health outcomes than the rest of the metro area, including:

- ♦ higher cancer mortality rate (including breast and cervical);
- ♦ higher diabetes mortality rate;
- ♦ higher heart disease mortality rate;
- ♦ higher HIV mortality rate (Denver);
- ♦ higher infant mortality rate (Denver); and
- ♦ higher COPD mortality rate (Adams).

In Denver and Adams counties, heart disease, unintentional injuries, and diabetes cause a greater number of deaths than national averages (see Table 2). These two counties report significantly higher rates of mortality and health risk behaviors than the other four metropolitan area counties. These disparities may be due to the larger proportion of minority and low-income populations residing in these counties and may be partially attributable to the poorer outcomes of African Americans and Hispanics in Colorado, similar to those adverse health outcomes identified in Denver and Adams counties.

INITIATIVES

Many public and private organizations, nationally and locally, are attempting to address health disparities using a wide range of approaches. While their approaches have varied, they can be grouped into the following categories:

♦ ***Research and education.*** This includes conducting research to identify factors that affect minority health and strategies that have been implemented to address health disparities. In addition, this includes data and information dissemination to educate the public, communities, and policymakers to better understand lessons learned in order to develop successful strategies to eliminate health disparities and improve health outcomes.

♦ ***Collaboration.*** This includes bringing communities, grantmakers, or other groups together to identify problems and develop solutions to eliminate health disparities. In addition, this involves working with organizations to identify gaps in the system and areas of overlap, and finding ways to better coordinate services between and across different organizations and communities.

♦ ***Community development.*** This includes working with communities to identify community issues and areas of concern, to collaborate and align the necessary resources to address these issues, and to empower communities to mobilize and develop effective strategies to improve their community's health.

♦ ***Minority development.*** This includes developing opportunities to encourage leadership and skills development programs for minority youth, strengthening capacities of minority communities, and developing programs to strengthen leadership of minorities in the medical, health, and health-policy professions.

♦ ***Systems improvement.*** This includes working to improve all systems affecting health – directly or indirectly – including, but not limited to clinical systems, major public health systems, educational systems, and other public and private systems that have an impact on minority health. One of the key areas foundations have focused on is clinical systems improvement. This has been accomplished by working with communities and organizations to identify gaps in clinical care and improve clinical systems to better address the needs of minorities, transforming clinical practice to ensure culturally competent care, increasing representation of minorities in the health profession, and improving the overall system to increase access to both care and health insurance for minorities. In addition, innovative solutions to address other systems need to be identified to affect and improve health status of minorities.

Below are a few examples of how select national and local organizations are addressing health disparities. While this is not an exhaustive list, it provides some insight into what different organizations are doing to eliminate health disparities. (see Appendix A for a summary table on these organizations).

National

Government/Public

The Agency for Healthcare Research and Quality's (AHRQ)
"Understanding and Eliminating Minority Health Disparities" Initiative and other Minority Initiatives
The Agency for Healthcare Research and Quality (AHRQ) is a public health service agency in the U.S. Department of Health and Human Services (HHS) that sponsors and conducts research that provides evidence-based information on health outcomes, quality, cost, use and access to help health-care decision-makers make more informed decisions and improve the quality of health-care services. AHRQ currently has several initiatives focusing on addressing health disparities, through ***research and education*** and ***systems improvement***. Through their initiatives, AHRQ will:

♦ Provide funding to develop nine centers of excellence to conduct research on which factors affect the quality, outcomes, cost, and access to health care for minority populations and develop practical tools for eliminating racial and ethnic disparities in the health-care system. This program is part of HHS's initiative on eliminating racial and ethnic health disparities and Healthy People 2010, and, therefore, will focus on the six health priority areas.

♦ Develop new research, tools, and information to improve health care for priority populations and help build capacity in the field of health-services research. Three initiatives include:

  ▪ ***Measures of Quality Care for Vulnerable Populations.*** This initiative seeks to develop and test new quality measures for use in the purchase or improvement of health care services for priority populations.
  ▪ ***Assessment of Quality Improvement Strategies in Health Care.*** This initiative seeks to expand the conceptual and methodological bases for improving clinical quality.
  ▪ ***Translating Research into Practice (TRIP).*** This initiative focuses on better understanding reasons for health disparities and finding ways to eliminate them.

♦ Support research that involves partnerships between academic researchers and health care providers who serve predominantly minority communities.

The American Public Health Association (APHA)
The American Public Health Association is partnering with HHS and its organizations to eliminate racial and ethnic disparities in health through ***systems improvement*** and ***collaboration***. This partnership is working to address:

♦ Limitations in access to health care among racial and ethnic minorities.
♦ Other aspects of life that impact health outcomes for minorities, such as housing, faith, education, workplace conditions, and social welfare.

The partnership further plans to collaborate with other organizations across the nation to address the overall health of racial and ethnic minorities in the U.S.

The Centers for Disease Control and Prevention's (CDC)
Racial and Ethnic Approaches to Community Health, "REACH 2010" Initiative
The Centers for Disease Control and Prevention's (CDC) initiative, "Racial and Ethnic Approaches to Community Health (REACH 2010)," is a demonstration project that targets six health priority areas: infant mortality; cancer screening and management; cardiovascular disease; diabetes mellitus; HIV/AIDS; and immunizations for children and adults. The CDC's approach focuses on the area of ***community development*** to address health disparities. REACH 2010 is a two-phased project designed to support organizations serving racial and ethnic minority populations at increased risk for these health disparities, including:

♦ ***Phase One.*** This phase provides support to identify problems and developing activities to reduce the level of disparity in one or more of the priority areas.
♦ ***Phase Two.*** This phase enables communities to implement these community-developed strategies with clearly defined interventions within a geographically defined minority population.

To date, the CDC has awarded $9.4 million to community coalitions in 18 states to help address racial and ethnic disparities. These awards put funds into the hands of minority health organizations to foster community mobilization and organization of resources in order to develop effective and sustainable community-oriented programs and strategies to reduce the burden of disease in minority populations. In addition, CDC collaborated with The California Endowment to fund three additional projects. This collaboration between the CDC and The California Endowment has created interest in developing similar partnerships across the country. The Denver Health and Hospital Authority has received funding for Phase One of the project to focus on the areas of cardiovascular disease and diabetes mellitus.

The Health Resources and Services Administration (HRSA) and Bureau of Primary Health Care (BPHC)
"100 Percent Access, 0 Health Disparities" Initiative
The Health Resources and Services Administration's (HRSA) 100 percent Access and 0 Health Disparities Initiative is a community by community movement to achieve 100 percent access to primary health-care services and zero disparities in health status by 2010. The campaign focuses on: ***community development***,

collaboration, and *systems improvement*. The initiative builds on the successful experiences of large and small communities that have identified ways to provide health care for everyone and have eliminated targeted disparities. HRSA's strategies to achieve the goals include:

♦ Building partnerships to help transform primary care delivery systems by restructuring and integrating existing health services by involving faith, business, and educational communities.
♦ Aligning federal government resources with organizations that have similar missions, assets they are willing to mobilize, and a commitment to work collaboratively.
♦ Transforming clinical practice to assure appropriate care within the network of providers so that morbidity and mortality from conditions such as diabetes and cardiovascular disease are reduced.
♦ Working with community champions who serve as advocates and take responsibility for helping communities move toward 100 percent Access and 0 Health Disparities by locating resources, providing information, and getting the assistance that communities need.

The National Institute of Health's (NIH)
Minority Health Initiative (MHI)
The National Institute of Health's (NIH) Minority Health Initiative (MHI) focuses on *research and education* and *minority development* to address health disparities. NIH's Minority Health Initiative is a partnership with NIH institutes and center, other federal agencies, and outside organizations. The multiyear program was developed to support biomedical and behavioral research aimed at improving the health of minority Americans and research training programs designed to increase the numbers of underrepresented minorities in all aspects of these fields. The MHI funds a variety of activities, including efforts to:

♦ improve prenatal health and reduce infant mortality;
♦ study childhood and adolescent lead poisoning, HIV infection and AIDS, and alcohol and drug abuse;
♦ conduct research in adult populations focused on cancer, diabetes, obesity, hypertension, cardiovascular disease, mental disorders, asthma, visual impairments, and alcohol abuse; and
♦ train faculty and students at all educational stages.

Office of Minority Health (OMH) and Office of Minority Health Resource Center (OMHRC)
The Office of Minority Health (OMH) focuses on eliminating health disparities through *research and education*, *collaboration*, and *community development*. The OMH serves as the leader within the U.S. Department of Health and Human Services (HHS) in the development and coordination of policies, information exchange, coalition and partnership building, and related efforts to eliminate racial and ethnic health disparities. The Office of Minority Health Resource Center (OMHRC) helps to research and gather information related to the latest health statistics and minority health programs and organizations, provide assistance in resource development and community partnerships, and provide other technical assistance to empower organizations and communities to address health disparities.

U.S. Department of Health and Human Services (HHS)
In 1998, the U.S. Department of Health and Human Services (HHS) launched a major initiative to eliminate racial and ethnic disparities in health by 2010. The initiative focuses on the six priority health areas affecting racial and ethnic minorities, including: infant mortality; cancer screening and management; cardiovascular disease; diabetes mellitus; HIV & AIDS; and immunizations for children and adults. Every agency within HHS is working to eliminate health disparities (various agency initiatives mentioned earlier), through the various approaches of *research and education*, *collaboration*, *community development*, *minority development*, and *systems improvement.*

Private/Nonprofit

Annie E. Casey Foundation
The Annie E. Casey Foundation has chosen to address health disparities through its larger initiatives, which aim to make reforms that will improve systems to more effectively meet the needs of disadvantaged children and families. Indirectly, Annie E. Casey is addressing health disparities through efforts of *systems improvement*, *community development*, and *research and education* within its larger initiatives:

- ♦ *Improving major systems serving disadvantaged children and families.* This initiative works to improve child welfare, mental health, health-care systems, and other public systems that affect vulnerable populations.
- ♦ *Transforming neighborhoods.* This initiative seeks to help multiple systems work together more effectively to address the needs of vulnerable populations, including communities, neighborhoods, city level systems, and so forth.
- ♦ *Promoting accountability and innovations.* This initiative works to identify and gather the best data on issues affecting families and children and then disseminate the data to educate practitioners, policymakers, and citizens to advance their efforts on behalf of disadvantaged children and families.

The California Endowment
The California Endowment works to reduce racial and ethnic disparities in health through *research and education*, *community development*, and *minority development*. The Endowment has two different approaches in its grantmaking: responsive and strategic grantmaking. Through its responsive grantmaking program, CommunitiesFirst, the goal is to develop the field of multicultural health by promoting community driven strategies that reduce sociocultural barriers to improving health and focuses on proposals that address access, health and well-being, and multicultural health. The strategic grantmaking program includes a number of initiatives in the areas of:

- ♦ cultural and linguistic competence;
- ♦ medical interpretation;
- ♦ health professions workforce diversity; and
- ♦ the elimination of racial and ethnic disparities in health.

The Endowment has also awarded a series of grants to community-based organizations to address the unique needs of underserved constituencies and had sponsored research and produced five papers exploring factors that give rise to disparities in health and to better understand the impact health has on the lives of people in these racial and ethnic groups.

The California Wellness Foundation
The California Wellness Foundation focuses on health promotion, wellness education, and disease prevention. Through these efforts, the Foundation has chosen to address health disparities by directly impacting health, health behaviors, and systems of diverse populations through *systems improvement*, *minority development*, and *community development*. The Foundation focuses on the following health areas to accomplish this:

- ♦ diversity in health professions;
- ♦ environmental health;
- ♦ healthy aging;
- ♦ mental health;
- ♦ teen pregnancy;
- ♦ violence prevention;
- ♦ women's health; and
- ♦ work and health.

The Commonwealth Fund
The Commonwealth Fund has devoted significant resources to address the health needs of minority populations through *research and education* and *minority development*. The Fund has two priorities: improving the quality of care for an increasingly racially and ethnically diverse population, and developing physician leaders in health policy who have a strong commitment to the needs of minority patients and their communities. The Fund established two national programs in minority health:

♦ *The Program on Managed Care and Minority Communities.* This program seeks to develop better information on issues concerning minority health for policymakers and health-care leaders and to advance health-policy and health-services research in this area.
♦ *The Commonwealth Fund/Harvard University Fellowship in Minority Health Policy.* This program was developed to increase the number of physicians particularly those from racial minorities, in health-policy leadership positions and incorporates intensive training in health policy, public health, and health-care administration.

The Fund also supports programs aimed at improving access to care that have a direct bearing on minority health. The Fund also released a publication, "Chart Book on Minority Health," which presents data to document the seriousness of inequities in health and health care across the nation.

Ford Foundation
The Ford Foundation takes a very broad approach to addressing health disparities by addressing the roots of these disparities through *systems improvement*, *community development*, *minority development* and *collaboration*. Rather than focusing specifically on health, the Foundation encourages initiatives from all facets of society that work closest to where the problems are located to ensure participation by diverse communities and individuals of all racial and ethnic backgrounds and socioeconomic statuses. The Foundation searches to eliminate disparities through community-wide efforts to counter the bigger issue of institutional racism. Through its larger initiatives, Ford is finding ways to eliminate health disparities indirectly through:

♦ *Asset building and community development.* This initiative focuses on developing economic improvements in the lives of the disadvantaged, sustainable and equitable communities, and human and social capital through strengthening relationships and social networks.
♦ *Peace and social justice.* This initiative focuses on ensuring social justice and looking after the rights of minorities by strengthening government performance and accountability, increasing citizen participation, and improving policymaking on their behalf.
♦ *Education, knowledge and religion.* This initiative focuses on enhancing educational opportunities for the disadvantaged and addressing the challenges of diversity through interdisciplinary and collaborative approaches.

Grantmakers in Health
The Community Foundation Access Project
Grantmakers in Health (GIH) has focused on *collaboration* and *research and education* to address health disparities. In 1998, GIH worked with HHS to plan a national leadership conference to bring together approximately 250 individuals, including health grantmakers and others representing different sectors interested in working to improve minority health status. The meeting provided participants an opportunity to work together to identify opportunities for action and to learn from each other about the kinds of partnerships that can be effective in producing change. Participants spent most of the day discussing partnership strategies and the strengths and potential contributions of different types of organizations in addressing racial and ethnic disparities in health, as well as focusing on other topics and issues related to the challenge of eliminating disparities. Since 1998, GIH has continued to hold workshops and conferences to provide opportunities for grantmakers, government, and others to work together to identify avenues to eliminate health disparities. GIH is continuing its work through the Community Foundation Access Project, a new collaborative initiative with community foundations, to improve access to health care. The project is working to strengthen the capacity of community foundations to assess local health needs and to stimulate the development of programmatic

initiatives to improve access, with the ultimate goal of reducing racial and ethnic disparities in health. In addition to its collaborative work, GIH is working to serve as a resource to collect and disseminate information on disparities and available information on interventions to address health disparities. One such project of GIH, was the development of a chart book documenting health disparities in the six health areas that the Department of Health and Human Services identified as priority health areas.

The Henry J. Kaiser Family Foundation
The HJ Kaiser Family Foundation's activities in minority health are focused on efforts to reduce racial and ethnic disparities in health care access through *research and education*, *systems improvement*, and *minority development*. The Foundation work includes funding to:

- ♦ develop more effective solutions to the problems contributing to poor health access and outcomes experienced by many racial and ethnic minorities;
- ♦ support leadership and skills development programs for disadvantaged youth;
- ♦ create and maintain a Native American health policy fellowship program and other efforts to develop more effective policy solutions for health problems facing Native Americans; and
- ♦ conduct policy research and analysis and media and public education activities to review, collect, and disseminate information on disparities that exist and what can be done to address inequities in care.

The Medtronic Foundation
The Medtronic Foundation addresses health disparities by focusing on *minority development* and *systems improvement*. Medtronic provides grants to programs that address problems encountered by economically disadvantaged people, minority communities, and those most vulnerable. These include programs that:

- ♦ strengthen the capacity of communities (both cultural and geographic);
- ♦ address access to health care;
- ♦ prevent violence; and
- ♦ encourage the development and maintenance of healthy lifestyles.

Northwest Health Foundation
The Northwest Health Foundation focuses on *research and education*, *systems improvement*, *collaboration* and *community development* to address the health needs of minority populations. The Foundation has sought to build nontraditional collaborations with other foundations, applicants, and community-based organizations and supports projects designed to improve the delivery of health care to culturally diverse communities, including issues of:

- ♦ health protection;
- ♦ quality of health care;
- ♦ access to health care;
- ♦ basic and applied biomedical, health, and socio-behavioral research;
- ♦ education for health professionals and consumers; and
- ♦ mental health.

The Foundation's work expands beyond simple grantmaking to offer technical assistance to grantees and other organizations interested in applying for grants. The Foundation reviews grants from the perspective of how they will reach and impact minority communities. Furthermore, the Foundation tries to spread its expertise in the area of minority health to other grantmakers and organizations by offering advice and technical assistance in program and grant development.

RAND
RAND is a nonprofit organization that works with public and private entities to help improve policy and decision-making through research and analysis. RAND's work focuses on *research and education*. RAND is working, with the support of the Robert Wood Johnson Foundation and the CDC, to provide information to the

REACH 2010 communities on existing community-based interventions to address health disparities. This includes:

- ♦ Conducting a formal literature review to identify and analyze the evidence from the literature on health-related community demonstration—particularly those that have targeted race and ethnic disparities and that have focused on the six targeted conditions—to arrive at an evidence-based understanding of best practices about community-level strategies for improving health;
- ♦ Synthesizing the lessons learned by those whom have either funded (e.g., foundations and federal agencies) or implemented (e.g., community-based organizations) community-level strategies for improving health and other social issues; and
- ♦ Disseminating the information to REACH 2010 communities to assist them in identifying problems and developing interventions within their own communities to address health disparities.

The RAND project will provide information to the REACH 2010 communities on previous work in community interventions, that is not easily accessible and is specific for the target populations and diseases of the REACH 2010 population.

Robert Wood Johnson Foundation
The Robert Wood Johnson Foundation (RWJF) has taken a different approach to addressing health disparities. Rather than creating a new initiative around this issue, RWJF has decided to continue its focus on its three priority areas: access to health care, substance abuse, and chronic-care management. Within these areas, however, RWJF constantly keeps in mind and focuses many of its grants on vulnerable, disadvantaged and at-risk populations—often the same populations that are being looked at by other health disparities initiatives. In addition, RWJF has reorganized into submanagement teams to address health disparities through *minority development* and *research and education*. Two submanagement teams specifically addressing health disparities include:

- ♦ *Priority Populations Team.* This team focuses on high-risk and vulnerable populations, which often are minority individuals of diverse racial and ethnic backgrounds.
- ♦ *Populations Health Sciences Policy Team.* This team researches racial and socioeconomic factors that contribute to differences in health outcomes.

RWJF also supports several programs that focus on building the supply of minority physicians and faculty, including:

- ♦ *Minority Medical Education Program.* This program is a summer enhancement program designed to help minority students compete for medical school acceptance.
- ♦ *Minority Medical Faculty Development Program.* This program offers four-year, post-doctoral research fellowships to minority physicians to study and conduct research in an area of interest to the Fellow.
- ♦ *Health Professional Partnership Initiative.* This program is a partnership with the W.K. Kellogg Foundation. The goal of the initiative is to enhance the academic preparation of minority students and nurture their interests in health careers, thereby increasing minority participation in all health professions.

Finally, RWJF supports the *Turning Point Program* in partnership with W.K. Kellogg Foundation with the goal of transforming and strengthening public-health infrastructure (see description under Kellogg). The Colorado Department of Public Health and Environment (CDPHE) is a local Turning Point grantee.

W. K. Kellogg Foundation
The W. K. Kellogg Foundation, though not taking a direct approach to "eliminating health disparities," has dedicated much of its time to a broad-based approach including a focus on *systems improvement*, *minority development*, *community development*, and *collaboration*. Kellogg has worked to:

- ♦ transform public health systems;

♦ develop stronger leadership of minorities in the medical, health care, and health policy professions;
♦ link resources to communities to foster cooperation at the family, neighborhood, community and policy levels; and
♦ develop models of access and prevention to improve the health of the underserved and uninsured, including minority and other vulnerable populations.

Kellogg has several initiatives, indirectly working to eliminate health disparities, including:

♦ ***Turning Point: Collaborating for a New Century in Public Health.*** This initiative is a partnership between Kellogg and RWJF. The goal of the program is to transform and strengthen the public health infrastructure in the U.S. so that states, local communities, and their public-health agencies may respond to the challenge to protect and improve the public's health in the 21st century. The program promotes the creation of sustainable broad-based partnerships involving business, government, faith-based, youth and community action groups to improve community health. The Colorado Department of Health and Environment (CDPHE) is a local Turning Point grantee.
♦ ***Community Voices.*** This is a five-year initiative to improve health care and access for the underserved and uninsured, including the working poor, by developing models of access and prevention as learning laboratories. With 13 Community Voices projects funded in 11 states, the program documents the models' efforts to increase access to primary care and prevention and strengthen the health care safety net. The projects serve to inform practice in the field as well as to inform public and marketplace policy about expanding access and coverage for the underserved and uninsured. Denver Health is a local Community Voices grantee.
♦ ***Health Professional Partnership Initiative.*** A partnership with the Robert Wood Johnson Foundation (see description in RWJF above).

In addition, the Foundation also supports several other programs designed to recruit and train minorities for the health professions. The Foundation's other program interests also indirectly contribute to eliminating health disparities, including: health, leadership development, capitalizing on diversity, and social and economic community development.

Local

Government/Public
Colorado Department of Public Health and Environment (CDPHE)
Turning Point Initiative
The Colorado Turning Point Initiative is a two-year, collaborative planning process that will develop a state health improvement plan, funded by the Robert Wood Johnson Foundation and W.K. Kellogg Foundation. The key goal of the national initiative is to allow states to create a plan to transform the public health system in their state to enhance public-health capacity and to improve health status. In Colorado, the project goal is to develop a state health-improvement plan that will be used by the state and communities to enhance the public health capacity in order to eliminate health disparities. The Colorado Turning Point Initiative is taking a comprehensive approach to address health disparities through *minority development*, *community development*, *collaboration* and *research and education*. A key focus of the plan will be to identify strategies to reduce health disparities to improve health status. Once a plan is developed, the Turning Point Initiative will apply for funds to implement the proposed strategies to build capacity to reduce health disparities in Colorado.

Denver Health
Benchmarking Project
Denver was selected by the U.S. Department of Health and Human Services as one of three communities to participate in a Health Benchmarking Demonstration Project. The Denver Health Benchmarking Project is working to address health disparities through *research and education*, *community development*, and *collaboration*. The goals of the Benchmarking Project are to:

- ♦ establish a neighborhood-based profile of leading health-related indicators and benchmarks that resonate for Denver's Enterprise Community; and
- ♦ empower those neighborhoods to take action to improve their residents' health status.

The Denver Enterprise Community (EC) is a geographic area composed of 12 of Denver's most economically distressed neighborhoods. The mission of the Denver EC program is to assist residents of these neighborhoods in making their neighborhoods healthier—both economically and physically. The Benchmarking Project developed a template for a health profile of the Denver EC and identified health disparities. From this, the project provided recommendations for future action to build on the existing data and provide potential solutions and strategies to address these problems. The Denver Health Benchmarking Project eventually hopes to institutionalize benchmarking across all of Denver's neighborhoods.

Denver Health
Community Voices
Denver Health Community Voices is one of 13 local learning laboratories working to improve health-care access and quality as part of a five-year national initiative funded by the W.K. Kellogg Foundation and The Colorado Trust. The Community Voices project is working to address health disparities by focusing on *research and education* and *community development*. Established in 1998, the goals of the Denver Health Community Voices initiative are to:

- ♦ improve the health of Denver's medically underserved through innovations in community outreach, enrollment in publicly funded health insurance and small-employment health plans, and clinical case management, and
- ♦ change public policy at the state and federal level for health program funding streams, reimbursement for community outreach and case management, and reduce barriers to enrollment in publicly funded health insurance.

The Denver Health Community Voices program focuses on community outreach, facilitated enrollment, and case management to achieve its goals. The community outreach program is designed to demonstrate that culturally sensitive community outreach to underserved populations improves enrollment of eligible individuals in health plans and engages and empowers communities to assume greater responsibility for health. The facilitated enrollment program's goal is to redesign the enrollment process to increase enrollment into publicly sponsored programs. The adult case-management program is designed to demonstrate, via a randomized, controlled study that case management of chronically ill adults across funding streams and clinical disciplines improves health outcomes and lowers costs.

Private/Nonprofit
Colorado Action for Healthy People
Colorado Action for Healthy People (CAHP) has been a resource for communities throughout the state of Colorado for over 15 years by providing expertise in developing programs targeted at improving community's health and wellness through prevention and health promotion. CAHP is working to eliminate health disparities through *community development* and *collaboration*. CAHP assists communities in program development, community partnerships and leadership development, funding development, and provides other technical assistance to develop successful strategies to improve health. CAHP has made a difference in tobacco control, adolescent health, violence prevention, child injury prevention, and in promoting physical activity, good nutrition, and other disease prevention. CAHP continues to work to increase community capacity and to assist making Colorado communities a healthier place to grow.

Colorado Community Health Network
100 Percent Access and 0 Health Disparities
The Colorado Community Health Network (CCHN) is the state primary care association – a membership organization for Community Health Centers. CCHN has joined forces with the Bureau of Primary Health Care, and the Colorado Coalition for the Medically Underserved, to work toward 100 Percent Access and 0 Health

Disparities. CCHN's approach to eliminating health disparities is through ***community development*** and ***collaboration***. CCHN is working to bring various sectors of communities together to understand a need, identify common goals, and mobilize resources within the community to achieve those goals. CCHN is working with communities to develop sustainable solutions and activities to increase access to primary and preventive health care and to reduce health disparities. CCHN helps to design and facilitate the Community Development process within a community, identify possible sources of information to use in defining needs and goals, and provide information about models and resources that have been useful in other communities.

THE HEALTH DISPARITIES FORUM:

Identifying the Role of Local Philanthropy in Eliminating Racial and Ethnic Health Disparities

This paper has provided some background on the complexities of the issues surrounding health disparities. It has identified some of the key health disparities that exist in Colorado and, more specifically, in the Denver-metro area, and it has described a variety of initiatives undertaken by national and local, public and private entities to address health disparities.

Now that we understand more about health disparities nationally and in Colorado (including the anticipated demographic changes that are likely to exacerbate these disparities) and are familiar with what many organizations are doing to address these disparities, it is necessary to begin thinking about:

- ♦ Should local philanthropy get involved in eliminating health disparities, and why?
- ♦ How can local philanthropy most effectively leverage resources to eliminate racial and ethnic health disparities?

In order to successfully eliminate health disparities, it is necessary to address a wide spectrum of issues: racism and discrimination, socioeconomic factors, educational issues, systemic problems within health care, environmental influences, social and cultural factors, and beyond. To accomplish this, many varied approaches are being taken, including:

- ♦ ***research and education;***
- ♦ ***collaboration;***
- ♦ ***community development;***
- ♦ ***minority development;*** and
- ♦ ***systems improvement.***

Some organizations have chosen to apply these approaches directly to factors affecting health—such as health behaviors and lifestyle, problems within the health-care system, and environmental health. Others have chosen to apply them more indirectly to the underlying causes of these disparities—such as discrimination, social injustice, and economic development. In addition, some organizations have chosen to focus and specialize in one of these areas, while others have chosen to span across a range of areas. In Colorado, organizations have limited their focus primarily to collaboration, community development, and research and education. In order to have a more far-reaching effect and greater impact on eliminating health disparities, it may be necessary for Colorado to address a wider range of approaches impacting health issues both directly and indirectly. To achieve this end, it would be useful to identify:

- ♦ Which approaches are working and which ones are not (e.g., directly vs. indirectly, focusing on one area or spanning across a range of approaches, or some combination) and the reasons behind this.
- ♦ Where the gaps are.
- ♦ Ways in which these different organizations can better coordinate to identify programs and solutions that complement rather than duplicate efforts.

Perhaps as Colorado begins to answer these questions, it will become clearer how the causes of racial and ethnic disparities interrelate and how local foundations can most effectively act to address them both independently and collectively.

Keeping these questions in mind, please begin to think about a few other questions that we will need to answer as part of the Health Disparities Forum:

- ♦ What are the key antecedents to health disparities?
- ♦ Why is it important for local philanthropic organizations to address health disparities?
- ♦ How are organizations and communities addressing health disparities? Which are successful? Which are not? Why or why not? How can these efforts be better coordinated?
- ♦ What can your experiences teach us?
- ♦ What are some solutions that organizations have missed in addressing health disparities?   What are potentials for success in addressing health disparities? *(Think outside the box!)*
- ♦ How can local philanthropy play a role in addressing health disparities?
- ♦ Who else should philanthropy be working with and what should the roles of the different partners be?
- ♦ What more do we need to know?
- ♦ What strategies can Rose Community Foundation and other organizations in Colorado take to address health disparities?
- ♦ What are the next steps for Colorado? For Rose Community Foundation?

Rose Community Foundation is grateful for your willingness to participate in the Health Disparities Forum on April 10, 2001. Please take time to think about your experiences in the field and let your expertise guide us through a day of learning and critical thinking to identify whether and, if so, how local philanthropy can successfully work to eliminate health disparities and address the complex factors that contribute to them.

REFERENCES

The majority of the data and information gathered in this report were taken from the following reports:

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