Colorado Health Disparities Strategic Plan
2008

Interagency Health Disparities Leadership Council

Working Together to Address Racial and Ethnic Health Disparities in Colorado

The **Interagency Health Disparities Leadership Council** (IHDLC), in partnership with the **Colorado Department of Public Health and Environment's** (CDPHE) **Office of Health Disparities** (OHD) and the **Minority Health Advisory Commission** (MHAC), is a resource available to Colorado's leaders as they seek to improve health and health care in Colorado. Formed in January 2006, IHDLC is an independent advisory council composed of fifty-one participants representing federal and state agencies, universities, community providers, and foundations. Beyond the OHD's focus on racial and ethnic health disparities, IHDLC is committed to reducing health disparities experienced by *all* vulnerable populations including rural populations, GLBT communities, disabled persons, and economically disadvantaged persons.

The United States spends considerably more on health care technologies, than on ensuring equity in health care delivery, despite the fact that eliminating excess deaths among African Americans in the past ten years would have saved more lives than medical advances did.[1] Health disparities have long been left off the policy agenda, both nationally and in Colorado. In seeking to act as a valuable resource for Colorado's leaders, and for all Coloradans working to eliminate health disparities, IHDLC, with the help of a wide range of community stakeholders, developed the **Colorado Health Disparities Strategic Plan**. This strategic action plan stems from work originally begun at the 2006 Colorado Health Disparities Conference where participants developed strategies for extending the state-level health disparities strategic plan to communities and addressing determinants of health disparities. In August 2007, a group of interested stakeholders was once again brought together to further inform and develop the goals and strategies to be included in the strategic plan. This completed plan is the product of these processes and was created with the goal of developing specific and tangible strategies that government agencies, community and other organizations can implement in working towards the elimination of health disparities across Colorado.

There are several unifying and overarching goals expressed throughout the strategies and priorities of the action plan:

- ❑ **Educate** and **raise awareness** about health disparities.
- ❑ **Build capacity with community and across sectors** to eliminate health disparities.
- ❑ **Create a sustainable movement** around eliminating health disparities in Colorado through **policy reform.**

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[1] Woolf (et. al.) "The Health Impact of Resolving Racial Disparities: An Analysis of U.S. Mortality Data." American Journal of Public Health, 2004.

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- [ ] Target the **determinants of health** that are the very root of health disparities

The first goal is to **educate** and **raise awareness** about health disparities, and the impact health disparities have on the community as a whole. This includes educating government and state agencies, the private sector, community-based organizations (CBOs) and the general public through advocacy.

The second goal is to **build capacity with community and across sectors** to eliminate health disparities. This means including all players in development of programs, policies, and strategies to eliminate health disparities. Further, this means ensuring communities have the capacity to address health disparities in a manner appropriate to specific needs, and that government, community based organizations, and state agencies help create the infrastructure necessary to support and collaborate on these efforts.

The third goal is to **create a sustainable movement** around eliminating health disparities in Colorado, and to ensure progress will not fade if funding fades. For this to occur, there must be an effort to implement **policy reform** at both the legislative and organizational levels. Another component of sustainability is continual evaluation of policies once they are instituted to prevent unintended consequences, and to ensure continued functionality for communities.

Finally, this action plan seeks not only to address the current symptoms of health disparities, but to target the **determinants of health** that are the very root of health disparities suffered by vulnerable populations.

Stemming from these cross-cutting themes, the action plan focuses on six specific areas important in eliminating health disparities:

I. Community Involvement/Community Partnerships
II. Addressing the Determinants of Health
III. Health Disparities Research/Evidence-Based Practices
IV. Policy and Legislation
V. Workforce Diversity in Health Professions/Cultural Competence
VI. Sustainability

Within each area of interest, priority areas are identified, strategies to address each priority are given, and action steps to support each strategy are listed.

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I. Community Involvement/Community Partnerships

Although often overlooked by both professionals within the public health field, and the layperson, social determinants of health, such as social cohesion, account for as much -- if not more -- of disparities observed in health than environmental and individual behavior factors.[2] The capacity of a community to identify and address the determinants of health within their community is contingent upon this social cohesion. Partnerships within communities and the connections to broader groups and resources build capacity within communities that enable them to thrive and to advocate for action, reducing disparities, and benefiting the community at large.

Priority #1: Build local partnerships for addressing health disparities.

Strategy #1: Be linguistically and culturally responsive in building trust, and increase communication among partners within communities.

Responsibility: OHD, IHDLC, MHAC, CDPHE, Local Health Departments, CBOs, Governor's Office
Timeline: May 2008 - Ongoing

Actions:

- Approach communities with an open mind, willingness to listen, and without an agenda.
- Identify what partnerships currently exist within and among communities.
- Create opportunities for dialogue in communities where partnerships do not exist.
- Provide opportunities for capacity building and dialogue around: trust, communication, community participation, skill-sharing, mutual respect, empowerment, networking, sustainability, community-based outreach strategies, and services in the community.
- Look for partners and leaders within natural community settings such as pow-wows, churches, or arts and crafts fairs. Compensate community leaders for their time.
- Establish clear expectations for responsibilities of all parties involved in partnerships. Include expectations of benefits, and financial incentives for community members.
- Work with funders to ensure collaboration and partnerships within and between communities are a priority in determining where resources flow.

Priority #2: Advocate to ensure providers, policymakers and funders are responsive to communities.

Strategy #1: Engage communities in program planning and policy development at the local and state levels.

[2] McKinlay. "Bringing the social system back in: An Essay on the Epidemiological Imagination." New England Research Institute, Boston. 1995.

Responsibility: Community Advisory Boards
Timeline: May 2008 - Ongoing

Actions:

- Establish a community advisory board consisting of community leaders, and policy makers. Allow community members to submit agenda items and subsequently, implement strategies created by the advisory board. (January 2008 - December 2008)
- Evaluate allocation of funding and grant distribution in community programs, and create recommendations for how funding could be more effectively utilized within the community. (January 2009 - December 2009)
- Develop a plan to recruit ongoing public input on health disparities issues into boards, commissions, and organizations. (January 2008 - December 2008)

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II. **Addressing the Determinants of Health**

The determinants of health refer to both specific features of, and pathways by which societal and environmental conditions affect health and that potentially can be altered by informed action. Health is not simply the absence of disease, but a sense of physical, emotional, and mental well-being. Therefore the determinants of health are profuse, and include income, education, occupation, sanitation, exposure to environmental hazards, family structure, social support, discrimination, and access to health care.

Priority #1: Create a public education/ awareness campaign that educates on the complex factors contributing to health disparities including access to health care.

Strategy #1: Demonstrate the economic, social, and moral benefits of eliminating health disparities.

Responsibility: Interagency Health Disparities Leadership Council (IHDLC)
Timeline: May 2008 - December 2009

Actions:

- ❑ Work with an economist to demonstrate the economic benefits that would result from the elimination of health disparities.
- ❑ Work with the community to help them identify their specific risks and protective health factors.
- ❑ Targeting the health system, including public health to address the health disparities and to create an inclusive system of care for all.
- ❑ Specifically focus on policymakers.
- ❑ Incorporate information on determinants of health in advocacy and educational publications, media and on the Internet.

Strategy #2: Create an inventory of health services and resources that target underserved populations, follow up with a gap analysis to determine services that are necessary and currently unavailable.

Responsibility: IHDLC, Students
Timeline: Inventory: May 2008 - August 2008; Gap Analysis: September - November 2008; Report: December 2008

Actions:

- ❑ Identify organizations and communities that have already collected information that would be useful in informing the database.
- ❑ Create an inventory of available health care services and resources that focus on and target underserved populations.
- ❑ Create a report detailing gap analysis.

Strategy #3: Develop a marketing strategy to broadly educate the public on services and resources available that focuses on the elimination of health disparities.

Responsibility: IHDLC, CDPHE, Local Health Departments, CBOs, Hospitals
Timeline: December 2008 - January 2009

Actions:

- ❑ Utilize leaders (community, government, faith, employers, local organizations) as conduits for information.
- ❑ Use media and advertising to educate the public.
- ❑ Generate an educational series of publications for various audiences (public, community based organizations, community leaders) on available health services.

Priority #2: Prevent and reduce health risks that contribute to disparities in health.

Strategy #1: Build awareness about how prevention can reduce health risks that contribute to health disparities.

Actions:

- ❑ Using culturally and linguistically appropriate interventions and resources, and employing established community channels, educate Colorado communities about:
  - personal health and lifestyle behaviors that influence risks for chronic disease, infant mortality, low birth weight, obesity, etc.
  - the importance of screening to bring about early detection and potentially improve health outcomes; and
  - the importance of self-management of chronic diseases in improving quality of life and the burden of disease.
- ❑ Include representatives of populations disparately affected by the burden of disease in the planning and implementation of programs and interventions for addressing chronic disease, infant mortality, low birth weight, obesity, etc.

Responsibility: Prevention Services Division (PSD) in partnership with the Office of Local Liaison (OLL) and the Interagency Health Disparities Leadership Council (IHDLC)
Timeline: Ongoing

Strategy #2: Promote the importance of prevention as a means of impacting determinants of health that are associated with health disparities.

Actions:

- ❑ Educate health care and public health professionals about the status of health disparities in Colorado and strategies they can incorporate into their work to address disparities in the prevention of chronic disease, infant mortality, low birth weight, obesity, etc.

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- ❑ Through recruitment and training, actively promote a culturally competent health care and public health workforce that is representative of the disparately affected communities served.
- ❑ Ensure that surveillance data are available to accurately describe and monitor disparities in chronic disease morbidity and mortality, and create data reports to educate state and local decision-makers, community leaders, and health and public health care professionals about the status of health disparities in Colorado.

Responsibility: PSD (Prevention Services Division)
Timeline: Ongoing

Priority #3: Increase availability of health care services to underserved populations.

Strategy #1: Form partnerships with health care providers/community based organizations to increase services to underserved populations.

Responsibility: IHDLC (Facilitator Role)
Timeline: January 2009 - January 2010

Actions:
- ❑ Develop mutual aide agreements and a database for documenting these agreements.
- ❑ Partner with community health centers to explore strategies to expand their services throughout the state.
- ❑ Increase the availability of patient navigators, promotores, and lay health advisors funded by public and private organizations and foundations across the state.
- ❑ Identify a hotline for the underserved to assist individuals in finding and accessing health care and public health services. Incorporate identified resources from the inventory.
- ❑ Provide education on culturally and linguistically appropriate services, such as utilizing qualified interpreters within health care facilities.

Priority #4: Champion policy recommendations for addressing social determinants of health across disciplines.

Strategy #1: Utilize data on social determinants of health for understanding associated issues of health disparities.

Responsibility: Advocacy organizations
Timeline: Ongoing

Actions:
- ❑ Collect and compile information linkage between social determinants of health and specific issues of health disparities that are relevant to the State of Colorado.

- ❑ Collect environmental data to better understand environmental factors contributing to health disparities.
- ❑ Produce data profiles by county on key population-based social and health indicator data related to social determinants of health.
- ❑ Develop policy recommendations based on the data analysis for addressing social determinants of health in the State of Colorado.
- ❑ Utilize policy recommendations as a tool for educating and engaging in dialogue with policymakers.

Strategy #2: Coordinate policy initiatives and advocacy focused on the social determinants of health.

Responsibility: Advocacy organizations
Timeline: Ongoing

Actions:

- ❑ Develop common talking points for use with media, legislators, and the general public.
- ❑ Capture health disparities stories from people for media and testimony.
- ❑ Foster champions among decision makers for addressing social determents of health.
- ❑ Develop story ideas detailing social and environmental issues that link health disparities to communities and people's lives

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III. **Health Disparities Research/Evidence-Based Practices**

Health disparities research is necessary to infuse practice with evidence-based innovation, and to expand the knowledge of community-based research and promising program strategies with others. Research is also necessary to identify gaps in capacity and provide funders with the statistics they are looking for when awarding monies.

Priority #1: Foster awareness of the importance of health disparities research

Strategy #1: Conduct a comprehensive literature review and program search to identify programs in the state that have health disparities components, and identify those that are evidence-based.

Responsibility: IHDLC, PSD, Epidemiology and Evaluation Committee, CHEIS
Timeline: May 2008 - January 2009

Actions:

- ❑ Create best-practices manual, featuring organizations with an evaluation component and distribute as a resource for other programs.
- ❑ Define evidence-based and promising practice components for utilization by organizations in Colorado.
- ❑ Assist programs in developing and moving towards evidence-based practice.
- ❑ Create a list of evaluation resources available in state and local programs and include information on which ones are free/government funded, and what populations they address.
- ❑ Provide infrastructure, linkages and resources to share evidence-based strategies
- ❑ Develop a process for review and study of innovative practices/strategies.

Priority #2: Enhance the capacity of communities, state agencies, higher education and other stakeholders to conduct, assess and utilize research findings to address health disparities.

Strategy #1: Build skills within state agencies to conduct health disparities research.

Responsibility: Research and Evaluation Unit, COTRAIN, State Programs, PSD, Epidemiology and Evaluation Unit
Timeline: May 2008 – May 2010

Actions:

- ❑ Increase training of state employees.
- ❑ Publicize training courses available to register on COTRAIN.
- ❑ Identify available training courses that can be scheduled and posted on COTRAIN.
- ❑ Assist in funding tuition for university courses.

Strategy #2: Build skills for research within communities.

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Responsibility: IHDLC in collaboration with the University of Colorado Social Sciences Programs, CBOs, and Evaluation Firms
Timeline: May 2008 - December 2009 (two semester projects to assemble interested community members); January 2009 - 2011 (to begin education in communities)

Actions:

- ❑ Create a training program to build capacity within communities around research and assessment/evaluation.
- ❑ Build Capacity to collect, design, use and analyze research and evidence-based practices for relevance/adaptability for target populations.
- ❑ Community involvement and Institutional Review Boards at every level of planning.

Strategy #3: Build infrastructure to enable sharing of resources and evidence-based strategies.

Responsibility: COTRAIN, Agency Contacts, IHDLC, CBOs, Colorado School of Public Health
Timeline: January 2009-2010

Actions:

- ❑ Gather list of community-based organizations currently running programs addressing health disparities and meet to discuss adding evaluation component to programs.
- ❑ Publish best practices manual, and forward through database of health resources contacts, and on COTRAIN.
- ❑ Share results of community-based research and promising strategies with others to infuse practice with evidence-based innovation
- ❑ Analyze research and evidence-based practices for adaptability for target populations.

Strategy #4: Assist local community in utilizing health disparities research to implement effective approaches to address health disparities.

Responsibility: IHDLC, CBOs, State Evaluation Units
Timeline: January 2010 - 2011

Actions:

- ❑ Generate input from communities in defining their needs for addressing health disparities.
- ❑ Work with community-based organizations to update current programs to include an evidence-based component.
- ❑ Provide county level data on key social and health indicator data in the form a county data profiles, and include local stakeholders in summarizing and interpreting the analysis of the data.
- ❑ Collaborate with higher education in identifying current evidence-based approaches for addressing health disparities.

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- Conduct community based participatory research in order to determine effective intervention and prevention programs impacting disparate populations.
- Recruit and retain public health students of color with an interest in health disparities research.

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IV. **Policy and Legislation**

Policy and legislation are the mechanisms by which state, local, and federal governments, as well as private organization priorities are determined. In seeking to address the complex issues related to eliminating health disparities, it is essential that policy solutions bridge across disciplines in order to increase partnerships within communities, and with government agencies, service providers, and the business community.

Priority #1: Improve education and communication among community stakeholders, elected officials, business, philanthropy and local, state, and federal policy makers and agencies.

Strategy #1: Improve policy development to ensure health equity by addressing disconnects related to communication and collaboration between decision makers and community stakeholders.

Responsibility: IHDLC
Timeline: July 2008 - Ongoing

Actions:

- ❑ Develop a process for ongoing engagement with stakeholders and consumers across the state.
- ❑ Develop culturally relevant educational tools and resources for community members to use as advocacy tools, or guidelines when engaging decision makers.
- ❑ Build trust and relationships among diverse communities, consumers, government and decision makers.
- ❑ Develop annual health equity policy agenda.
- ❑ Create a community progress report, a check list of policies in alignment of health equity agenda.

Strategy #2: Establish meaningful voices, leadership and development of multi-ethnic/cultural leaders. Ensure that policymaking is participatory and inclusive.

Responsibility: Advocacy Organizations
Timeline: May 2008 - Ongoing

Actions:

- ❑ Provide resources, tools, and training to community members, and leaders to create an advocacy voice.
- ❑ Establish opportunities and secure resources for community-based participation on decision-making bodies.
- ❑ Partner with community stakeholders and consumers throughout the policy process from initiation and during implementation and evaluation.
- ❑ Develop and sustain partnerships among diverse communities, government agencies and service providers.

- ❑ Increase the membership and representation of disparately affected populations on public policy boards affecting the distribution of funding and policy making.

Strategy #3: Collaboratively develop policy solutions that include diverse stakeholders.

Responsibility: Advocacy Organizations, IHDLC, State, Local, and Private Partners.
Timeline: May 2008 - Ongoing

Actions:

- ❑ Assess levels of achieving health equity.
- ❑ Identify the sub-committees of health policy groups that are working on health reform issues to determine if the Interagency Health Disparities Council can participate or communicate recommendations.
- ❑ Identify and address the consequences of and solutions to multiple, conflicting or overlapping policies that target the elimination of health disparities.

Priority #2: Strengthen and sustain leadership among policy makers to address the determinants of health in Colorado.

Strategy #1: Utilize IHDLC as a venue to discuss fiscal resources and policy opportunities to achieve health equity policy commitments for addressing health disparities.

Responsibility: IHDLC
Timeline: May 2008 - May 2009

Actions:

- ❑ Solicit commitment to review and reform policy from state agencies such as IHDLC and MHAC, private funders, businesses, insurers, advocacy organizations, and state institutions of higher learning.
- ❑ Identify and communicate key fiscal and policy issues to achieve health equity including:
  - Culturally competent preventative care to reduce burdens on community health
  - Capacity to support advocacy development
  - Mechanisms to measure the progress toward achieving health equity
- ❑ Utilize the Bringing Health Disparities into Public Policy and Practices Template as a tool for developing policy recommendations.
- ❑ Engage the executive branch of state leadership to review policy recommendations to make certain that uniform approaches to addressing health equity across state departments exists.

Strategy #2: Establish collaboration across state departments to improve funding to achieve health equity.

Responsibility: Community Level Advocacy Organizations
Timeline: May 2008 - Ongoing

Actions:

- ❑ Create flexibility in funding streams to allow for holistic approaches to service delivery.
- ❑ Develop solutions to assure multiple year funding for services in order to make sustainable impacts toward health disparities among community-level providers.
- ❑ Address the increasing complexity of Medicare and Medicaid reimbursement practices and the low reimbursement rates for providers.

Priority #3: Institute collaboration across sectors and disciplines; including local, state, and federal governmental agencies, and CBOs, including nonprofit organizations, foundations, and businesses.

Strategy #1: Build capacity within communities to educate stakeholders across sectors and to advocate for the elimination of health disparities.

Responsibility: IHDLC, Community Stakeholders
Timeline: January 2009 - Ongoing

Actions:

- ❑ Provide trainings, and programs that equip community members with leadership, educational and advocacy tools.

Priority #4: Ensure oversight and regulation to ensure that the development and implementation of policies are consistently evaluated.

Strategy #1: Create memoranda of agreements between the IHDLC and other statutory groups to identify committee members to implement various parts of the Colorado Health Disparities Strategic Plan.

Responsibility: OHD, IHDLC
Timeline: May 2008 - Ongoing
Actions:

- ❑ Continually evaluate policies to ensure relevant outcomes.
- ❑ Identify the state statutory groups that will be engaged as partners.
- ❑ Look at alignment of the Colorado Health Disparities Strategic Plan with the strategic plans of the statutory groups.
- ❑ Prepare an issue paper on collaborating across statutory groups to address health equity
- ❑ Hold a joint meeting of chairs of the statutory groups to discuss agreements of how the groups will work together and support each other in addressing health equity in policy and action.

V. **Workforce Diversity in Health Professionals/Cultural Competence**

A means to achieving cultural and linguistic competency in an organization is the strategic training, recruiting, hiring, enhancing and retaining of a diverse workforce. Cultural competence, and workforce diversity are also a mechanism by which to increase access to services by increasing the comfort, and comprehension consumers feel in health care settings. Cultural competence has been defined in many ways; for the purposes of this action plan, we will define it as follows:

> Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. (Adapted from Cross, 1989).

Priority #1: Increase workforce diversity among health and social services professions.

Strategy #1: Improve training, recruitment, placement, retention and enhancement of a diverse workforce in public health, health care, mental health and social services professions.

Responsibility: OHD, IHDLC, Recruiting and Retaining Youth of Color Task Force
Timeline: June 2008 – June 2009

Actions:

- Develop a Recruiting and Retaining Youth of Color Task Force
- Generate and support innovated approaches for creating a "pipeline" for health and social service professions. The pipeline should include rural and urban areas and tie in with professional organizations such as the Association of Black Physicians, Hispanic Nurses, and CAHEP.
- Develop partnerships with the Health and Human Services Professions.
- Conduct performance evaluation, with incentives, for groups or organizations who support and practice cultural competence and work force diversity.
- Connect with existing groups who are working on developing pipelines.
- Coordinate work diversity issues statewide by developing collaborative initiatives to engage schools and educators.
- Utilize IHDLC as an opportunity to share good practices; coordinate strategies and develop collaborative relationships.
- Identify and learn from successful efforts within state departments and within institutions of higher learning.
- Educate providers of the impact of cultural differences on care provided and medical outcomes.

- ❑ Educate providers of the impact of culture on health and wellness.
- ❑ Advocate for increased compensation rates for physicians who serve communities in a culturally competent manner.
- ❑ Actively encourage colleges/universities to integrate cultural competence within the core curricula of training for health care and social service students.
- ❑ Demonstrate the need for cultural competence with research.
- ❑ Ensure cultural competence trainers are qualified and culturally competent themselves.
- ❑ Identify and review restrictive policies that hinder diversity within state departments.
- ❑ Coordinate with the School of Public Health to improve diverse representation in the school's staff.
- ❑ Provide opportunities for disadvantaged persons to develop their capacity in advocacy and communications skills, which can help strengthen the pipeline.
- ❑ Conduct a cost benefit analysis comparing organizations that do and do not comply with cultural competence standards, and disseminate on the OHD website.

Priority #2: Retain a diverse workforce in health and social services professions.

Strategy #1: Provide opportunities for professional development, promotion from within, and standards to hold organizations accountable for workforce diversity.

Responsibility: Recruiting and Retaining Youth of Color Task Force, CDPHE Human Resources
Timeline: January 2009 - Ongoing

Actions:

- ❑ Actively mentor people of color to build their skills within the health field.
- ❑ Conduct performance evaluations around cultural competence.
- ❑ Educate and train senior management to eradicate tokenism.
- ❑ Aggressively develop environments that are welcoming and accepting of diverse populations on all levels
- ❑ Promote from within organizations and local areas that they serve.

Priority #3: Accountability

Strategy #1: Persuade leaders and policymakers to openly promote and endorse workforce diversity and cultural competency to combat health disparities.

Responsibility: OHD, IHDLC, MHAC
Timeline: May 2008 - Ongoing

Actions:

- ❑ Marketing campaign by OHD/IHDLC/MHAC.
- ❑ Performance evaluation of all government employees at all levels, including, boards, commissions, senior management, human resources, etc.

- Develop recommendations for state departments and institutions of higher learning to review recruitment, hiring, professional development and retention processes.
- Determine non-compliance with applicable civil rights laws, for example, Title VI as it pertains to Limited English Proficiency.

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VI. **Sustainability**

Health disparities are a result of complex social, environmental and other factors that have developed over time. Because of this, it will take time to eliminate disparities, and thus it is imperative, to achieve sustainable development- referring to the ability to continue an activity into the future or maintain a condition undiminished or improved over time. Sustainability involves integrated ecological, personal and social (including economic) goals and implies changes in behavior and practices by individuals and organizations.

Priority #1: Increase the representation of diversity on state departments, boards, councils, and commissions.

Strategy #1: Develop a plan both for the increase of appointment and volunteerism of diverse populations to state and local departments, boards, councils, and commissions.

Responsibility: IHDLC, Advocacy Organizations, OHD, Governor's Office, University of Colorado at Denver, and Programs of Higher Education, State and Local Boards, Commissions, Councils.
Timeline: May 2008 - January 2009

Actions:
- ❑ Identify and inventory local and state departments, boards, councils, and commissions, and impact and relevance on health disparities issues.
- ❑ Identify eligibility and application/selection processes for participation.
- ❑ Determine diversity and current leadership structure and how decisions are made.
- ❑ Increase opportunities to participate among local populations by developing recruitment/marketing strategies.
- ❑ Develop incentives for diverse community members to join, and incentives for state and local departments, boards, councils, and commissions to appoint/select diverse participation.
- ❑ Ensure continued participation by solidifying decision-making roles of diverse members on boards and eliminating tokenism in order to institutionalize recruitment/selection and retention of diverse members.

Priority #2: Sustainability, structure, and functions of OHD.

Strategy #1: Ensure sustainability of the Office of Health Disparities and strengthen funding to improve public health.

Responsibility: Advocacy Organizations, IHDLC
Timeline: January 2009 - 2011

Actions:
- ❑ Partner with organizations committed to eliminating health disparities.
- ❑ Require all *state* programs to allocate resources to the elimination of health disparities within their targeted category.

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- ❑ Develop OHD marketing strategy.
- ❑ Fund OHD offices within local health agencies.

Priority #3: Establish sustainable funding for OHD, IHDLC and MHAC.

Strategy#1: Develop plan for funding OHD, IHDLC and the MHAC.

Responsibility: CDPHE, OHD
Timeline: May 2008 - January 2011

Actions:
- ❑ Develop funding and needs assessment for addressing health disparities.
- ❑ Institutionalize OHD within the CDPHE
- ❑ Fund OHD at capacity.
- ❑ Build and establish relationships with advocacy organizations.

Priority #4: Engage private funding sources.

Strategy #1: Educate funding sources on health disparities issues.

Responsibility: IHDLC, OHD, CDPHE
Timeline: Ongoing

Actions:
- ❑ Recruit representatives from private funding sources for membership on IHDLC and MHAC.
- ❑ Meet with private funders to educate and raise awareness of health disparities issues.

Priority #5: Strengthen partnerships with institutions of higher learning and volunteer groups.

Strategy #1: Educate and utilize interns, students, retirees, and volunteers for addressing Health Disparities.

Responsibility: OHD, IHDLC, Volunteers and CBOs, University of Colorado, and Other Programs of Higher Education
Timeline: January 2008 - 2011

Actions:
- ❑ Identify needs of OHD, institutions of higher learning, volunteer and community based organizations and IHDLC.
- ❑ Develop and implement intern and volunteer program.
  - Identify roles and responsibilities
  - Provide supervision
  - Identify need areas
  - Recruit from multidisciplinary specialties
  - Provide incentives for volunteers.

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Priority #6: Ensure ongoing commitment to health disparities elimination.

Strategy #1: Follow up on relationships and programs and develop a strategic communication plan.

Responsibility: OHD, IHDLC, State and Local Health Department Staff, Volunteer Organizations, Students
Timeline: Ongoing

Actions:

- ❑ Provide leadership at state and local levels.
- ❑ Participate in state and local community events.
- ❑ Develop relationships in local communities.
- ❑ Assist in capacity building activities to identify resources and develop local programs and policies for addressing health disparity needs.
- ❑ Provide technical assistance to communities and organizations to meet local needs.
- ❑ Convene and facilitate meetings and forums to address local health issues.
- ❑ Encourage and assist in developing agreements between programs and other state and local agencies.
- ❑ Share working strategies across programs and agencies.

Acronym Glossary:

- ➢ CBOs: Community-Based Organizations
- ➢ CDPHE: Colorado Department of Public Health and Environment
- ➢ CEUs: Continuing Education Units
- ➢ CHEIS: Center for Health and Environmental Information and Statistics (CDPHE)
- ➢ CO.TRAIN: Colorado's Public Health Learning Management System
- ➢ CSI: Center for System Integration
- ➢ IHDLC: Interagency Health Disparities Leadership Council
- ➢ MHAC: Minority Health Advisory Commission
- ➢ MOU: Memorandum of Understanding
- ➢ OHD: Office of Health Disparities
- ➢ PSD: Prevention Services Division (CDPHE)

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