

THE **DRA** Accelerating Disparity  
Reducing Advances  
**PROJECT**



**DRA Partners Meeting September 29, 2008  
Meeting Summary**

## DRA Partners Meeting Summary

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## SEPTEMBER 2008 DRA MEETING SUMMARY

### Introduction

Health inequities are widespread problems that communities across the nation face every day. Healthcare disparities occur in a range of chronic and infectious diseases and affect racial, ethnic and low-income groups. From the neglected inner city to the isolated hills of Appalachia, poor health is endemic. The root causes of these disparities are difficult to identify. They arise from a range of factors such as poverty and a lack of education to a lack of access to quality health care and community structure. However, providing universal, continuous, integrated healthcare and championing community based prevention could prevent many of these disparities.

Representatives from a spectrum of leading health, voluntary, and government organizations gathered in Alexandria, Virginia on September 29th to discuss strategies to eliminate health inequities. They met under the aegis of the Disparity Reducing Advances (DRA) Project, IAF's multi-year, multi-stakeholder project to identify and accelerate advances that can reduce disparities in healthcare. The DRA Project is a three-year project supported by a network of organizations and individuals dedicated to eliminating health disparities. The DRA Project is supported by funding from the National Cancer Institute, the Agency for Healthcare Research and Quality, the Robert Wood Johnson Foundation, the Centers for Disease Control and Prevention, the American Cancer Society, the University of Texas Medical Branch, Novo Nordisk and Florida Hospital. A complete list of sponsors and partners involved with the DRA Project is located in the Appendix.

The September 2008 meeting focused on five areas which the DRA Project has focused on over the last three years. A distinguished partner tackled each topic, including Dr. Rochelle Rollins, who stood in for Dr. Garth Graham from the Office of Minority Health, and discussed partnership activities occurring in the federal government and the new Healthy People Goals. The participants also spent time discussing future goals for the next phase of the DRA Project as it enters into a new three-year cycle.

## DRA Project Scenarios

Part of the meeting tackled four scenarios on health inequities created by the DRA Project. IAF Founder & Chairman of the Board Clement Bezold went over the key trends captured by the scenarios and facilitated a large group discussion on the key issues to consider in relation to the scenarios.

The first scenario, *Gaps Grow*, extrapolates current trends over the next 20 years to envision worsening health inequities. The U.S. enacts goals and programs designed to “eliminate health disparities” and provide universal access to effective healthcare. Despite these advances, disparities will increase in the US over the next two decades because the more significant social determinants of health are not addressed. During this time healthcare access and quality improves yet the underlying factors of poor health and social determinates continue to remain unaddressed.

The second scenario, *Depression, Disasters & Self Protection*, looks at the worst-case scenario for health inequities based on current conditions. The triple threats of global economic disarray, global climate change and peak oil occur simultaneously, causing widespread stress across the United States, hitting underserved communities first. Natural disasters strike vulnerable communities and the government is incapable of responding. Society takes on a survival mindset that focuses on self and family first. Healthcare worsens and health disparities increase.

The third scenario, *Sharing the Burden*, looks at the best-case scenario for health inequities. Similar to the worst-case scenario, the U.S. enters into a Great Depression of the 21<sup>st</sup> Century caused by natural and manmade disasters. However, unlike the previous scenario, an economic hard time causes the country to come together around a New Fair Deal that radically changes our view of health and healthcare. This New Fair Deal creates more personal and family care along with more effective economic and social programs focused on the social determinants of health that leads to reductions in health disparities. More frugal and effective healthcare led by community health centers (CHCs) adds its contribution to reducing disparities, as well.

The last scenario, *Mind & Heart Shift*, looks at a visionary future for reducing health inequities. In this scenario, society changes its mind *as well as* its heart the same way it did in the 18th century on slavery and in the 20<sup>th</sup> century on segregation and women’s rights. This 21<sup>st</sup> century mind and heart shift occurs

towards equity and fairness, including health equity. New generations of inspirational leaders emerge from inside poor and minority communities to inspire the country to make justice and caring an active part of American ideals. These new leaders come into the community to tackle the social determinants of health and demand change from local, state and national governments. Based on their example, society recognizes the most important levers for health equity are the social determinants of health such as jobs, living wage, affordable housing, education, access to healthy foods, and safe, activity friendly neighborhoods.

Overall, the large group discussion on the scenarios was very constructive. A number of participants recommended changing the names of the scenarios to 'health equity' in order to focus on the issues of justice and fairness inherent in the aspirational scenario. Other participants questioned whether there needed to be a crisis in order to bring about a national understanding of health equity. Rather than waiting for a "mind and heart" shift, we can start now by convincing policy-makers, businesspeople and others that creating health equity makes monetary as well as ethical sense. As one participant suggested... "don't bother with people's hearts, but change their minds." Some felt that unnecessary hospitalization and the growth of preventable chronic diseases provide more than enough of a case for pursuing health equity. Others felt that subtler changes were occurring and could be amplified.

The group also suggested creating signposts for the scenarios and creating a workbook around the scenarios so the partners can use them in their organizations. The DRA Project will expand on these scenarios and create a "scenario kit" with signposts and exercise sheets to make the scenarios more useful for the Partner Network. The kit will be available in the reports section of the DRA Project webpage ([www.altfutures.com/draproject](http://www.altfutures.com/draproject)) by the end of the year.

## The Health Equity Movement: Developments in the US and Beyond

An expert panel of DRA Partners discussed developments in the Health Equity Movement both in the U.S. and abroad. Jeremy Cantor, from Prevention Institute, discussed events at the recent Congressional Black Caucus meeting and data showing that 1 in 3 African American males will spend time in prison and 1 in 4 school children in urban areas show signs of post traumatic stress disorder (PTSD). Violence is a key part of the health disparities puzzle and is a determinant of a range of health issues including mental health, asthma, and nutrition and physical activity. Prevention Institute is working to prevent violence in communities nationally through the UNITY Program (Urban Networks to Increase Thriving Youth). Prevention Institute is also developing recommendations and evidence for the next administration on how to support prevention through investment and aligning decision making with health. For example, a recent report they authored with Trust for America's Health, based on a model created by Urban Institute, demonstrated that a \$10 per-capita investment in community-level prevention nationally (targeting nutrition, physical activity, and tobacco use) could lead to a 5% reduction in disease and over \$16 billion in annual savings within 5 years. Such economic analysis is vital to public policy and needs to be incorporated in the analysis of government bodies such as the Government Accountability Office (GAO) and Congressional Budget Office (CBO).

Linda Blount, from the American Cancer Society (ACS), reviewed the most recent research that ACS is conducting in disparities and cancer. The data clearly shows the importance of having insurance both before and after diagnosis of cancer. The likelihood of having late stage breast cancer is much higher for those on Medicaid or uninsured. Education is also major factor in self-assessing and monitoring one's health. However, even if you control for insurance, minority populations are still more likely to have late stage breast cancer. This indicates that socioeconomic status plays a role in cancer outcomes since there is no known genetic predisposition for breast cancer linked to race/ethnicity. On the value of Patient Navigators, the ACS data indicates that for every \$35,000 paid for Community Navigators 5 times more money will be saved.

Joyce Essien, who works with Emory University and the Centers for Disease Control and Prevention, directly addressed the health of the health equity movement, coming to the conclusion that it is not healthy at all. For example, infant mortality in the United States is on the same level as countries like

Cuba and Croatia, yet well below other developed nations such as Sweden. This dismal statistic is due largely to health inequities. Additionally, the problems of health equity are often stated, but little evidence exists to indicate a clear resolution. There needs to be more experimental research to test out the various options and propagate those interventions that work. There is a tremendous opportunity for the DRA Partners to work together on policy and program recommendations that directly address the benefits, in both dollars and health, of eliminating health inequities.

Alexandra Nolen, from the University of Texas Medical Branch and formerly on the Secretariat staff of the WHO Commission on the Social Determinants of Health, provided an international perspective on the health equity movement. Dr. Nolen highlighted the report, [Laying the Groundwork for a Movement to Reduce Health Disparities](#), written by the DRA Project and Prevention Institute, as an excellent summary of opportunities and challenges facing the health equity movement. She specifically referred to a number of actions that need to occur, including:

- The need for a high level of leadership to support the movement
- A strong bottom-up structure to enhance and empower local leadership and community groups
- The health care system itself needs to become more rational
- Intersectoral action to address various determinants of health
- Identifying public policies that either better support health or could undermine health
- Careful “messaging” of issues to align with other interest groups

The WHO Commission worked with a number of countries to jump-start such movements, while the Global Equity Gauge Alliance (which Dr. Nolen was the previous coordinator of) developed and operated programs in 13 countries working on health equity and the social determinants of health. There is much that can be learned from these grassroots efforts that can be applied to the health equity movement in the U.S.

In the United States, health equity runs the risk of being pushed aside in the political debate due to the economic and financial difficulties currently facing the nation. However, these crises should also be seen as an opportunity to draw attention to supporting a more rational health system. To regain momentum for the health equity movement requires action from the bottom-up that connects with other priorities such as education, transportation and energy, while also linking with other movements such as the “Smart Growth” movement. Primary health care providers are not enough to create real change in either health equity or the social determinants of health. Rather, real change will require the healthcare community to work with a wide variety of groups such as transportation and housing planners, city

officials, child care advocates, architects, engineers, the media, and the donor community. Training and health impact assessments are the keys to linking the social determinants of health in these areas, and must include reaching out to other sectors in a more integrated and sustainable way.

The DRA Project will continue its focus on promoting the health equity movement through the release and use of the Health Equity Scenarios. The DRA Project will also be holding a briefing on Capitol Hill in early 2009 that will discuss the role of the social determinants. We will also be fostering or supporting planning sessions for the Health Equity Movement.

## Disparities & the National Partnership

Rochelle Rollins, Director, Division of Policy and Data in the Health and Human Services/Office of Minority Health (HHS/OMH), discussed the work on health disparities at the Office of Minority Health. The mission of the Office of Minority Health (OMH) is to improve and protect the health of racial and ethnic minority populations through the development of health policies and programs that will eliminate health disparities.

A key part of the OMH's work is the implementation of the National Partnership for Action (NPA) to End Health Disparities. The NPA believes real action starts at the community level and endeavors to establish a nation-wide, comprehensive, community-driven, sustained approach to ending health disparities. The 5 NPA Objectives are 1) increase awareness of health disparities, 2) strengthen leadership at all levels, 3) improve patient-provider interaction and communication, 4) improve cultural and linguistic competency and, 5) improve coordination and utilization of research and evaluation outcomes. The NPA is accepting requests for partnership through its website [www.omhrc/npa](http://www.omhrc/npa) and the DRA Project has applied to be a partner. One of the contributions that the DRA Project Partners can make to this effort is identifying other government and non-governmental organizations for OMH to partner with. A Visionary Panel will help create a National Blueprint for Action. The OMH is looking for nominations for the Visionary Panel which will meet in early November 2008. The National Blueprint will be released at the OMH Third National Leadership Summit on February 25-27<sup>th</sup>, 2009.

Dr. Rollins also discussed developments with regard to the progress of Healthy People 2020. The Healthy People 2020 goals will be vital to the future work of the DRA Project and the OMH. The OMH is closely involved with other agencies in developing the Healthy People 2020 goals including advocating for a health disparities goal and a criteria that links to the goal. This is a critical time for the development of the Healthy People 2020 goals and the Healthy People 2020 website is still open for public comment. Dr. Rollins encouraged all the Partners to go to the [site](#) and contribute to the public comments.

## The HRSA Health Disparities Collaboratives and Their Evolution

The DRA Project has been working closely with Ahmed Calvo and HRSA on the evolution of their Health Disparities Collaboratives. The Collaboratives are a 10 year-old activity that brings a systems focus to quality improvement of community health centers. The Collaborative process has been utilized in health centers on conditions such as diabetes, cancer and other conditions. It has also been utilized in the fields of patient safety, pharmacies, and the operations of the community health centers. The work on the Health Disparities Collaboratives is part of the DRA Project's work on the Expanded Care Model, one of the eight priority areas of the DRA Project. Dr. Calvo discussed the Expanded Care Model and how it represents the evolution of the HRSA Health Disparities Collaboratives. The Expanded Care Model takes the medical home concept beyond the walls of the clinic and hospital, positing that health care requires a team level approach that extends to primary prevention (lifestyle choices, habits, etc). An Expanded Care Model paper co-authored by the DRA Project and Ahmed Calvo will be available soon.

David Stevens, from the National Association of the Community Health Centers (NACHC), also joined the panel. Stevens discussed his work as the previous director of the Health Disparities Collaboratives at HRSA. The Health Disparities Collaboratives recognize that knowledge management and effective partnerships are keys to good healthcare and works to provide support to HRSA service delivery organizations and partners. HRSA support includes systems to communicate new methods for improving care and programmatic support.

Wayne Jonas, from the Samueli Institute, also joined the panel to discuss the DRA Project's work with other Partners around the Integrated Care Model. The Integrated Care Model combines the Expanded Care Model with complementary and alternative medicine (CAM). In April of 2008, the DRA Project, in partnership with the Samueli Institute, held a meeting on the Integrated Care Model in Alexandria, VA. The attendees discussed key items for integrated care including: 1) evidence and quality issues, 2) the role of CAM in providing patients with tools for self-care and empowerment, 3) the use of cultural practices as gateways for enhanced access and care, 4) and a philosophy that seeks to enhance well-being and healing as complementary to the treatment of illness. The participants also discussed the need to identify the state of practice for CAM and pass that information onto funding agencies and community health centers. The ability to add CAM to an expanded model of care has the potential to

reduce health disparities in ways that are culturally appropriate, reducing costs and dependency on medical care.

The DRA Project will work with the Samueli Institute and HRSA to develop a Vanguard Group to pursue effective, appropriate use of CAM and integrated medicine in community health centers. The DRA Project will also work with NACHC to do a Capitol Hill briefing on the Health Disparities Collaborative and their evolution on November 24<sup>th</sup>, 2008. Finally, The DRA Project will work with HRSA on the development of the Expanded Care Model and the integration of the social determinants of health and integrative medicine into the focus of community health centers.

## Biomonitoring & Reducing Disparities: Update and Next Steps

In July of 2008, the DRA Project, in partnership with Dr. Molly Coye, founder and CEO of the Health Technology Center, held a high level meeting at the Academy for Education Development on the Future of Biomonitoring for Reducing Disparities. The DRA Project had looked over developments in biomonitoring and found that the forecasts in 2006 for important developments are on track. Yet a number of biomonitoring advances are currently available that can reduce health disparities. The problem is not that the technology does not exist or needs to be created; rather innovation needs to occur that repurposes existing technologies to the problem of health disparities. Some of the trends discussed at the meeting include the shift in care upstream to earlier diagnosis and treatment, minimally invasive therapies and in-home biomonitoring. These biomonitoring and related advances may cause a shift toward community health workers deployed by nurses and physicians, rather than relying solely on doctors and nurses themselves. Simultaneously, new models of care using existing technologies are emerging, for example the shift to chronic care management from episodic care.

However, there are significant barriers to deployment of these technologies both in the healthcare system and those parts of the system that serve poor and minority communities. These obstacles include reimbursement issues, the legal and regulatory frameworks, lack of infrastructure in rural areas, need for technical and operational talent, lack of technological literacy by patients and providers, and the concern of physicians about the loss of traditional care patterns. These barriers are not technical, rather they are related to finances, business models, culture, or training.

Joshua Seidman from the Center for Information Therapy was one of three DRA Partners who also attended the Future of Biomonitoring for Reducing Disparities meeting, and was a panelist at the DRA Partners Meeting. Seidman believes the key to ensuring that biomonitoring technologies reduce disparities is to link new technologies to the needs of real people. Technology developers need to think about the interfaces of these technologies, linking them to usable information and making it easier for people to access the information they need.

Cheryl Austein-Casnoff, from HRSA and a working group on HIT and Disparities, discussed how health information technology (HIT) has the potential to reduce health disparities. Information technology can either be a great equalizer or a great divider; it can empower disadvantaged groups and break down silos between sectors. For example, Personal Health Records (PHRs) can empower patients with their own health information. PHRs can also aid care, especially in migrant populations, populations with episodic healthcare and in communities devastated by disasters.

However, HIT is not a panacea. Some have portrayed HIT as a magic bullet that can go right to the heart of the problems in the U.S. healthcare system. HIT can improve efficiency and quality of care, but it will not remove the underlying problems that challenge our healthcare system. In many ways, the policy discussions over HIT mirrors the discussions over managed care in the 1990's where managed care was thought to be the solution to cost and quality challenges of the healthcare system.

David Ellis, from the Detroit Medical Center, described the entrance of new technology in healthcare as 'an earthquake rocking the foundations of the healthcare system' and described changes in four broad areas. To begin with, technology will allow increased *simplification* as seen already by the growth of sophisticated surgery done by less specialized practitioners, the growth of outpatient clinics and physician extenders. Simplification of care lowers costs and makes more procedures available to poor and marginalized populations. Simplification also ties into the growing trend of *automation* in healthcare. Robot assisted surgery, clinical decision aids and home monitoring devices all allow for the simplification of care. It allows machines to do what doctors and patients once did while patients take over some of the doctor's rolls.

The trend of *globalization* is already changing medicine by allowing radiologists in India to read scans from the United States, leading to the growth of medical tourism and advances in tele-medicine and

tele-surgery. Better technology for communication and travel will extend the trend of globalization, although it is unlikely to help those communities that do not have access to care in the first place. Finally, there are a number of technological advances that will form *post-modern medicine*. Stem cell therapies, implanted tissue, engineered organs, molecular medicine and bionics will all create new options for care. Non-invasive surgery, digital medicine based on advanced computer simulations and integrative medicine will transform the delivery of care. The key for reducing disparities with these advances is ensuring that underserved populations have access.

The DRA Project will continue to monitor developments in Biomonitoring, encouraging pilots in low income and minority communities and their providers. We will also continue to work with Federal Agencies on their approaches to biomonitoring and disparities, and periodically update our forecasts.

## Navigators & Disparities

One of the most persistent disparities in the healthcare system is the inability of poor and minority patients to navigate the maze of rules, regulations and institutions to access the care they rightly deserve. This is a separate issue from access to care in the first place, however. It focuses on the disparities resulting from the inability of patients and health care providers to ensure that patients are able to receive appropriate care. For poor and marginalized patients, initial disparities in incidence of disease parallel the inability of patients to navigate healthcare systems. This is particularly true where treatment is complex and specialized, such as cancer treatment, and where patients have multiple, uncoordinated providers for different chronic conditions.

A panel consisting of Maria Lemus, from Vision Y Compromiso, Angelina Esparza, from the American Cancer Society (ACS) and Craig Bettles, from the Institute for Alternative Futures discussed navigators and disparities. Lemus discussed her work with promotoras and health workers as well as some of the differences between patient navigators and promotoras. Vision Y Compromiso is an umbrella group that brings together community health workers and promotoras to improve care in the California Latino community. Lemus used a video and discussion to highlight the importance of volunteerism and service, as well as the promotoras connection to their community.

Lemus observed that promotoras often differ from patient navigators by working directly in the community addressing the social determinants of health while patient navigators deal primarily with the medical system. Promotoras also differ from community health workers in that health workers usually have formal healthcare training while promotoras are drawn directly from the community and receive their training from programs like Vision Y Compromiso. She also voiced the fear of many in the community health movement and the promotoras community that payment for services and institutionalized standards for promotoras would ruin the spirit of the movement and reduce the pool of available promotoras. Making navigation a sustainable advance will require a large pool of promotoras and therefore too many institutionalized standards could be counterproductive.

Angelina Esparza discussed the work ACS is doing in patient navigation. Unlike promotoras, ACS patient navigators start with cancer diagnosis and work to overcome barriers to care and identify resources. The ACS sponsors navigators in 130 sites across the country. The current state of science supports the claim that patient navigators are decreasing disparities, but more analysis is needed. Navigation increases screening and optimizes the use of resources. Currently, the patient navigator community is discussing the role of navigators, payment for services and how they should be tiered and integrated with other service providers.

Craig Bettles from the Institute for Alternative Futures provided an overview of previous work by the DRA Project in the area of Consumer/Patient Navigation. Consumer/Patient Navigation was one of the original priority areas identified for the DRA Project, resulting in the release of two papers on the subject: [Enhanced Consumer Navigation Support](#) and a [Patient Navigation Overview](#). The DRA Project has also discussed electronic enhancement of navigation activities at previous DRA Partners Meetings. Currently the DRA Project has been tasked by its Partners and Dr. Harold Freeman to conduct a survey on patient navigators. The online survey looks at who patient navigators are and what they do in an attempt to address the long-term sustainability of their work. The survey will be open through November 14<sup>th</sup>, 2008. Please contact Craig Bettles at [cbettles@altfutures.com](mailto:cbettles@altfutures.com) to get involved.

## Next Steps and Commitments

IAF and its Partners are committed to moving forward with the next phase of the DRA Project. The Centers for Disease Control and Prevention, the American Cancer Society, the University of

Texas Medical Branch, Novo Nordisk, the Health Resources & Services Administration and the National Institutes of Health have already committed to sponsorship and funding related projects. The Agency for Healthcare Research & Quality and Florida Hospital are also considering sponsoring the next phase of the DRA Project. The DRA Project will continue discussions with other funding sources and raise resources. The next phase of the DRA Project will pursue the topics listed above as well other ongoing efforts on tobacco control, modeling and mapping, congressional briefings and the newsletter. The DRA Project is currently pursuing a large conference grant from AHRQ for the next DRA Partners Meeting to be held on November 9<sup>th</sup> and 10<sup>th</sup>, 2009, so save the date.

**For more information or to join the DRA Project contact Craig Bettles at  
cbettles@altfutures.com.**

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# Appendix: DRA Project Sponsors & Partners

As of October 2008

## DRA Founding Sponsors

National Cancer Institute

Agency for Healthcare Research and Quality

## DRA Sponsors

Robert Wood Johnson Foundation

Centers for Disease Control and Prevention

American Cancer Society

Novo Nordisk

University of Texas  
Medical Branch

Florida Hospital

## DRA Partners

Active Living by Design

Alliance for Health Reform

American College of Nurse Practitioners

American Diabetes Association

American Health Assessment Association

Bastyr University

BodyMedia, Inc.

The Brady Center to Prevent Gun Violence

California Newsreel

Center for Applied Research and Environmental Systems (CARES)

University of Missouri

Center for Community Health Education Research and Service, Inc. (CCHERS)

Center for Future Health at the University of Rochester

Center for Information Therapy

Center for Integration of Medicine and Innovative Technology (CIMIT)

Center for Minority Health at the University of Pittsburgh

Center for Public Health Practice at Emory University

Central Florida Family Health Center

City Year Detroit

Clinical Directors Network

Convenient Care Association

Corporate Office of Science and Technology (COSAT), Johnson & Johnson

CRW, Inc.

Detroit Medical Center at Wayne State University

Directors of Health Promotion and Education

DrTango, Inc.

El Paso Diabetes Association

Families USA

Health Care Center for the Homeless, Inc.

Health Resources and Services Administration (HRSA)

Hebni Nutrition Consultants, Inc.

Henry Ford Health System

Hill Health, New Haven, Connecticut

Institute for Alternative Futures

Institute for Community Health

Institute for the Elimination of Health Disparities at  
The University of Medicine and Dentistry of New Jersey

Institute for Healthcare Improvement

Institute for Palliative & Hospice Training, Inc.

Integrated Healthcare Policy Consortium

Intercultural Cancer Council

The Joint Center Health Policy Institute

Joseph P. Addabbo Family Health Center, Inc.

Lance Armstrong Foundation

Maryland Department of Health and Mental Hygiene

Medical Automation Research Center at the University of Virginia

Mobile Dentists and Children's Dental Health Foundation

National Assembly of School Based Health Care

National Association of Community Health Centers, Inc.

National Association of Social Workers

National College of Natural Medicine

National Medical Association

National Nursing Centers Consortium

Office of Disease Prevention and Health Promotion (ODPHP)

Outside In Clinic

Policy Analysis Center

Planetree

Prevention Institute

Resource Center for Health Policy at the University of Washington

Samueli Institute for Information Biology

The School of Social Welfare at Stony Brook University

Siemens Communications, Inc.

The Society for Social Work Leadership in Health Care