2024

ANNUAL REPORT

IMPACT AND SOLUTIONS

HealthTeamWorks®

A Special Thanks
To Our Supporters

We are thankful for our clients, donors, funders, partners and volunteers. Without whose support we could not accomplish all that we do.

Health Forward FOUNDATION

Telligen® Community Initiative

Sunflower Foundation

Table of **Contents**

Letter from the CEO: **Cecilia L. Saffold**

Dear Colleagues, Partners, and Friends,

Reflecting on 2024 to prepare this report filled me with immense gratitude for the collective accomplishments of HealthTeamWorks. This year, we built upon our strong foundation, leveraging our history of transformative work in value-based care, population health, and health equity. From our contributions to federal healthcare innovation models to local and regional transformation initiatives, we have consistently focused on improving patient outcomes, reducing costs, and enhancing care delivery across the nation.

Our success is rooted in our ability to adapt and lead in evolving health care landscapes. For example, through our partnerships, we have supported primary care and specialty practices in integrating behavioral health services, aligning clinical and community resources, and adopting new care models. Our projects have exemplified our ability to foster long-lasting change in care delivery and health outcomes—advancing efforts to provide accessible, compassionate, and comprehensive care for all.

As we look toward 2025 and beyond, our vision includes deepening our support for value-based payment models, particularly as we continue to coach and provide technical assistance to providers striving for excellence in care delivery in programs like the Colorado Alternative Payment Model 2.

We are also committed to advancing integrated care delivery, driving innovation in digital health adoption, and addressing health-related social needs through our community-led programs and advocacy. Dedicated to health equity, we will continue to forge partnerships that enable systems to deliver culturally responsive care and to address the unique challenges faced by older adults, veterans, and those living with disabilities.

In 2025, we will deepen our support for strategically implementing digital health solutions and learning platforms to better equip care teams with the tools and knowledge needed for sustainable transformation. I am confident that our values of innovation and collaboration will guide us as we pursue our mission to collaboratively improve health outcomes and advance equity in health care.

Thank you for your continued trust and partnership.

Sincerely,

Cecilia L. Saffold, MBA

Chief Executive Officer, HealthTeamWorks

HealthTeamWorks helps transform **the way health care is delivered.**

HealthTeamWorks exists to solve complex health care problems in the pursuit of health, equity, and resilience. We collaboratively transform healthcare through performance improvement, organization development, and training resulting in a strengthened community and culturally responsive high-quality care.

Performance Improvement

HealthTeamWorks' expertise and solutions aim to improve outcomes and efficiency while reducing costs and risk. We identify key performance priorities and objectives, then leverage quality and process improvement principles to achieve your goals.

Organization Development

HealthTeamWorks focuses on helping organizations build capacity for meaningful change. We assess the current state, clarify strategic focus and help you define a clear path forward, offering a significant competitive advantage.

Training

HealthTeamWorks' training programs transfer knowledge, build capabilities and skills, and enhance productivity, ultimately resulting in high performing, highly engaged individuals, teams, and communities.

Practice Transformation

At HealthTeamWorks, we prioritize equipping care teams to meet the needs of their patients in a rapidly evolving health care landscape.

Focused on advancing health through our transformation services, we have helped practices integrate key elements of population health management, such as risk stratification, data-driven decision-making, and care team collaboration.

National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) and Patient-Centered Specialty Practice (PCSP) recognitions serve as our gold standard for practice transformation. By helping practices achieve these recognitions, we've ensured that they deliver coordinated, patient-centered care that improves outcomes while fostering greater provider-patient trust.

We maintain our designation as NCQA Partner in Quality, which reflects our role as a trusted partner in helping practices achieve and maintain high standards of care. We remain steadfast in our commitment to comprehensive and sustainable practice transformation and look forward to continuing our work in supporting practices and care teams as they strive for excellence and equity in health outcomes.

Facilitating Quality Improvement Training: ***Empowering Change in Health Care***

HealthTeamWorks' Facilitating Quality Improvement (QI) Training equips health care professionals with the tools and strategies to drive meaningful, sustainable improvements within their practices. Participants learn to use data, process mapping, and Plan-Do-Study-Act (PDSA) cycles to identify gaps, implement solutions, and measure outcomes. We offer a variety of learning formats—online, virtual, and in-person—allowing learners to choose the option that best suits their needs.

HealthTeamWorks' Practice Transformation services help healthcare practices transition from volume to value-based care. With over 25 years of experience, we offer tailored coaching, resources, and consultation to drive continuous improvement through actionable data, patient engagement, integrated services, and community partnerships. Our support includes NCQA recognition, performance improvement, workforce development, and customized solutions based on each practice's goals.

What We Deliver:

- NCQA Recognition: Tools, coaching, and resources to achieve NCQA PCMH/PCSP recognition.
- Custom Transformation: Support in performance, financial management, and behavioral health integration.
- Workforce Wellbeing: Focus on leadership, burnout prevention, and workplace efficiency.
- Proven Process: Over 25 years of experience in delivering better clinical outcomes and lower costs.
- Comprehensive Resources: Access to tools, training, templates, and data, tailored to each practice's needs.

Learn More About Our Practice Transformation Work:

Scan the QR code for more on our approach to Practice Transformation.

Hanna Moffett brings over nine years in health care and 15 years in telecommunications to our work. As Program Manager, she oversees client project management, tool and resource design, marketing, and website operations. Having been with HealthTeamWorks since 2015, she played key roles in the Comprehensive Primary Care (CPC) and CPC+ initiatives. Known for her event management, communication strategies, and process improvement expertise, Hanna brings a global perspective from her career at Nokia and her multilingual background.

Hanna Moffett
Program Manager

Value-Based Care:
Health Equity through APM Success

What is APM Success?

Achieving success in Alternative Payment Models (APMs) is not just about financial sustainability—it's about delivering high-quality care that meets the needs of patients.

Achieving success in Alternative Payment Models (APMs) is about delivering high-quality care that meets the needs of all patients.

Our expertise in guiding organizations through the transition from volume to value is deeply intertwined with our commitment to health equity. By aligning care delivery with value-based care models, we ensure that vulnerable and underrepresented populations receive the comprehensive, patient-centered care they deserve.

Building on our experience with initiatives like Comprehensive Primary Care Plus (CPC+)—which supported over 2,800 primary care practices in optimizing their care delivery—HealthTeamWorks continues to drive value-based transformation across the country. Our involvement in many past and active national care delivery payment innovation models further demonstrates our ability to lead improving outcomes, reducing costs, and addressing health disparities.

Colorado's Alternative Payment Model 2

Currently, through a Train-the-Trainer program, we are supporting providers in successfully participating in Colorado Alternative Payment Model 2 (APM2). APM2 prioritizes patient experience and high quality and appropriate utilization as gateways to shared savings incentives.

By integrating population health management, digital health solutions, and risk stratification in our approach, we equip care teams to improve care for vulnerable and high-risk populations.

We believe that value-based care models, when properly implemented, have the power to close gaps in care and deliver better outcomes for all patients—regardless of their background or socioeconomic status.

Digital Health and Data Analytics: **Enhancing Care Delivery**

KC Health Equity LAN & Improved Health Outcomes

The Kansas City Health Equity Learning and Action Network (LAN) advocates for effectively using race, ethnicity, and language (REL) data to address disparities in health outcomes. By collecting and analyzing REL data, health care providers can proactively identify disparities and gaps in care and implement targeted interventions for impacted patients. The LAN's work exemplifies the power of data in advancing health equity and improving maternal morbidity and mortality.

Custom Risk Stratification Algorithm for Fully Capitated Primary Care Organizations

HealthTeamWorks led the development of a two-step risk stratification algorithm as part of an initiative to enhance care management and population health infrastructure in a fully capitated primary care organization. The dynamic algorithm, uses a weighted scoring system to identify moderate to high-risk patients who are then prioritized for care management and targeted interventions to improve care outcomes. We provided practical tools, including data dictionaries, standing orders, and staffing model examples, to ensure seamless integration into system workflows.

Digital health and data analytics propels health care organizations forward with the information and insights needed for smarter, data-driven decision-making. Our consulting services help practices optimize the use of patient portals and electronic health records (EHR), ensuring seamless integration with daily work flows and optimized risk stratification and population health management strategies. Our approach coaches care teams to identify high-risk patients, coordinate care, and track progress more efficiently, ultimately improving patient outcomes. We support the incorporation of Remote Patient Self-Monitoring technology into clinical workflows, helping practices establish processes that improve chronic disease management and patient engagement.

Our role on the advisory council for the Colorado All Payer Claims Database (CO APCD) has been pivotal in shaping strategies to better utilize comprehensive claims data for population health management, cost containment, and quality improvement across the state. This involvement enables us to guide health care providers in using publicly available data more effectively to improve outcomes and streamline care.

As we look ahead, we will continue to drive innovation in digital health by helping practices harness the power of data analytics and emerging technologies to deliver more personalized, efficient care.

Behavioral Health Integration: **Advancing Integrated Care Delivery**

In 2024, HealthTeamWorks continued to lead efforts in Behavioral Health Integration (BHI), ensuring that behavioral health services are seamlessly incorporated into primary care settings and vice versa. Our expertise in integrated care delivery empowers practices to offer comprehensive, patient-centered care that addresses both physical and mental health needs.

BHI Implementation in KS Rural Health Centers

HealthTeamWorks partners with the Sunflower Foundation to support rural health centers in Kansas as they implement Behavioral Health Integration. We provide technical assistance and quality improvement coaching, helping these centers address gaps in mental health services and deliver holistic, patient-centered care in rural settings.

Implementation Support for MOUD and BHI In Colorado

ISM focuses on training primary care teams to provide medication for opioid use disorder (MOUD). Our team coaches and trains Co care teams to build confidence in treating opioid use disorder. This life-saving program ensures that more patients receive the care they need. Under the Colorado HB 1302 program, our team supports practices creating integrated care models that meet patients' mental and physical health needs.

Mid-America Mental Health Technology Transfer Center

Through MHTTC, in partnership with the University of Nebraska, HealthTeamWorks provided technical assistance to Community Behavioral Health Clinics in HHS Region 7. We directly trained and advised clinics implementing evidence-based mental health practices and integrating behavioral health into primary care, improving access and outcomes for patients with serious mental illness.

Angela Schindler-Berg brings twenty-six years of experience in community-based behavioral health, trauma-informed care, crisis intervention, and integrated care to HealthTeamWorks. She played a key role in Nebraska's CPC+ initiative and supported the University of Nebraska Medical Center in leading the Mid-America MHTTC. Angela coaches behavioral health organizations integrating primary care in Colorado HB-1302 Behavioral Health Integration Initiative and leads our work to Implement BHI in eight Kansas Rural Health Centers funded by Sunflower Foundation projects.

Angela Schindler-Berg
Project Lead & Facilitator

HealthTeamWorks delivers tailored solutions for integrating behavioral health into primary care, recognizing that no one-size-fits-all model works for all organizations. Our approach emphasizes whole-person care by addressing diverse behavioral health needs, such as substance use disorder, chronic pain, trauma, and severe mental illness, through culturally sensitive and fully integrated team-based models. HealthTeamWorks supports practices with technical assistance, coaching, and workforce development to drive sustainable improvements, enhance efficiency, and reduce burnout and compassion fatigue.

Learn More About Our Integration Care Services:

Scan the QR code for more on our approach to Behavioral Health Integration.

What We Deliver

Tailored Behavioral Health Solutions

We conduct needs assessments and recommend approaches to integrated team-based models of care to meet the needs of target populations.

Comprehensive Practice Support

We offer technical assistance, workforce development, stigma training, and coaching to enhance behavioral health integration and improve care delivery.

Whole-Person Care Focus

We guide clinical, cultural, and organizational changes to promote collaboration, shared outcomes, and patient engagement in care.

Data-Driven Improvement

We use data collection and analysis to identify care gaps, evaluate performance, and support decision-making for enhancing services.

Workforce Development

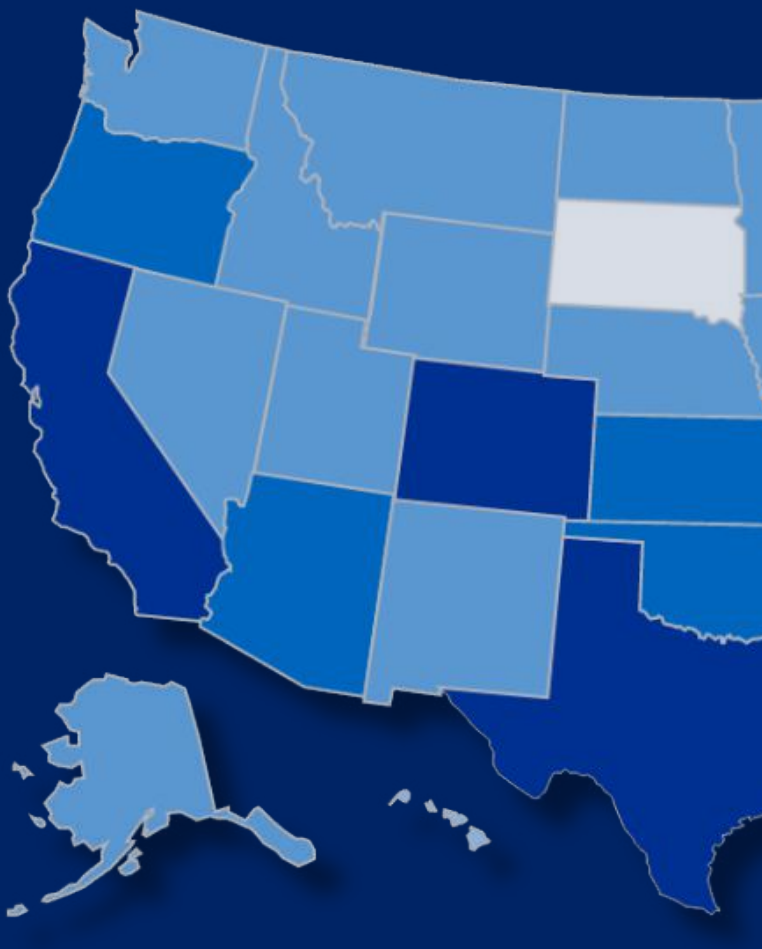
We address burnout, leadership development, and integrated care workforce training and coaching to create sustainable care environments.

Impact and Solutions

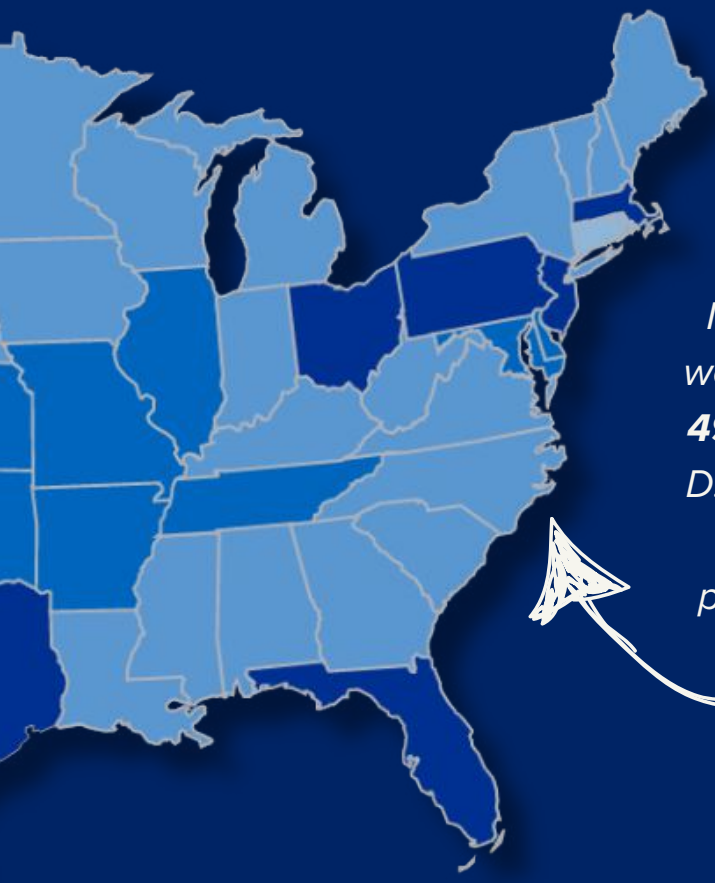
Our Growth

2022

2023



Evidenced by the practices we engaged and patient lives touched, we have made significant strides in promoting value-based, population health, and whole-person care models. Our focus on building resilience in primary care and fostering strong community-clinical linkages has equipped practices to meet the challenges of today's health care landscape.



*In 2024 our work spanned **49** states and D.C., touching **690,000** patient lives.*

> It is so hard to make time to take an online training, but this was one of the few that brought me meaningful knowledge and perspectives on the topics and stimulated reflection on the ways I can do better in my clinical setting. I highly recommend it to all healthcare workers.
>
> Sandra Beirne, MD
> Culturally Relevant and Affirming Care Training

3,587 Organizations Impacted

184 Practices Engaged in Transformation

313 Health Professionals Trained

Population Health:
Care to Improve Health Overall

HealthTeamWorks provides proven strategies to help healthcare organizations build population health infrastructure, equipping care teams to address physical, mental, and social factors impacting health. Through training, coaching, and leadership development, they enable organizations to enhance care management, improve patient outcomes, and foster patient activation. HealthTeamWorks focuses on risk stratification, data utilization, and care team integration to successfully meet population health needs and increase patient satisfaction.

What We Deliver:

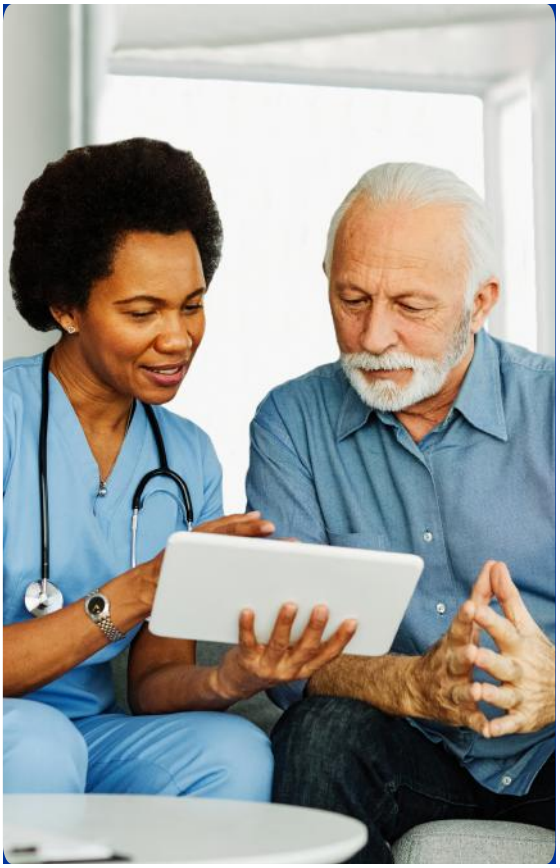
Population Health Infrastructure	Care Management Training	Leadership Development	Patient Activation & Engagement	Tailored Strategy & Implementation
Support for empanelment, risk-stratified teaming, and actionable data to address population health needs.	Essential and intermediate training for managing high-risk patients and integrating interdisciplinary care teams.	Guidance on overcoming barriers like staffing, role clarity, and securing provider and team buy-in for care management success.	Tools and processes that promote self-care management and improve patient outcomes through a holistic approach to care.	Collaboration to align workflows, define success measures, and incorporate infrastructure based on social determinants of health and community needs.

Care Management: **Workforce Development**

HealthTeamWorks' Care Management Trainings provide comprehensive, online learning paths for care managers, from foundational skills to advanced leadership strategies. The courses cover essential care management techniques, working with high-risk populations, care team integration, and developing effective population health infrastructures. With a focus on reducing costs, improving patient outcomes, and preventing burnout, these trainings equip care managers and leaders to excel in today's healthcare landscape.

Learn More About Our Care Management Trainings:

Scan the QR code for more on our current Care Management Training opportunities.



What We Deliver:

- Essentials of Care Management: 15 online courses covering patient engagement, population health, care management processes, and patient-centered techniques like motivational interviewing.
- Intermediate Care Management: Advanced training for care managers focusing on high-risk populations, interdisciplinary team integration, and addressing social needs.
- Leading Care Management: Provides leaders with strategies for planning, hiring, coaching, and implementing population health solutions and care management programs.
- Benefits of Care Management: Reduces hospitalizations, treatment costs, and redundant processes, while improving medication management, patient outcomes, and care team communication.
- Support for Vulnerable Populations: Training emphasizes care management for high-risk groups, integrating behavioral health and addressing social determinants of health for comprehensive care.

Population Health Career Lattice: **Building Workforce Resilience**

In 2024, HealthTeamWorks continued to expand its impact on workforce development through the Population Health Career Lattice (PHCL), a program designed to address critical workforce shortages while advancing health equity. Our innovative approach focuses on providing a clear, structured pathway for individuals to advance from entry-level to experienced community health worker (CHW), care management (CM) clinical health coaching (CHC) roles. This career lattice empowers individuals to develop their skills, serve their communities, and take on leadership roles in health care.

This year, we were honored to receive a grant from the Telligen Community Initiative (TCI), which supports our efforts to foster a diverse and skilled workforce. The TCI grant funding allows us to expand the PHCL by enhancing training opportunities and providing additional resources to participants, including student stipends and funds to mitigate emergency childcare, health, transportation and housing challenges trainees may encounter. The grant also enables us to strengthen partnerships with primary care providers, local health systems, public health departments, and community-based organizations, ensuring a broad network of support for those entering the health care workforce.

By focusing on building workforce capacity and addressing trainee health related social needs, the Population Health Career Lattice not only creates opportunities for individual growth but also contributes to the overall health of the communities we serve. As we move forward, we remain committed to addressing health inequities by ensuring that diverse, skilled professionals are empowered to meet the physical, behavioral, and social health needs of all populations.

Cynthia Keenan, Director of Organizational Excellence at HealthTeamWorks, plays a critical role as the Regional Health Connector for Colorado's Boulder and Broomfield Counties. She is instrumental in developing clinic-community linkages that enhance overall population health. Cynthia spearheads the Population Health Career Lattice, a framework that guides aspiring and established health care professionals through progressive career stages, ensuring equitable workforce development. With her deep understanding of health equity, she helps bridge gaps in care, emphasizing social justice and community-based results.

Cynthia Keenan
Director of Organizational Excellence

Community Health Worker Training: **Online and Apprenticeships**

The Community Health Worker Professional Skills Training equips both new and experienced Community Health Workers (CHWs) and front-line professionals with essential skills to advance community health and health access. The training, delivered through five online courses and 4 live virtual sessions, covers core competencies, professional development, and applied skills for improving individual and community health. Upon completion, learners earn certificates and continuing education credits, while gaining the expertise needed to support community health across diverse settings.

Learn More About Our CHW Trainings:

Scan the QR code for more on our available CHW Training opportunities.

What We Deliver:

- Comprehensive Training: Five online, on-demand courses covering CHW roles, public health, health equity, client-centered care, and professional skills.
- Core Competencies: Training focuses on cultural humility, implicit bias, client interviews, care management, and home visits.
- Applied Skills: Modules on chronic conditions, trauma recovery, pandemic response, and community resource navigation prepare CHWs for real-world challenges.
- Certificates & CEUs: Participants earn certificates and can receive 45 CEUs for nurses and AMA PRA Category 1 credits for health care professionals.
- Growing Field: CHWs play a vital role in bridging health gaps, with the workforce projected to grow 14% by 2032, per the U.S. Bureau of Labor Statistics.

Deb Kazmerzak
CHW Program Lead

Debra Kazmerzak leads HealthTeamWorks' Community Health Worker (CHW) Program, bringing over 30 years of experience in Iowa's health and human services systems. Her work focuses on developing innovative systems and supporting underrepresented populations. Debra was integral in creating a CHW training program and a US Department of Labor-approved CHW Registered Apprenticeship. Prior to HealthTeamWorks, she served with the Iowa Chronic Care Consortium, where she championed CHW workforce development. Debra holds a BASW from the University of Northern Iowa and a Community Health Center Executive Fellow certificate from the University of Kansas Medical Center.

Clinical Health Coach® Training: **Online and vFusion**

The Clinical Health Coach® Training Program equips health care professionals with essential skills to improve patient engagement, foster behavior change, and enhance chronic care management. Delivered through the Clinical Health Coach® Online Training and v-Fusion Training, this program offers flexible learning options, combining self-paced online modules with live virtual sessions. By focusing on patient-centered care, health coaching techniques, and population health strategies, participants are better prepared to drive positive outcomes in value-based care models.

Learn More About Our Clinical Health Coach Trainings:

Scan the QR code for more on our current CHC training opportunities.

What We Deliver:

- Flexible Learning: The Clinical Health Coach® Online Training is a 6-12 week self-paced course, while the v-Fusion Training adds live 90-minute virtual classes for enhanced coaching practice.
- Patient-Centered Coaching: Training covers engagement strategies, communication skills, and tools to build trusted relationships and drive patient behavior change, particularly for those with chronic conditions.
- Comprehensive Curriculum: Courses include health coaching techniques, population health strategies, health literacy, and care management, ensuring a holistic approach to patient care.
- CEUs and CME Credits: Participants can earn 26 AMA PRA Category 1 Credits™ for the online training and 18 credits for the virtual classes, with CEUs available and approved through the California Board of Registered Nursing.
- Value-Based Care: The program helps organizations improve staff efficiency, support Medical Home recognition, and align with billing codes for key care services like Chronic Care Management and Advanced Care Planning.

Clinical Health Coach®
Transform the Conversation. Transform the Care.™

Culturally Relevant & Affirming **Care Training**

Our Culturally Relevant and Affirming Care Training program equips health care teams to provide equitable, inclusive care by addressing systemic barriers, biases, and health inequities. Through eight online, self-paced courses, participants advance their understanding of cultural humility and belonging while learning to combat bias, build trust, and improve care outcomes for marginalized communities. The training is structured into three phases: Awareness, Learning, and Growth, each designed to foster personal and professional development in culturally responsive care.

Learn More About the Culturally Relevant and Affirming Care Training:

Scan the QR code for more on our newest training opportunities.

What We Deliver:

- Awareness: Participants define their "why" for health equity, combat implicit biases, and learn to use inclusive language and cultural humility to build trust and openness.
- Learning: Explores the connection between structural inequities and health disparities, and teaches how to use data to identify and address care gaps in marginalized communities.
- Growth: Focuses on best practices for inclusive communication, using correct gender pronouns, and applying cross-cultural communication skills to empower patient decision-making.
- Action-Oriented: Encourages healthcare teams to "call in" bias, discrimination, and stigma in real-time, fostering a culture of accountability and proactive change.
- Equity Focus: Addresses the unique needs and experiences of patients across gender identity, race, ethnicity, disability, socio-economic, and veteran status to ensure patient-centered care for all.

Callen Willows
Program Coordinator

Callen Willows is a Program Coordinator at HealthTeamWorks, providing crucial logistical and technical support for online learning and events, and ensuring the accuracy of training content by reviewing references and resources. He is actively involved in the Kansas City Community Benefit Coalition, helping to increase transparency in community benefit spending. Callen's role includes refining training materials to keep them timely and relevant. Her background in the nonprofit sector and personal experiences navigating health care have fueled his commitment to improving systems for marginalized communities, particularly LGBTQ+ individuals.

Community Clinical Linkages: **Bridging Gaps for Better Health**

At HealthTeamWorks, we understand the importance of strong community-clinical linkages in improving population health. In 2024, we expanded our work in this area, partnering with local organizations and health systems to create seamless connections between clinical services and community resources. These linkages help address social determinants of health and ensure patients receive the full spectrum of care they need, from medical services to housing, nutrition, and behavioral health support. By fostering collaboration between health systems and community organizations, we help improve patient outcomes, reduce health disparities, and promote overall well-being.

One of our key initiatives is the Regional Health Connector program, where we serve as the host organization for Boulder and Broomfield Counties. Our connector builds relationships between primary care, public health, and community organizations to ensure patients have access to non-clinical services that improve health outcomes, such as housing and behavioral health support.

In Kansas City, we continue to work with the KC Health Equity LAN and the KC Community Benefit Coalition. The LAN focuses on using race, ethnicity, and language (REL) data to drive health equity initiatives, while the Community Benefit Coalition advocates for transparent, accountable community benefit spending by local hospitals.

Our partnership with the Mid-America Community Support Network allows us to provide technical assistance to community health clinics, helping them establish strong linkages with social services and other community-based organizations. This approach ensures that patients receive comprehensive care, improving both clinical and social outcomes.

Cecilia Saffold
Chief Executive Officer

Cecilia Saffold, Chief Executive Officer at HealthTeamWorks, brings over two decades of expertise in community health and engagement. A dedicated advocate for maternal and infant health, she serves on Uzazi Village's Community Expert Review Board, and partners with Birth Equity Statewide Operations for Birth Centers (b.e.s.o.), in Colorado. Nationally, Cecilia supports community-driven strategies that promote health equity. Her passion for public health and community well-being drives her work, which includes fostering strong clinical-community connections to address social determinants of health. Under her leadership, HealthTeamWorks remains committed to delivering comprehensive, equitable care for all communities.

Regional Health Connector

As the Regional Health Connector host organization for Colorado's Boulder and Broomfield Counties, HealthTeamWorks connects care teams with services to support their patients' needs. Our connector bridges gaps between clinical care and community services, ensuring practices are aware of essential non-clinical support, such as housing, food assistance, and mental health services, improving health outcomes.

KC Community Benefit Coalition

The KC Community Benefit Coalition advocates for transparency in non-profit hospital allocation of community benefit dollars to address health related needs. HealthTeamWorks convenes community leaders to increase community member awareness of the community needs assessment an action planning process and to foster trusting open relationships between community-based organizations and our valued hospitals and health systems.

Mid-America Community Support Network

In partnership with the Mid-America Community Support Network, HealthTeamWorks provides technical assistance to the CSN, which develops and fosters strong linkages between health care and with social service providers. This ensures that patients receive coordinated, high quality clinical care and the support they need to address underlying social factors impacting their health.

KC Health Equity LAN

Through the KC Health Equity LAN, HealthTeamWorks helps health systems use race, ethnicity, and language (REL) data to identify disparities and implement targeted interventions. This work improves health equity by addressing social and structural factors that affect patient outcomes, particularly in maternal and chronic care.

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BUILD HEALTHIER COMMUNITIES WITH US.

VISIT our website to learn more about our programs, services and initiatives.

ENGAGE with us for your transformation projects.

PARTNER to advance quality and health equity in the communities we serve.

FOLLOW us on social media to stay up to date with our latest news, photos and videos.

DONATE to support any of our trainings and initiatives. Your gift is tax deductible.

For more ways to get involved, contact us at info@healthteamworks.org.

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