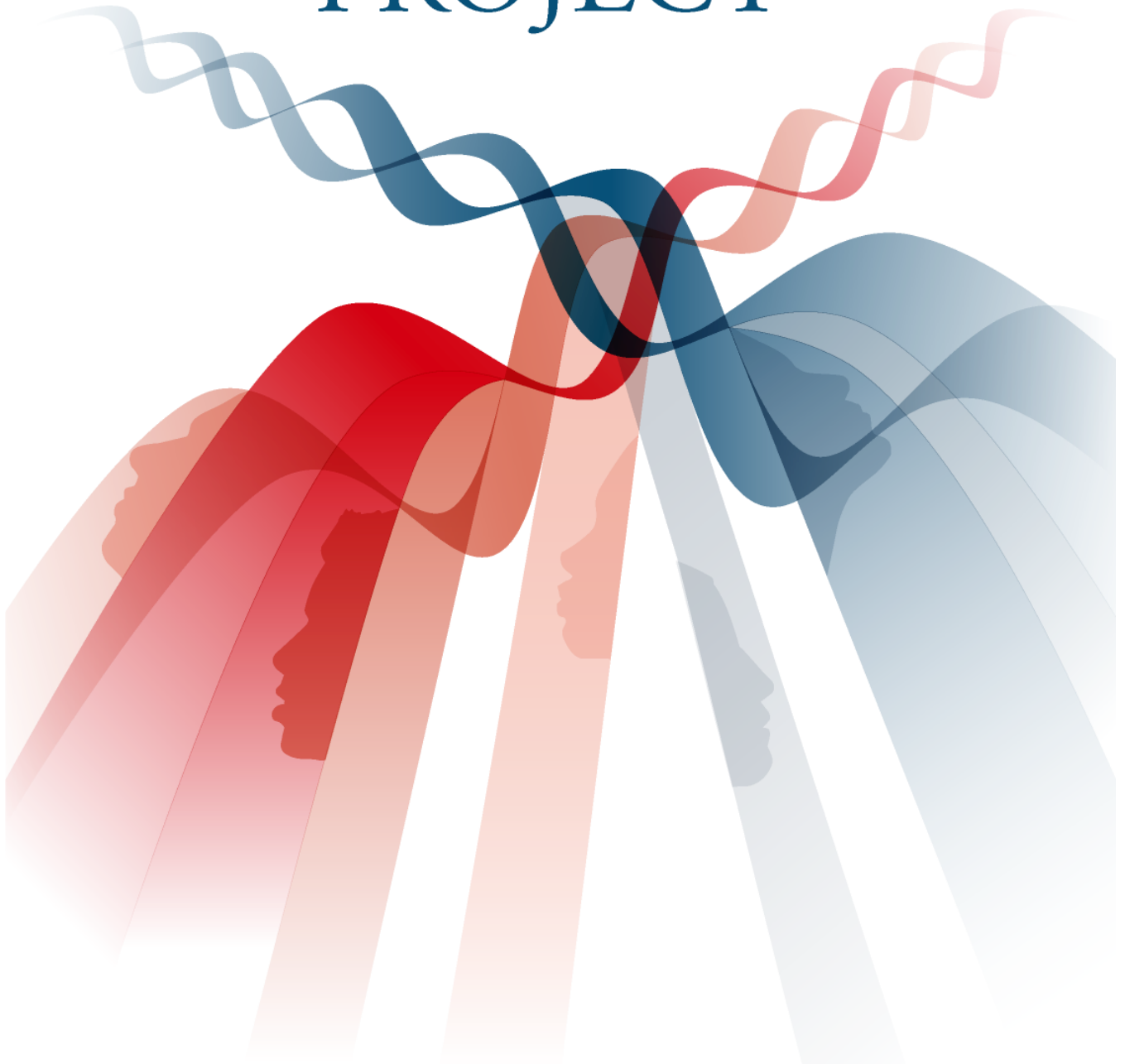


THE **DRA** Accelerating Disparity  
Reducing Advances  
**PROJECT**



**April 2007 Partners Meeting Summary**

Report - April 11<sup>th</sup>, 2007

## April 2007 Partners Meeting Summary

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## Introduction

Representatives from 40 organizations dedicated to reducing disparities in health met in Alexandria, Virginia on April 11<sup>th</sup>, 2007 to discuss the most important advances for bringing health gains to the underserved. These organizations are partners in the Disparity Reducing Advances Project (the DRA Project). The DRA Project is a multi-year, multi-stakeholder project developed by the Institute for Alternative Futures (IAF) to identify and accelerate the development and deployment of these advances to reduce disparities. The project is funded with support from the National Cancer Institute's Center to Reduce Cancer Health Disparities, the Agency for Healthcare Research and Quality, the Robert Wood Johnson Foundation, the Centers for Disease Control and Prevention, the American Cancer Society, University of Texas Medical Branch and Florida Hospital. A complete list of the sponsors and partners of the DRA Project is available at the end of this summary.

The DRA Project and its Partner Network are working diligently on eight priority areas for reducing health disparities. Four of the initiatives focus on reducing health disparities using community based prevention while another four initiatives focus on reducing health disparities by providing continuous, appropriate care. Each of these eight was selected due to its importance and to the commitment of DRA Partners to pursue them. The 8 Efforts are:

### **Public Health/Community Efforts**

- Refocusing on Community Conditions/Social Determinants of Health
- Healthy Eating and Active Living (HEAL) Programs
- Obesity Prevention in Schools
- Racial and Ethnic Approaches to Community Health (REACH 2010)

### **Health Care Focused Efforts**

- Promoting the Care Model
- Integrated Primary Care
- Consumer-Patient Navigation
- Continuous, Passive Biomonitoring

The DRA Project is also working on other activities including reinforcing the importance of tobacco control through its partner network, monitoring opportunities in the early detection of cancer, promoting biomonitoring as a disparity reducing advance and communicating the results of the DRA Project.

The April 11<sup>th</sup> meeting considered the social determinants and the navigator topic in detail. The other six priority areas were considered in small groups. Also, participants used an input form to provide additional comments and to identify the efforts they will work on. The summary below provides the highlights of the full group discussions (social determinants and navigator topics) and the small group discussions (the

remaining 6 efforts, plus the DRA Project's communication activity). The summary also includes objectives gleaned from the input forms of the participants.

The DRA Meeting also highlighted the important work partner organizations are undertaking to identify and eliminate health disparities. Summaries of the recent activities of The Joint Center Health Policy Institute, California Newsreel and the Rural Policy Research Institute are also included below. The DRA Project encourages everyone in our partner network to participate in the [Public Impact Campaign](#) organized by the Joint Center and California Newsreel to draw public attention to the causes of health disparities. The campaign will culminate in a documentary series on health disparities, [Unnatural Causes: Is Inequality Making Us Sick?](#), developed by the California Newsreel and scheduled to air on PBS in the winter of 2008. The DRA Project also encourages its network of partners to explore the powerful online tools developed by the Rural Policy Research Institute (RPRI). The RPRI's [Community Resource Information Resource Center](#) provides a comprehensive set of online mapping tools that allow researchers to aggregate regional and community data. These tools are valuable in preparing proposals, developing community outreach materials and conducting research on local communities.

## Refocusing on the Social Determinants

### *Laying the Groundwork for a Movement to Reduce Health Disparities*

The DRA Project decided to focus on two of the eight priority areas during the meeting. One of those priority areas explored in more detail was the Refocusing on the Social Determinants priority area. The group discussion was started by Larry Cohen, Jeremy Cantor and Rachel Davis of the Prevention Institute. They began the discussion by reviewing the highlights of their new report: *Laying the Groundwork for a Movement to Reduce Health Disparities*. This report builds on the work the Prevention Institute completed in their previous report for the DRA Project, [The Imperative of Reducing Health Disparities through Prevention: Challenges, Implications, and Opportunities](#). During the presentation, the Prevention Institute laid out what it would take to create a synergistic, strategic approach to addressing the community conditions that influence health disparities. Larry Cohen presented their findings in the three key areas of *attention and resources, coordination and participation, and strategy*.

**Attention and Resources:** The resources allocated and attention paid to health disparities are growing. For instance, funding has increased for health disparities research and the creation of numerous academic and government research centers also demonstrate the increased recognition of health disparities as an issue. To date, the major emphasis is on the medical system and improvements in treatment. However, there are indications of a growing awareness of community conditions of health, but attention has not been sufficiently paid to the "framing & understanding" of the issue. Statistics are often presented that identify health disparities related to particular communities. While this is important, it is also important to realize that many of the

same community factors are eroding everyone's health, they are just more persistent and frequent in low income communities and communities of color.

**Coordination and Participation:** While there has been growing momentum for tackling health disparities, an analysis of ongoing efforts reveals that there is a lack of coordination and cross-fertilization across sectors, efforts, and disciplines. Although there are significant efforts taking place in terms of both research and practice, there is inadequate interaction and cohesion. Many sectors and movements do work that impacts disparities, but they don't see themselves as engaged in reducing disparities in health. Some examples of these movements include those involved in smart growth, economic development, youth development and education, community organizing and sustainable agriculture. Bringing these disparate movements together to project a stronger community voice can be a powerful way to address health disparities.

**Strategy:** There are a number of efforts to reform health systems at the state and national level and these efforts provide opportunities for change. At present, these changes have focused on access to treatment, insurance coverage and expanded health education efforts. The depth and sustainability of these reforms depend on their ability to address root causes of disparities including community conditions in the neighborhood, school, workplace and health care settings. Health disparities are deeply rooted, complex, and pervasive. In order to make substantive changes a high-impact coordinated effort is required. Looking at the landscape of current activity, it is clear that such an effort is not currently underway.

Given that health disparities are rooted in such factors as racism and socioeconomics, it is hard to imagine that health disparities can be eliminated without a social movement that can mobilize a broad base of people to demand the necessary attention, resources, leadership and policy that will make a difference. Understanding the key elements of successful social movements is a major component of creating a "Marshall Plan" for preventing health disparities. Common elements of successful movements include clearly articulated goals, a universal framing of the issues (e.g., this affects us all), mobilization of resources and people (leadership, grassroots activism/community voice, elite support), and political opportunity (e.g., a faltering health care system and health care reform debates, the aftermath of Hurricane Katrina, the 2008 presidential campaign). Using this approach, the Prevention Institute identified key elements and opportunities for eliminating health disparities by refocusing on the social determinants of health.

**Political Will:** Inadequate resources and time have been put into thinking about how to communicate about health disparities in a way that engages a broad audience. In particular there are specific messages and stories that need to be told in order to make it clear that health disparities is an "us" issue and not a "them" issue. And those messages need to be delivered consistently and through multiple means. The broader the audience that is engaged and motivated to support change, the more political opportunities such as the upcoming presidential election, dissatisfaction with the health

care system, and revealing events such as Hurricane Katrina can be leveraged in support of structural changes necessary for disparities reduction.

**Refined Conceptual Approach:** The conceptual approach laid out in [\*The Imperative of Reducing Health Disparities through Prevention: Challenges, Implications, and Opportunities\*](#) is a useful guide and can be refined further and applied more broadly to identify additional levers. The dissemination of that paper itself was and will continue to be a critical step in coalescing conversation and thinking about a community-level approach to reducing disparities. The key strategies identified in that paper, such as Economic Development and Sustainable Agriculture, need to be engaged, and a further analysis of the community factors and key health issues will lead to identification of additional strategies and sectors that need to be involved.

**Strategy/Roadmap:** In order to move public opinion, attract resources, and take advantage of opportunities, an informed strategy will need to be established and modified depending on changing conditions. The strategy will need to include many of the elements described here: principles and policy platforms (and the use of such documents), communications, responses to political opportunities, and the convening of leadership groups and broader constituencies.

**Engaged Sectors and Defined Roles:** Reducing health disparities requires a broad group of sectors owning the problem and working together for its solution. Engaging these sectors and defining their role is a key component of reducing health disparities. Some of the key sectors and partners needed included: researchers, funders, government, business, media and coalitions.

**Leadership/Coordination:** Within different sectors there are centers of activity focused on disparities, and in some cases there is leadership or centrality within a sector (such as NACCHO for public health and practice). What is lacking is an overarching leadership structure and hub for communication that draws expertise from different sectors and leaders and can coordinate activities, generate communications, and provide a passionate and consistent voice pushing the agenda of reducing disparities forward. Similarly, resources exist within pockets, driving particular efforts, but what are missing are resources for coordination and building leadership.

The next logical step for the DRA Project is to hold a small, intensive, national design meeting to begin to answer key questions about what is needed (strategy and political will) and how we can get there (movement building), such as what resources are necessary, what messages need to be crafted, what sort of leadership structures need to be put in place, and what should be the timeline for actions. This design meeting would be structured to substantively involve participants in critically thinking about the current status of action and working together to outline specific elements of a theory of change. It would involve a carefully selected set of individuals from diverse sectors and would begin the process of laying out the specific actions as well as setting the broad agenda for a sustained, coordinated disparities reduction movement.

In the group discussion on the social determinants a number of intriguing questions were discussed. One of the conversations centered on the use of the term community conditions rather than social determinants. While social determinants is the most common term in the literature on health disparities, and is relatively well know inside the health policy field, Larry Cohen argued that community conditions is a better term for connecting with the public. Community conditions as a term of art connects with the pubic by creating a clear mental image.

Another discussion focused on the addressing the root factors that lead to health disparities – many of which are found embedded in the community and community institutions. Some of the socio-economic root factors, such as racial injustice, are very difficult to address. However, as the Prevention Institute observed in their report, they have a large impact on the health of individuals in underserved communities.

### *The Joint Center Health Policy Institute*

One of the goals of the DRA Project is to share the exciting work our partners are doing to reduce health disparities. Gail Christopher, Vice President of The Joint Center For Policy and Economic Studies and director of [The Joint Center Health Policy Institute](#), discussed the work of the Joint Center to develop leadership among African-Americans in public policy positions. Christopher focused on the core work of the DRA Project – addressing the unjust burden and suffering occurring everyday and our shared commitment to change.

When discussing health disparities, a key consideration is our understanding the collective “we” that are impacted by health disparities. When we say “we” in our discussions about disparities – who do we mean? If we go back to the civil rights movement – we have a clear image of the “we”. If we look at the issue today – it is unclear who the “we” is. Why is that important? For those who suffer, the future is now. Without understanding those in our communities that suffer from the undue burdens of disparities we cannot change. When we connect with the shared humanity of those who suffer, it is clear there is urgency right here and right now to make changes. And that is our commitment.

If everyone has the inalienable right to happiness – then everyone should have the right to healthy lives. It is the mission of The Joint Center Health Policy Institute (HPI) to ignite a “Fair Health Movement” that gives persons of color the inalienable right to equal opportunity for healthy lives. HPI frames its mission in terms of a “Fair Health” movement to acknowledge the legacy of activism and coalition that underpin racial, political and economic progress. A “Fair Health” movement also shifts the focus to the desired outcome and the implied strategy needed to eliminate health disparities. The Joint Center Health Policy Institute’s research, publications, activities and projects are designed to accelerate progress beyond listing and analyzing the litany of health disparities, toward collective strategies that produce real change.

HPI is part of the [Joint Center for Political and Economic Studies](#) based in Washington D.C. The Joint Center was founded in 1970 as a collaboration between Howard

University and the Ford Foundation to support African-Americans entering public policy positions. The Joint Center is recognized today as one of the nation's premier think tanks on a broad range of public policy issues of concern to African Americans and other communities of color. The Joint Center's principle areas of work include political participation, economic advancement, and health policy.

The strategy of the HPI is to look at seven key areas needed to advance a "Fair Health" movement.

1. Identifying and addressing the economic, social, environmental and behavioral determinants that can lead to improved health outcomes.
2. Increasing resource allocations for prevention and effective treatment of chronic illness.
3. Informing the policy and practice of reducing infant mortality and improving child and maternal health.
4. Reducing risk factors and supporting healthy behaviors among children and youth.
5. Improving mental health and reducing factors that promote violence.
6. Optimizing healthcare access and quality.
7. Creating conditions for healthy aging and improving the quality of life for seniors.

Currently the HPI is working on three major initiatives. The first major initiative is to address life options for men of color. Men of color see their rights denied and their options reduced from elementary school onwards. This deplorable condition is the legacy of enslavement and the result of unjust policies such as three strikes and you're out. The HPI has released a body of work that took social determinants and turned them into policy changes and recommendations. Recent reports can be found [here](http://www.jointcenter.org/publications1/health.php) on the Joint Center website. (<http://www.jointcenter.org/publications1/health.php>)

Infant Mortality is another major initiative of the HPI. The U.S. ranks only 28 in infant mortality – below Cuba and tied with Malaysia. HPI is looking at the underlying conditions leading to infant mortality and connecting to leading researchers. For example, breast feeding can reduce infant mortality by 15%, but African American women have the lowest rates of breast feeding. In another example, the U.N. has standards for baby friendly hospitals and only five hospitals in the United States meet that standard and they are not in communities of color.

### *Unnatural Causes – Public Impact Campaign*

The third initiative of the HPI is a [Public Impact Campaign](#) organized by the Joint Center and California Newsreel to draw public attention to the causes of health disparities. The center piece of the campaign is a series of documentaries produced by California Newsreel that go beyond new medical technologies and access to care issues to explore how the social conditions in which we are born, live and work profoundly affect our well-being and longevity. The [Unnatural Causes](#) series is a medical detective story

out to solve the mystery of what's stalking and killing us before our time, especially those of us who are less well off and darker skinned.

The series is set in seven parts. The centerpiece of the series is an hour-long opening episode that shows how health and longevity are correlated with socioeconomic status. It makes the case that people of color face an additional burden and the solution to the problem does not lie in more pills, but in better social policies. Supporting the hour-long opening episode are six half hour episodes set in different racial and ethnic communities. The programs will be packaged two to an hour and broadcast on PBS in the winter of 2008. They will also be available as separate modules on video and DVD. A preview of the series is available online [here](#) at the California Newsreel website. (<http://www.unnaturalcauses.org/disclaimer.html>)

The video preview, screened at the DRA Partner's meeting, establishes a framework for communicating the seriousness of health inequalities by looking through the lens of a single city, Louisville, KY. The unequal health gains in this microcosm over the last generation are illustrated in the context of America's poor overall showing among industrialized nations for both life expectancy and infant mortality. Finally, the video goes on to establish a discussion of these outcomes in the context of social determinants rather than simply access to medical care.

The truth is that the history of our lifetime is written into our bodies. "The determinants of whether we get sick or not are linked to the broader society," observes the prominent sociologist David Williams in the opening of the video preview. Louisville, like many other cities, shows a clear divide in health between different communities. In some Louisville neighborhoods, residents die 13 years sooner than in others. While America spends almost twice as much on healthcare as any other nation and produces the most Nobel laureates in medicine, the U.S. does not make it into the top twenty nations for many common measures of public health such as infant mortality and life expectancy. While access to medical care is important, it is the social and environmental conditions in our community that are central for health.

The DRA Project encourages its partners to join with the Joint Center and California Newsreel in their [Public Impact Campaign](#). The Campaign will reach out to key media outlets to bring attention to health disparities. The Campaign is also developing a network of partners to organize screenings, hold town hall meetings, develop forums and trainings to educate and advocate for health equity. The Campaign will also be developing a website that will serve as a hub for campaign participants and a unique on-line gathering place for those interested in learning—and doing—more. It will feature policy suggestions, a Community Action Tool-Kit, webcasts and podcasts, discussion guides, lesson plans, fact sheets and other resources. Those interested in joining the campaign can go online [here](#) at the California Newsreel site. (<http://www.unnaturalcauses.org/signup.html>)

### *Rural Policy Research Institute*

Christopher Lee Fulcher from the Rural Policy Research Institute's Community Information Resource Center (CIRC) and Joyce Essien from the Center for Public Health Practice at Emory University presented a set of powerful new online tools for using national, regional and local data on health. Whereas previously, data was compiled in sector specific fashion, the goal of CIRC is to aggregate disparate data sources and combine them with geographic information technologies to examine the place based impact of public policies.

CIRC is integrating data across federal, state/local and non-profit agencies. Since data is continuously being created, updated, and made available to the public in a "chaotic" fashion, CIRC acquires data on an ongoing basis, and focuses on how it can be utilized for decision support at the community, regional and national levels. CIRC's information systems enable policy makers and researchers to:

1. Geographically visualize community, regional, and national-level data via the Internet.
2. Integrate new spatial data and overlay these data to conduct location-specific analyses.
3. Generate maps, dynamic reports, and "what if" scenarios that utilize the integrated nature of our information systems.

Christopher Lee Fulcher and Joyce Essien provided a demonstration of the capabilities of CIRC's online tools at the DRA Meeting. Using an intuitive online interface, they were able to build detailed maps of community health factors in a local region. The DRA Project encourages its members to experiment with the CIRC's online interactive mapping tool. It is available [here](http://circ.rupri.org/index.htm) on the CIRC website. (<http://circ.rupri.org/index.htm>)

CIRC is located in the Harry S Truman School of Public Affairs at the University of Missouri–Columbia. CIRC works with stakeholders to link people and place through interactive visualization, analytical tools, and spatial analysis. The mission of the CIRC is to make public information publicly accessible in a decision support framework. CIRC has a unique understanding of rural resource limitations and the challenges faced in data management, small area data statistics, and mapping applications in rural settings which defines their specific role among information technology-based centers.

### *Summary of the Social Determinants Working Group*

Over the course of a rich discussion later in the day, the **Social Determinants** Committee selected 'convening a strategy meeting' as the most promising activity to take on next. Group members pointed out that identifying the right participants would be crucial to the success of this kind of meeting and emphasized the idea that representatives from targeted communities should have a strong voice at the table. In its discussion, the group concluded that the most important work of this committee is to

promote policy change by convening key stakeholders with the ultimate objective of changing funding flows.

In the input sheets from the meeting a number of DRA Partners signed on to the objectives outlined for the Social Determinants Working Group. Several partners were interested in developing a strategy meeting for the second half of 2007 and several were also interested in developing a Capitol Hill Briefing around the issue of social determinants. Likewise several partners were interested in joining the HPI's public impact campaign.

## Patient Navigators in Health Care

The other priority area discussed in depth at the April 2007 Partners Meeting is the Consumer-Patient Navigation area. Patient navigation can reduce health disparities by giving better access to screening and testing, and by ensuring that diagnosed patients, particularly with complex treatment regimes, as with cancer, can get to their appointments, understand what is happening, and that treatment is covered. This is the premise or the hypothesis that current navigator programs are testing. DRA Partners presented their ongoing work in patient navigation and other attendees discussed their ongoing patient navigation programs. The DRA Project has developed an initial comparison of several patient navigation programs in the *Patient Navigation Program Overview*, which will be available on the DRA Project website at [www.altfutures.com/DRA](http://www.altfutures.com/DRA).

Elizabeth Clark of the National Association of Social Workers (NASW) began the discussion with an overview of the patient navigation toolkit developed by NASW and C-Change. A pre-release video clip from the toolkit featuring Dr. Harold Freeman was screened at the meeting. In the video Dr. Freeman pointed out that in a health care system as complex as the United States' people of all economic backgrounds can benefit from patient navigation, but that the poor, who tend to get treatment later, are the most helped. The video went on to profile a Jackson, KY resident who benefitted greatly from navigation services after he was diagnosed with cancer. The purpose of the toolkit is to market the concept of patient navigation. C-Change will formally release the toolkit in October 2007. More information on the toolkit and how to get it will be available at the C-Change and NASW websites.

Angelina Esparza discussed the American Cancer Society's Patient Navigator Program. The American Cancer Society funded the first patient navigator program at Harlem Hospital and runs the largest patient navigator program in the country. The program currently operates in 60 sites nationwide and another 50 sites will be added over the next five years. In 2006, the ACS served approximately 12,000 patients. During the question and answer period, Angelina discussed two of the biggest issues faced by patient navigators in the ACS program. Translation services and finding financial assistance, especially for medications, were two of the biggest challenges facing patient navigators and the patients they serve. Esparza felt that effective partnering with other

organizations is the key to bridging the gaps in care experienced by many low income and minority patients.

Jonathan Tobin of the Clinical Directors Network provided an overview of their ongoing patient navigation study. Last year, CDN published a randomized study of 1,413 women in a phone based patient navigation program designed to improve cancer screening. The women were regular patients at one of 11 community and migrant health centers in New York City. All the women were overdue for one or more cancer screening tests and most were from low-income neighborhoods (78% were enrolled in Medicaid). Women in the control group were contacted by trained care managers who encouraged them to receive screening, provided information on screening, and provided assistance in arranging appointments and transportation. The women received an average of 4 calls. The care managers were provided with seven hours of training on screening, screening guidelines, techniques for motivational interviews and role-playing. Rates of screening for all three cancers (breast, cervical and colorectal) in the intervention group increased dramatically.

Barbara Wingrove from the Center to Reduce Cancer Health Disparities (CRCHD) at the National Cancer Institute discussed their Patient Navigation Program. The NCI program is focused on research on the navigator effort and its effects in nine sites. Each of the sites partners with local organizations to serve underserved populations such as racial/ethnic minorities, patients with lower socioeconomic status and patients in rural areas. Some of the research questions the principal investigators are exploring include:

- What is the impact of the type of navigator on success?
  - Volunteers vs. paid professionals?
  - The type of navigator (i.e. social worker, nurse, lay individual, community worker)
- Does the location of the navigator effect outcomes (i.e. inpatient or outpatient)?
- Does race/ethnicity or language matching improve outcomes?
- Does the type of navigator impact cost-effectiveness?

During the question and period Subash Duggirala discussed the ongoing patient navigation project of the Centers for Medicare and Medicaid Services (CMS). In response to questions about cost and benefit analysis and reimbursement, Duggirala observed that CMS needs to be able to reimburse licensed providers for the navigator program (paying social workers or nurses, or paying health care providers rather than directly paying for the services of unlicensed lay or volunteer navigators). And in evaluating whether it will fund navigators on an ongoing basis CMS will only do so if the navigator programs are overall cost-neutral or lower costs. The CMS navigator program is designed to answer these outstanding questions about cost, benefit and reimbursement.

A key topic during the question and answer section was how to make patient navigator programs sustainable and the state of the evidence for patient navigator programs. The two questions are linked since making patient navigator programs sustainable requires solid evidence on outcomes, costs and benefits. Jonathan Tobin observed that we need

to think broadly about the costs and benefits of patient navigator programs. Funding for patient navigator programs often comes from other sources inside health centers and medical systems and can be a zero sum game. Elizabeth Clark and Angelina Esparza observed the importance of effective training of navigators to achieve the objectives of the program whether they are community health workers or licensed providers like social workers. Both Barbara Wingrove and Subash Duggirala observed that their respective patient navigation programs are designed to answer many of the outstanding questions around costs and benefits through rigorous research. They are also looking to answer questions about the most effective patient navigators and the most effective methods of training and teaming for patient navigators.

One contribution of the DRA Project is to anticipate where a field or topic may be headed – to consider what the future holds. The Navigator issue is a complex mixture of what the patient and their family knows, their health literacy, their access to care, the cultural competency of their health care providers, as well as the medical record keeping of the patient and their providers. In this context the question of “virtual navigation”, electronic medical records, and enhanced information for patients/consumers needs to be considered.

During the Navigator session, DRA Partners also discussed virtual navigation and related issues. Josh Seidman from the Center for Information Therapy discussed ongoing advances in virtual navigation and some examples that could show promise for reducing health disparities. One example of the use of technology to address disparities is [MiVIA](#). MiVIA is a free service to migrant farm workers that provides them with a digital personal health record. It is likely that in a decade decision support tools will be significantly advanced to provide almost human interactive dialogue which will make it easier to use consumer navigation technologies with underserved populations. Some of the other emerging technologies discussed include social networking, interactive media and next generation cell phones. David Ellis from the Detroit Medical Center discussed an emerging platform for navigation in the virtual world of Second Life. While virtual online spaces, such as Virtual Life, are beyond the experience of many, particularly low income, elderly, or others who don't use computers, they are becoming more significant. David Ellis thinks that, like the Internet, health care encounters will move to virtual space and that they are relevant to considering where navigation is going.

The group discussion revealed disagreements over whether these technology-enabled approaches to navigation are or should be relevant to low income patients. Some thought that work on navigators should remain focused on human navigators. Other DRA Partners thought that the DRA Project should look at all levels of consumer-patient navigation including current patient navigator programs, leveraging existing technologies to assist navigators and emerging technologies for consumer navigation that could diminish or exacerbate health disparities.

### *Summary of the Patient Navigator Working Group*

In the small group session, members of the **Patient Navigators** Committee discussed the relative benefits of both electronic and human navigation, looking at what future technologies might be available to both patients and navigators. The committee recommended taking a broad view of navigation and drawing community outreach/health workers into the process and promoting navigation as a shared responsibility of everyone in the health care process. The committee felt that the DRA Project can make a significant contribution in promoting this shared responsibility to the public and policy-makers.

The most important next step to emerge from the small group session and the input sheets was to continue ongoing discussions on making patient navigators sustainable. Eight partners signed on to this continuing effort. Others thought more information was needed on the current state of evidence for patient navigators. In relation to the virtual navigator, the next step for the patient navigator committee is to develop a compelling forecast of the virtual navigator including its role in patient navigation, target populations for the virtual navigator, the technology used and how it can assist both patients and patient navigators.

### **Discussion & Next Steps in Other DRA Project Efforts**

**The Healthy Eating/Active Living (HEAL)** group members saw the planned report summarizing 'best practices' for working in disparate communities as the most promising option, to be distributed among program organizers themselves. However, the projected timeline for this work, producing a published report before the DRA Project's September meeting, was seen as potentially too ambitious. With this in mind, DRA will continue to work toward this initial target with the option of extending the deadline if needed. As a next step, the DRA Project has arranged interviews with several HEAL program heads. On the other hand, the option of pursuing a popular magazine piece on HEAL as it relates to preventing health disparities raised the question of defining the exact outcomes this move would be intended to accomplish. The possibility of tying Healthy Eating and Active Living approaches into the broader focus on Social Determinants was raised, as was the sharing of information among committee members.

The committee's discussion of **School Obesity Programs** emphasized the importance of communications. In addition to the DRA Project's ongoing partnership with City Year Detroit, the National Coordinating Committee on School Health and Safety, which is connected to most school health programs, was mentioned as an ideal partner for formulating the next step of this communications work, as was the National Assembly of School Based Health Care. Much of this discussion centered on appropriate targets for DRA Project communications. The possibility of targeting political figures and fund allocators was brought up and the examples of Mike Huckabee and Bill Clinton as

politicians who have taken action on this issue were raised to illustrate the prospective strength of this strategy. Further, the potential of engaging faith based programs to address both school fitness and health disparities generally was emphasized with the observation that the Catholic Church is in a position to be the biggest driver of the disparity conversation if engaged on the issue.

In the discussion of **REACH** Committee objectives, a hill briefing and encouraging the use of the CDC's community guide to preventive services emerged as the most promising next steps. However, progress in these areas was seen as contingent on further upcoming activity within REACH itself. Group members pointed out that Hill Briefings were a way that the DRA project could make a difference by providing this opportunity. The DRA Project is in an ideal position to facilitate these briefings; it was also noted that no lobbying or seeking to affect legislation would be part of these and that Federal agencies would have constrained, if any, roles in these Hill Briefings.

Committee members looking at **Biomonitoring** focused on possible contributions DRA could make to finding funding for development of these activities. The National Institutes of Health (NIH), National Science Foundation (NSF), Telemedicine and Advanced Technology Research Center (TATRIC), and Department of Defense were identified as key potential funders on the assumption that developments would migrate from military to civilian use. Advocating the use of the BodyBugg or similar advanced biomonitoring tools for weight control in the military was mentioned as a possible step in this direction. Relationship building with these agencies was suggested. Further, working with groups like the FDA and AHRQ to compile data on cost savings to secure reimbursement was also identified as a potential strategy. Similarly, the possibility of an IAF conference on reducing disparities through biomonitoring- bringing together companies, like Intel and cell phone developers, that are working in this area was raised.

The **Communications** Committee pointed out that the DRA Project has a lot of interesting material to disseminate. Committee members discussed the questions of what audiences to target and deciding on the best way to frame the messages that the Project puts out. Clara Wilkerson will work with the DRA Project to focus Project messages and audiences. Several other Partners have volunteered the use of their newsletters or distribution lists for getting out DRA information. The group liked the idea of working to get Gail Christopher on the Oprah show, and publishing a thought piece in the Atlantic Monthly as examples of the kinds of communications activities that could have a wider impact.

The committees will continue to work through the spring and summer on the eight priority areas. They will present their finding at the next DRA Partners meeting on September 25 in Alexandria, VA.

## List of DRA Sponsors and Partners

The DRA Project would like to thank its sponsors and partners for their continued support of the project. Without the assistance of these organizations the DRA Project would not be possible.

### *Founding Sponsors*

- The National Cancer Institute:  
Center to Reduce Cancer Health Disparities
- Agency for Healthcare Research and Quality

### *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.
- California Newsreel
- Center for Information Therapy
- Center for Minority Health at the University of Pittsburgh
- Center for Public Health Practice at Emory University
- Central Florida Family Health Center
- Clinical Directors Network
- City Year Detroit
- Corporate Office of Science and Technology (COSAT), Johnson & Johnson
- CRW, Inc.
- Detroit Medical Center at Wayne State University
- Directors of Health Promotion and Education
- Health Care Center for the Homeless, Inc.
- Health Resources and Services Administration (HRSA)
- Henry Ford Health System

### *Sponsors*

- Robert Wood Johnson Foundation
- Centers for Disease Control and Prevention
- American Cancer Society
- University of Texas Medical Branch
- Florida Hospital
  
- Hill Health, New Haven, Connecticut
- Institute for Alternative Futures
- Institute for Community Health
- Institute for Healthcare Improvement
- Institute for the Elimination of Health Disparities at The University of Medicine and Dentistry of New Jersey
- Intercultural Cancer Council
- Joseph P. Addabbo Family Health Center, Inc.
- Leadership by Design
- Maryland Department of Health and Mental Hygiene
- Medical Automation Research Center at the University of Virginia
- National Assembly of School Based Health Care
- National Association of Social Workers
- National College of Natural Medicine
- NovoNordisk
- Outside In Clinic
- Planetree
- Prevention Institute
- Resource Center for Health Policy at the University of Washington
- Samueli Institute for Information Biology
- Siemens Communications, Inc.
- The Joint Center Health Policy Institute