Institute for Alternative Futures

# March 31, 2008 DRA Project Partners Meeting Summary

## Executive Summary

Representatives from nearly 40 organizations met in Alexandria, Virginia on March 31st, 2008 to discuss health equity, and came to the conclusion that reducing health disparities is the best way to improve the health care system in the United States. The objectives of the meeting were to better understand the range of the DRA Project activities, to clarify the next steps for 2008, and obtain partner input. Specifically, the DRA Project sought input on the DRA Project's Health Equity Scenarios, Biomonitoring, The Expanded Care Model, the movement around social determinants, and Disparities Foresight Briefings on Capitol Hill.

After a brief introduction and update on the DRA Project, the partners expressed their aspirations for the Project. These included promoting access to biotechnologies, seeking out partnerships with the objective of taking initiatives nationwide, collaborating to create synergy around reducing health disparities to showcase what works with underserved populations, supporting and mobilizing the focus on social determinants, and incorporating more community voices into future DRA meetings.

**Health Equity 2028 DRA Project Scenarios**
Four health equity scenarios developed by IAF looking at what is likely to happen over the next 20 years, what could go wrong, what it would take to move in the right direction, and how to do something about it, were critically evaluated. The partners indicated that they would like to see the scenarios broadened in scope to include mental health and its integration into primary health care as well as fuller development of informatics. The partners also discussed the role of non-profits and for profits, and the future of public health. Recommendations were made to identify the role of public-private partnerships, and to reach beyond biotechnology and biomonitoring and into behavioral sciences and more applied research. Another draft of the scenarios will be prepared taking these along with individual recommendations into account.

**Biomonitoring**
An update on biomonitoring activities was presented. Partners were then asked where do we go next and what is the right contribution for the DRA Project? Partners pointed out that algorithm use in conjunction with biomonitoring could lead to a change in care and development of a new set of vital signs based on biomonitoring information. The importance of interoperability of wireless monitors and "minute clinics" with physician offices was discussed. Most agreed that reimbursement is an essential factor in making sure that biomonitoring devices reach low-income, minority populations. There was some debate as to whether or not these devices are evidence based, and whether lack of evidence from randomized trials would hinder reimbursement. The Partners also discussed how to use the information obtained from biomonitoring at the individual and physician level. Specifically, partners discussed finding a way to give the patient only the information he or she needs in an understandable format. There must also be appropriate use of the information obtained to achieve a change in health. Monitoring weight does not cause a patient to lose weight; it only informs them of where they are. Counseling and education must accompany the information. Some concern was expressed over ensuring that biomonitoring devices were used in a culturally appropriate way along with whether these technological advances will dangerously distance us from medical providers. It was suggested that the DRA Project look outside of the health box at how companies like UPS handle logistics, or how machine health monitoring applies to human health monitoring.

**The Expanded Care Model**

The DRA Project identified the HRSA sponsored Health Disparities Collaboratives as a new significant enhancement to health care quality and to reducing disparities. The Expanded Care Model is the next step for the Chronic Care Model, underlying the Collaboratives. Partners discussed what the Expanded Care Model looks like in practice and how these models have been disseminated and taught. The Collaboratives require the inclusion of administrative staff in their training, so administrative and clinical staff are all able to use the same language. They are then on a routine basis able to use list serves sorted by disease etc. to obtain evidence based information. The list serves include subject matter experts to ensure that the information being distributed is valid. The Collaboratives have shown that proven innovations and evidence-based research and guidelines now can be diffused widely in less than a year rather than the much longer traditional time (up to 17 years). The Collaboratives have been an effort at wide deployment of new insights of dissemination science and of frameworks about how to organize all of the variety of activities that are needed to make improvements. One challenge encountered was how to move from the consciousness raising that the Collaboratives do to an empowered and informed community. Chronic disease management organizations are looking for ways to have more direct contact with the community. The Addabbo Center gave examples and noted that the key is to get to know what institutions are important in the community and then partner with them and hire from within the communities. You want to penetrate and become part of the community. Peer-reviewed literature on “communities of practice” is useful for this.

**Social Determinants and Health Equity Movements**

In terms of the DRA Project supporting the movement to health equity, the partners agreed that we have come to a place where we need to be talking about political will. They directed attention to the fact that we already have a lot of research and answers, but need political will to make the changes happen. They pointed out that social security will likely run out and that the timing is right to focus on Medicare, Medicaid and Social Security. The discussion then turned to how to go about doing this. It was decided that a simulation is needed to demonstrate the effects that health disparities have on everyone in order to bring about the political will needed. Nothing will happen policy wise until there is a threat and the case needs to be made in a tangible way. It was suggested that the simulation also be presented online to engage the public, particularly the young population. Finally, a suggestion was made to frame this from a different perspective. We can show how bad it can get, or we can look at it like this – A healthy community makes you more competitive. We need to find a way to show positively that it is not just because it is right, but that as a result we will get a better world. We need to change our minds as a country.

**Disparities Foresight Briefings**

The topics for the next two Disparities Foresight Briefings were discussed. The first briefing will present the Expanded Care Model. The second briefing will focus either on social determinants and diabetes or biomonitoring and diabetes. Each table was asked to discuss which they would chose and why and then share with the rest of the group. The consensus was to focus on social determinants, emphasizing the connection between social determinants and health as these categories are often separately addressed. It was noted that the case needs to be made showing how disparities in social determinants affect an enormous number of people that have a cascading effect on everyone. There is not a clear understanding of what it costs the nation when we don’t take care of everyone.

**Next Steps**

Partners discussed what their organizations could commit to in 2008 and beyond. This included disseminating information through partner networks, incorporating measurement tools on social

determinants into studies testing biotechnology, leveraging research money to address some overlapping components such as CAM and the Expanded Care Model, and networking with groups who have important contacts with Congress in order to focus on the role of social determinants. The next partners meeting will be held on September 29, 2008.

**Summary DRA Project Partners Meeting**
**March 31, 2008**
**Hilton Old Town Alexandria**

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## Introduction:

Representatives from nearly 40 organizations dedicated to reducing health disparities met in Alexandria, Virginia on March 31st, 2008. The objectives of the meeting were to better understand the range of the DRA Project activities and commitments, to clarify the next steps for 2008, and obtain partner input. Specifically, the DRA Project sought partner input on DRA Project Health Equity Scenarios, Biomonitoring, The Expanded Care Model, focusing on and creating a movement around social determinants, and Disparities Foresight Briefings on Capitol Hill.

The DRA Project is a multi-year, multi stakeholder project developed by the Institute for Alternative Futures (IAF) to identify and accelerate disparity reducing advances in partnership with the DRA partner network (including over 60 partners) and those we affect. The project is funded with support from the National Cancer Institute, the Agency for Healthcare Research and Quality, CDC, the Robert Wood Johnson Foundation, the American Cancer Society, the University of Texas Medical Branch, Florida Hospital, and Novo Nordisk. The DRA project is motivated by the fact that health disparities in the US are significant, but most Americans are unaware the problem exists. The pursuit of equity (fairness) is a trend, like civil rights, anti-slavery and women's rights. It will take time and support for society to change its mind, but the process can be accelerated. The commitment to Health Equity is growing with support coming from WHO, Healthy People 2010, IOM's Crossing the Chasm & Unequal Treatment Reports along with foundations such as the Robert Wood Johnson Foundation.

Clem Bezold, Chairman of the Institute for Alternative Futures and director of the DRA Project, described disparity reducing advances as a movement, policy, technology, or health care delivery approach that leads to more equitable health. "There will be disparity reducing advances that we can accelerate over the next decade. The goal is to figure out how we can do that." In his introductory presentation he explained that a disparity reducing advance can be accelerated by spreading awareness, supporting and enhancing movements, ensuring that testing and developments are focused on low-income populations and their providers, and shortening the diffusion time of innovations. "The DRA project does not make or do things, we make things better."

The DRA Project was launched in 2006. Eight efforts, four public health priorities and four health care priorities were selected as focal points of the DRA Project in the initial phase. The last two years have been spent accelerating these priorities. They include:

Public Health Priorities:

1) Refocusing on the community and social determinants of health and disparities
2) Health eating and active living (HEAL) – Lessons on reducing disparities
3) Obesity prevention in schools
4) Reach U.S.

Health Care Priorities:

5) The Expanded Care Model
6) Integrative Primary Care
7) Health Care Navigators
8) Continuous Passive Biomonitoring

## Partner aspirations for the DRA Project

The March 2008 Partners' Meeting was launched by asking each table to discuss their aspirations for the DRA Project. Some of the responses included:

- Work with the DRA Project to continue access to biotechnologies that are not yet being targeted on low income populations.
- Seek partnerships that can lead to funding opportunities and take initiatives nationwide once they have been demonstrated at the local level (e.g. AmeriCorps).
- Collaborate with established groups to create synergy around reducing health disparities to showcase what works with low income and minority populations.
- Be supportive as a partner. Continue communication and dissemination of project reports. Create national partnerships for actions. There will be two regional meetings with the intent to create a national plan for minority health.
- Work on patient navigation. There are interesting collaborations and possibilities regarding navigators and the social determinants of health.
- DRA is the coalition-building body that leads to policy change.
- There is a need for a community voice – We would like to have the presence of a few people from the actual community: community members as well as hospital board members, people who have a finger on the pulse of the community
    - For travel, organizations can sponsor someone
    - Possibly set up travel scholarships
- Be supportive as a partner with a listserv which will be a place to disseminate projects
- Support and mobilization for social determinants

## Health Equity 2028 DRA Project Scenarios

At the end of the last DRA Project Partners meeting it was suggested that the DRA Project do scenarios, since at IAF we are futurists. So we have developed draft Health Equity Scenarios. These scenarios enable us to stimulate imagination and creativity, and to check assumptions and strategies. They have a 20 year focus and use IAF's Aspirational Future's Approach. There are two main goals of scenarios; 1) better understand what might happen – the plausible future and, 2) support creating the preferred future. The draft scenarios provide four rough frameworks for the future of health equity. The first is a "best guess of what's most likely"; the second considers "what could go wrong". The third and fourth explore different visionary paths to health equity. The four scenarios are:

**Scenario 1: The Gaps Grow: What is most likely to happen?**

Despite goals and programs to "eliminate health disparities" and universal access to effective health care, health disparities increase in the US over the next two decades. Health care access and quality improves, but the more significant social determinants of health and disparities are not dealt with.

**Scenario 2: Depression, Disasters and Self Protection: What could go wrong?**

It's a dark time in America. Many things can and did go wrong. The worst economic conditions in 80 years, peak oil, climate change, and recurring natural disasters lead to an inward focus (me and my family first). Health care worsens and health disparities increase. Low-income and minority populations are disproportionately affected.

**Scenario 3: Sharing the Burden - The New Fair Deal: What it would take to move in the right direction.**
The response to the Great Depression of the early 21st Century and a range of natural and manmade challenges paralleled the response to the Great Depression of the 1930's. More personal and family caring and more effective economic and social programs focused on the social determinants of health which reduced health disparities. More frugal and effective health care led by community health centers adds its contribution to reducing disparities.

**Scenario 4: The Mind and Heart Shift: How to do something about it.**
Society changes its mind. It did so with slavery, segregation and women's rights. In the first part of the 21st Century, society changed its mind on equity or fairness, including health equity. Our mindset is evolving. People dying and being sick for causes that are avoidable is considered unfair. Inspiring leaders and a new generation made justice and caring an active part of American ideals. The same kinds of policies are put in place, but more active leadership as well as a generation of younger people who pursue it makes the difference. Disparities that are avoidable are no longer looked at as normal. In the 60's there were freedom writers. In 2010, there are justice writers. We recognized that the most important levers for justice and for health equity are the social determinants. Jobs, living wages, affordable housing, education, access to healthy foods, and safe and activity friendly neighborhoods became targets of local, state, and federal policy. Health care played its role, anticipating patient needs, being patient centered, lowering costs, and leveraging the social determinants.

## Discussion of the Preliminary Scenarios

The discussion reinforced the importance of the scenarios and several partners identified internal or external sessions for using the final scenarios.

Joyce Essien of the CDC and Emory School of Public Health (and on the same day the recipient of AMA's award for outstanding practice of medicine) was asked to make some initial comments on the scenarios:

- As I looked at "The Gaps Grow" scenario, I thought about what might need to change to narrow the gaps. I think that our scenarios can benefit from some more explicit statements of the gaps. The first episode of Unnatural Causes (PBS miniseries) points out that there are a lot of problems out there and most people who view it think, "Well that's just the way it is". But the video does not direct people to what can be done.

- The scenarios should include our collapsed mental health care system. The intersection of mental and physical health has not been bridged. In thinking about framing this, when you imagine that white males live to be 76.4 years and black males in DC have an average life expectancy of 57.9 years, there is a 20 year gap that rivals what we see in countries of different developing stages.

- Most people are still imagining we have a good health system. The concept of quality would have to be broader. The concept of quality originally grew out of pathology. We are still talking largely about process controls. We need to extend beyond process and into the individual.

- Informatics could be more fully developed in the scenarios. Physicians are left out of the scenarios completely. If we are going to think in terms of conditions that have to exist to achieve health potential, the person who knows the patient the best is the person in the

best place to do that. The physician does not have the full picture of the patient. If we want to build a bridge between the doctor's office and the communities we need to advocate for the necessary environment and improve informatics.

- The role of government may shrink as we know it, even related to health access. Telling stories about increasing the role of the non-profit sector is important. Look at fundraising for the American Cancer Society. It's amazing. These organizations should put the money back where they raised it. You can imagine a different scenario around the non-profit sector with public health left out all together.

- In urban and rural settings, public health remains the provider of last resort. One imagines that if we were to, in a strategic way, realign our resources we would have to look at what we're now doing in a different way. The role of public health would be where the town hall meeting takes place, bringing together stake holders and presenting what we know. We are the only country in the industrialized world that does not produce a report on the social health of the country. We can't make progress if we don't even know where we stand.

- The other piece that we've left out in the draft scenarios is research, beyond biotechnology and biomonitoring, reaching into behavioral sciences and more applied research.

In the discussion other options were considered:

- We need a population based focus for health care that moves beyond community health centers and public health departments and creates regional systems, realigning public and private assets.

- Peter Nelson of the Addabbo Community Health Center noted that the idea of for profit in health care is relatively new, taking off during the Reagan years along with deregulation that brought us to this place. There have been recent studies on nursing homes that show that for-profit settings do not provide as many services as the non-profit settings. Since 1945 the health insurance industry has taken over health care. It is a six billion dollar industry shuffling paper around and making no contribution to reducing disparities. As the CEO of federally qualified health center, we are described as picking up the slack when things go wrong. We are subsidized by the federal government for helping the uninsured. We get better results because of this. Putting more money up front in getting people to comply and providing some hand holding results in less resource utilization in hospital care. The question is, how do we realign things so that we are putting more money upfront into health care, and putting it towards what we know works. Most money has been put into hospitals, but not successfully. Money is not being put into primary care and prevention. The New Deal was the first time we saw an income tax system. I'm for Robin Hood taxes, redirecting funds for national good.
- Penny Bailer of Detroit City Year agreed that the integration of mental health and primary care is important. In Detroit this is happening. Bridges are being built between mental health, primary health care and housing. The whole community health center idea will be accessible in one place. It is happening, and is a great innovative way of thinking. So glad that you said it first.

- Jonathan Peck: CHC's could be an important vehicle for employment and professional development, encouraging long term sustainability within communities. The health department is relatively underrepresented in community development efforts. It is important to identify the role of public-private partnerships in health. The role of the department of health in partnerships for economic development should also be reassessed because integration is critical.

- Part of our foresight should be to think about corporations that are interested in being more green. What are the social pressures that influenced green companies and how do we use these in health?

- We have made health care, not health, the priority. How do we educate people and give them the tools they need to be proud that they have their health? That's a piece that needs to be built in, not just health care.

- Poverty has to be addressed. Poor people don't traditionally have a voice in health policy. There are the insured and the uninsured populations. The blue cross populations vs. poverty populations. In some communities the CHC's are crashing. Or they are merging because they don't have enough money. They are losing their buildings because they are condemned. Community mental health centers are no longer around. Health, water and disposal of trash are the main issues the governor hears about. The overall picture of the scenarios needs to be realistic.

These comments, along with the comments from DRA Partners beyond today's meeting will be considered in revising the scenarios.

## Biomonitoring

New technology for monitoring patients in their homes and in their daily routines offers promise in conducting research, preventing disease, screening for risk factors and monitoring treatment or progression of disease. The Robert Wood Johnson Foundation funded the Biomonitoring Futures Project (BFP), a component of the DRA Project that explored the emerging possibilities in biomonitoring, e.g. detecting pre-cancer or early stage cancer in blood, breath or saliva tests, using continuous passive biomonitoring to significantly improve care; and the potential for these advances to be disparity reducing rather than disparity increasing. The BFP project reports are available at: www.altfutures.com/bfp. A follow up report is being prepared with the Commission to End Health Care Disparities, sponsored by the AMA, NMA and other organizations, on a biomonitoring focused strategy for technology.

It is forecasted that by the year 2016, advances in biomonitoring, biotechnology and imaging will have improved the prevention, early detection and screening of cancer. Biomarker tests will allow providers to assess the risk of future cancers, and diagnose early, asymptomatic (even precancerous) disease for a variety of cancers. Molecular imaging will allow clinicians to visualize early cancer changes years before symptoms appear.

Colleen Kigin, Center for Integrating Medicine and Innovative Technology, pointed out that algorithms utilizing biomonitoring can lead to change in care. To date no one has been able to predict the

immediate onset of a seizure with a device. There is now a device that can give people enough notice to get off the road before a seizure using an algorithm. Additionally, algorithms are able to predict who has the greatest propensity of mortality within 3-6 months of a heart attack.

There is a strong interest in wireless monitors that can be worn in the home and integrated into the physician's office system, with the goal of having a dash board of data. Physicians will be able to identify which of their patients have had significant changes that require follow-up just by looking at the biomonitoring data.

David Ellis, Detroit Medical Center, noted that reimbursement will be essential for shortening the diffusion time for effective biomonitoring tools. It is also important to note biomonitoring information must be used appropriately to change health. The Detroit Medical Center has had a partnership with a home monitoring service to sell devices to elderly patients for over two years now. Devices such as scales and blood pressure cuffs have been sold to nearly 200 patients. In addition there is a group that pays for biomonitoring at home for Medicare patients who need home nursing follow-up because their payments from Medicare are enough to cover these biomonitoring costs without them being directly paid for. They do this because the biomonitoring saves the provider money. The diffusion curve for biomonitoring will not take 17 years. Clinicians realize technology is changing but there is still the need for reimbursement.

Cecelia Horwitz, Center for Future Health, University of Rochester, has received $1.2 million from the Robert Wood Johnson Foundation to develop in-home biomonitoring. Given the large amount of information and tools that will be used in the home, we'll need to manage and use that information. This is the next phase that we are exploring. If we can monitor for what we need on the fewest possible and essential sensors and look across the diseases that are most prevalent, then we can look at patterns to tell us what we need to know. We believe that we will develop new vital signs that will give us early warning of serious health events. We are looking for partners to work with us on diabetes and COPD. In one system the patient would assist with data and input commentary into a cell phone. It would be important to educate the patient first and then enable them when they need to alert the physician. There is a concern about having data only in an electronic repository. We believe that individuals need to have their own data in their own back up on their key chain.

Josh Seidman, Center for Information Therapy, noted that there are many exciting possibilities emerging, but fears that their development will be ad hoc rather than integrated. We will need to make sure that these biomonitoring tools are maximizing their utility and don't yield parallel processes. How do we make sure these devices are accessible and understandable? How is the information used and how is the information transmitted to the clinicians?

What biomonitoring platforms are we developing that help patients manage behaviors and choices as opposed to simply supplying information back to the providers? At the individual level, data from biomonitoring devices are put into dash boards that educate the consumer and therefore help change behavior. Will we integrate public health data? Will we wear something that tells us how much stress we are under and that something needs to change? Is there a way for biomonitoring to effectively include psychosocial issues?

http://www.patientslikeme.com/ is a website that now takes care of tracking mental health. They figured out how to track various measures of how a person is feeling. This can be tied together with

smart software to coach people based on data. It can also be linked to incentives. The challenge is the need to learn more about how to change behavior.

Retailers, where we shop, could be involved. A person could have measurements taken and then receive information on the right foods to buy. If the advice is available at the same place where measurements are being taken it could be useful.

We could use a device, like a mood ring, that provides a reading of oxygen levels. Right now respiratory therapists measure oxygen levels using a tiny clip-on device. It provides very quick measurements. They are expensive now. But consumer versions, used in the home could let patients know if they need to hook up their oxygen.

Cultural beliefs will need to be included. There is a large segment of minority populations that do not consider themselves ill unless they feel bad. The health belief is that if I don't feel bad, I don't need pills. Health beliefs need to be investigated and we need to look at culture.

Culturally appropriate health aspects do need to be talked about, and algorithms can be developed. A dashboard for consumers/patients might be different from the doctors. As a driver, we don't want to know everything. We need to know whether we need gas. We don't need to know the current temperature of the oil. We need to link a set of measures that a patient needs and a set of measures clinicians need. Interoperability will eventually come into play. We don't have a good sense of what it means to have a good health care index. We still don't have a good composite measure for health care.

Some participants noted that despite the excitement about technological advances, the patient's dignity needs to be considered. Most patients would not want to share their medical information with the clerk at Wal-Mart, and these advances could distance us from our providers. This needs to be considered.

Along with privacy, the security of our information and protection from discrimination because of our health data is necessary.

We have created this echo chamber – we get into rooms full of health care people. Ultimately, we want to get to a place where we can create the equivalent of a medical FICO score that tells us our credit-worthiness. One way to get out of the echo chamber is to ask the financial services people how they created a system that is regularly understood by consumers. Likewise, ask UPS how to deal with the logistics of health care. For something that is futurist driven, we need to get out of the health echo chamber.

Cecelia Horwitz noted that they are doing something similar – for the development of health monitoring tools they are talking with the engineers who monitor the health of machinery. They can anticipate when things will break down. We have much to learn from them.

## Expanded Care Model

The DRA Project identified the HRSA sponsored Health Disparities Collaboratives as a significant enhancement to health care quality and to reducing disparities, including the data showing that the Diabetes Collaborative had a statistically significant impact. See www.healthdisparities.net

The Expanded Care Model is the next step for the Chronic Care Model, underlying the work of the Health Disparities Collaboratives.

The Expanded Care Model started in 1998 with chronic diseases and has moved on to detection of cancer, prevention, and community systems collaboratives. The Cancer Collaborative had a dramatic improvement in screening rates and the resulting impact. However, as the volumes exceeded the capacity of the pre-existing arrangements with specialists and hospitals, the health centers then ran into ethical issue of inability to offer enough needed services. It became clear that the literature on "communities of practice" was critical, in addition to the traditional medical literature and management literature. Taking the lessons learned from the wide variety of collaboratives, HRSA in 2007 made a decision that the next national collaborative would be on patient safety and clinical pharmacy services, which requires a community systems approach. There is a need to take into consideration that Complementary and Alternative Medicine (CAM) in the form of herbs and other modalities are being used by a significant number of patients nationally. Public health aspects need to be taken into consideration to a greater degree than initially anticipated in the original Chronic Care Model. Another key insight has been that many current EHRs are physician centered and not patient centered, so they were not designed to improve outcomes on a population sense, even if able to document individual patients care. These EHRs are evolving fast as they address population based data, which needs registry-systems modules incorporated.

Peter Nelson, The Joseph P. Addabbo Family Health Center, noted that the biggest challenge at the local level is how to move from the consciousness raising that the collaboratives do to an empowered and informed physician/community. At the center of that, the first step that the health centers are taking is working with a great chronic disease information management system. A sophisticated registry system or EHR with that module does address an empowered, informed community rather than just a clinical doctor-patient approach. The health centers have always had a population as well as an individual approach. Chronic disease management organizations are looking for ways to have more ground contact with the community. They are financing a nutritionist to do a culturally sensitive Weight Watchers model. Weight Watchers is not typically integrated into low-income communities due to the $18/month fee. They also support food cooperative models. There is no immediate big impact. Bloomberg is sending green cards for buying food into low income communities in New York City. The concept is that he's bringing subsidized truck loads of food into communities, sort of a farmer's market idea. In the past our health center encouraged a farmer's market. This did well at first and then dwindled. The community wasn't ready for it. A cooperative, our current approach, tends to be more community directed, and therefore more successful.

Ahmed Calvo responded to these comments by noting that the pieces of the Expanded Care Model, evolving as it is from the Health Disparities Collaboratives, are linked. And most are made available on the website www.healthdisparities.net. On any given day this site receives 10 times the volume of all of rest of the HRSA websites combined. Healthdisparities.net is all evidence based systems approach to quality improvement and being used by many partners nationally, at state level, and in many communities in all 50 states and all U.S. territories. Beyond the HRSA Health Disparities Collaboratives, many state health departments are running their own collaboratives. Also, private foundations, and other local community efforts are using collaborative methods. They are using the same language and same way of conversing about quality improvement as a result of the collaboratives. Over 90% of all health centers are using this model. In this approach, the community health leader is considered just as important as the medical expert such as the endocrinologist.

Peter Nelson pointed out the challenge of building IT systems.  In New York City, we've just had $109 million poured into RHIO development. The trickle down for the Addabbo Center will be about $100,000 to help with IT, specifically the chronic disease management tool Medical Management Outcomes System (MMOTS) (http://caseinpoint.cmrg.com/2007april.pdf ). There is another similar company, McKesson. The exciting part of this tool and the collaborative we've built is that chronic care management is interfacing with MMOTS. We know what's happening inside Addabbo, but also what's happening in the hospital. We're on the cusp of using smart cards to create a patient portal for patients to access their health information. What do we put on those cards that would be self-motivating? If we're giving them real time health lab information, how does that translate into their life expectancy or how they are going to look in 10 years?

One of the things that MMOTS has built into it is a predictive modeling individualized to the patient. If you look at HA 1c blood sugar levels and weight and don't change anything, you may start to lose eye sight or have organ damage.  If you exercise like this every day you can reduce your risks of x by x%. This capacity is in the MMOTS software. It will be used with patients to motivate them. We will have computer kiosks to assist patients.

Ahmed Calvo, when asked if this is the leading edge of community health centers, replied that there is a spectrum. Some are more advanced, some less so. But, essentially all are using this dialogue developed in the Collaboratives. So, they know where they are. The Health Disparities Collaboratives required that administrative staff be sent to national learning sessions for training in addition to clinical staff as well as the CEOs, CFOs, CIOs, etc.  So, this changed the culture of many health centers, both internally, and as a national network of health centers.  For example, since it meant that front office staff and back office staff across the nation could now easily communicate with each other. There is now a beehive of communication on the list serve. Hundreds of CHC's are on these list serves which are sorted by disease etc… Questions can be asked 24 hours a day every day of the year, in an asynchronous way. The functionality is superb. Through this list serve they were able to pick up methicillin resistant staph aureus cases (MRSA) a year before the media did, and upgrade their protocols nationally.

Jonathan Tobin, Clinical Directors Network (CDN), noted that the level of energy and engagement at all levels of the CHC's has been important. There are times when a clinical trials approach is needed and other times when the collaborative approach is better. All efforts need to reach a broader population, not just the communities they initially serve.  For example, CDN has also been partnering with several Medicaid patient navigators around cancer early detection. Services could be significant and successful, but not really affordable.  The new clinical trial we are doing now is to determine if we can get the same kind of results with a community based approach.

Ahmed Calvo noted that there is some variation in the framework and mechanics of the collaboratives depending on which article you read. Yet what is significant is the rapid diffusion of these innovations. Traditionally, many NIH research findings or CDC guidelines take 15 – 17 years before they get deployed as a practice out in the field. But the Collaboratives have developed ways to deploy within a year. These processes take evidence based practices already validated by NIH and massively deploy them.

We are dealing with culturally, insurance and access challenged populations. I don't feel like I need to do a randomized trial to test whether something should be attempted in these underserved communities. Why should we have to wait 17 years for community facilities to have access to that? For example: with the DPP study it is clear that for pre-diabetics, with exercise and weight loss, you can prevent more than 50% of those at high risk from becoming diabetic.  These insights are known already.  What is needed is

rapid dissemination of these practices. This kind of rapid diffusion being used by the collaboratives makes that type of new knowledge and practice known almost instantly. This is especially important for chronic diseases, like cancer and diabetes that take years to develop. It is especially important that tools be distributed to low-income populations and their health care providers.

Jonathan Tobin: 17 years is troubling. We need to conduct well designed clinical trials and then release the information. You conduct the good trials in the setting where you want to do the translation so that you understand the associated challenges. I don't think that medicine has a very good way of getting the results out (e.g. the Women's health study). The communications/social networks that the collaboratives represent are allowing rapid deployment faster than the traditional model. HRSA can support this even more.

Peter Nelson: The research just cited on activity, weight loss and diabetes, the DPP study, is so important. Reducing one's body weight by 10% can prevent onset of type II diabetes. Also, if you have type II diabetes, reducing one's weight by 10% reduces risk of cardiovascular disease by 60%. The more important piece that has been identified is that 30 min of exercise a day reduces risk. But in communities where you don't feel safe going out on the street and can't afford to join the women's fitness center Curves, what can be done? We have funded some of our Addabbo patients to join Curves, but they injured themselves in 2 weeks due to being overweight and not having enough oversight. So we started a gym at our health center that has proper oversight. But, we need to be able to make some money to keep this stuff going; our in-house health center is at risk. As health care providers there are other things we can do – we can leverage our community assets for fitness and health promotion. Our area of Queens has a 17 mile stretch along the Atlantic Ocean. Most of that 17 miles is a boardwalk. We could not send our patients there to walk because it was unsafe. We went to the local police and had them agree to patrol specified sections of the boardwalk for defined periods of time. Now the board walk has certain times of day where police are out to make it safe to walk outside in the most isolated, poorest and sickest part of New York City. It is very easy for health centers to work with community leadership and get the police involved.

Ahmed Calvo: Too often the patient feels like they are in a relay race where the baton is dropped between the physician, the lab, or the community. The point of this example from Addabbo is that all of the systems have to process together, and they can. What Peter Nelson needed to do was get out and organize police to enable safe activity and that was just as important as a physician prescribing exercise.

Michael Mawby, Novo Nordisk, pointed out that in the DPP study the best results were with the older population. Those who were 61 or older had a 71% decrease in type II diabetes.

Ahmed Calvo: It is important to note also that the information gathered by the Collaboratives was quality improvement information. It represents advice within and between CHCs. This is not regulatory data. There is a separate formal report filed by all of the CHC's. 100% of all health centers are required to report and the survey questions has to go through OMB approval. But, in the Collaboratives, since the health centers were sharing information and insights with each other there was no need for OMB approval. They had national experts that were allowed to give insights on a community topic to that volunteer local and national community of practice on that specific given topic. The community decided what the priorities were. By having great subject matter experts participate, the collaborative was able to stay focused on evidence based

Byron Sogie-Thomas, National Medical Association, Our members (African American physicians) are very interested in getting to a place where coordination of care becomes common practice. The poorest of the poor and the sickest of the sick are areas of great concern. We would like to spend more time dealing with populations where the burden is disproportionately borne. We need to get to a place where we can develop a way to coordinate and measure the data, for example how well we are tracking HA 1c. If we can measure indicators well and coordinate data then we will know how well the interventions are working. In general what is the quickest way to get to coordinated care? The main disparities tracker is the black report. The report resulted from the recommendations in the IOM study "Unequal Treatment". As our members look at the annual report they say that the progress being made is painfully slow. Even though we have a national report to track progress, it is at the policy level not at the level where the rubber meets the pavement.

Peter Nelson noted that a real key, regardless of what ethnic group you are approaching, is to get to know what institutions are important in those communities and then partner with them. The lack of resources to sustain programming is a problem. Try to hire from within the communities (e.g. for the front desk). You want to penetrate, become a part of the community.

## Social Determinants/Health Equity Movements & DRA Project

One of the most important disparities reducing advances will be the refocusing on the social determinants of health. The work of the DRA Project has shown the importance of focusing "upstream" on the determinants of health and disparities and on the movement needed to do this. Three reports have focused on this: the DRA Project Report on the "Most Important Advances", and two Prevention Institute Reports for the DRA Project: "The Imperative of Reducing Health Disparities through Prevention: Challenges, Implications, and Opportunities", and "Laying the Groundwork for a Movement to Reduce Health Disparities". These reports are available at: www.altfutures.com/dra.

The December 6, 2007 Disparities Foresight Briefing on Capitol Hill, co-sponsored by the Congressional Hispanic Caucus, focused on presenting the importance of social determinants and leveraging those. Additionally, many DRA Partners are tuning in to the Unnatural Causes series on PBS and finding ways to use and promote it. Clem asked "In terms of the DRA Project pushing the movement, what are the most important things that need to be done to attain health equity? What is the best contribution of the DRA Project? Where should we be looking?" This yielded several suggestions:

Penny Bailer of Detroit City Year noted that Detroit has a new model of federally qualified health centers that have received awards for providing housing to the homeless linked with mental and physical care.

Byron Sogie-Thomas: We've come to a place where we need to be talking about political will. We have a lot of research and answers. We need political will to make the changes happen. We are about a decade to a decade and a half away from running out of money because of Medicare. Social Security will run out by 2041. There will be a lot of people in this elderly population with baby boomers starting in 2011. It affects 90 million Americans (1:3 people) and could bleed over into everyone else. The wait in hospitals may be longer.

Roland Garcia: Now is the time to pay attention to Medicare, Medicaid and Social Security. With elections coming up, these candidates will not be able to avoid discussing these issues. The timing is right and the window here. If we don't do something about it, there could be additional scenarios. I thought we'd have a scenario about when there's no Medicare or Medicaid. In terms of cancer,

reimbursement is low. This results in not getting care. This will just continue to grow. The time is right to start making noise on this. The National Medical Association and other DRA Partners are in the place to make a lot of noise. In terms of future directions and futures meetings/briefings on the hill my suggestion is to get the attention of Capitol Hill as the election nears.

Byron Sogie-Thomas: The ability to make noise is in each of the groups here. Moving from noise to change is key. For 113 years there's been noise being made by NMA. Disparities are still here.

Rebecca Myers: We should look at tying the social determinants strategy in with groups that are working to address these determinants, but do not realize their work will also reduce health disparities. For instance, The Washington Interfaith Network (WIN), an Industrial Areas Foundation community organizing group in Washington, DC, is working on housing issues, but has not framed their work in terms of health care or social determinants of health equity. Somehow we need to create a network of organizations like WIN to get information out and back and forth in order to better frame these housing and related issues in a health disparities view.

Regarding political will, there may be ways to see if the public is sympathetic and will vote for politicians who are willing to address health disparities. For instance, NASW works with Every Child Matters, a 501(c)(3) that provides information about children's issues and tries to get people registered to vote and out to vote who care about these issues. Sometimes we work with a 501(c)(4), Project Vote Kids, which highlights candidate's records on children's issues. Project Vote Kids has done research that shows that a significant amount of voters will vote for the candidate who best supports children. Could a similar strategy work for health disparities?

Linda Blount: Related to the scenarios presented this morning, there is a tool called community issues management. It helps frame issues for a community and can simulate this issue. Political will is not good due to a crisis of leadership. If we can simulate and demonstrate the effects that health disparities has on everyone, then politicians may bring about the political will needed. Nothing will happen policy wise until there is a threat. We need to be able to make the case in a tangible way and procure funding. Joyce Essien, Chris Fulcher, and Linda Blount are using this Community Issues Management approach for putting these tools together to show disparities and their impacts. The DRA Project and its Partners will be able to use this tool later this year.

Jonathan Peck: Whether that comes through an Obama presidency or not, he's shown that engaging the young online is a brilliant strategy. Perhaps a simulation could be communicated as pictures as well as words with the young people. They are ready.

Bill Rowley: A report rating all 50 states showed that states with highest access to health care had the highest quality. Those with the highest access to Medicare also have the lowest price. Three things are important: access, quality and price. Data from the Commonwealth Fund study says that you can't have one without having all three. The real change is that we need to fundamentally change our minds. We need to change our minds as a country. We can show how bad it can get, or we can look at it like this – A healthy community makes you more competitive. We need to find a way to show positively that it's not just because it's right, but that as a result we will get a better world. This is the only intelligent thing to be doing. We will be more successful in the long run. Argue to the core values rather than the margin. In the beginning of the scenarios there is data. We want to start with the strongest arguments.

## Disparities Foresight Briefings

To disseminate the learning from the DRA Project and promote disparity reducing advances. Disparities Foresight Briefings will be held on Capitol Hill. IAF has been doing such look-ahead briefings on health innovation on Capitol Hill since 1978. These briefings will be done in conjunction with relevant members of Congress and focused on Congressional staff and the Washington policy community. On December 6th, the DRA Project and the Congressional Hispanic Caucus hosted a Disparities Foresight Briefing on Reducing Health Disparities Faster: Addressing Social Determinants of Health that highlighted the public health efforts of the DRA Project.

The Health Disparities Collaboratives and the expanded care model is the next focus for the Hill Briefings. What can we celebrate? People on the Hill want to know what to fund and what to vote for. We want to give them an idea of what the bigger picture is.

The topic of the second Disparities Foresight Briefing will be social determinants or biomonitoring.

Social determinants are the bigger issue. Biomonitoring would be timely moving into a healthcare reform political setting. You can get improved access, quality, etc.

- In terms of social determinants, it gets you in the door.
- Biomonitoring is more high end and in terms of reimbursement, some feel there is no evidence that it works. We need clinical trials with comparison groups to show cost effectiveness.
- We talked about modeling and making sure that we highlight the interdependence of these determinants. You can't have optimal health unless the determinants come together (Education, etc…). We should focus on what it costs to have these disparities persist. For example, uninsured people being treated in the ER and increasing costs and wait times. There is not a clear understanding of what it costs everyone to not take care of everyone.
- It also has to do with the ease of getting the message across to the policy makers. They are used to dealing with questions of jobs, housing, education, and health. What hasn't happened is that there has not been a case made that these social determinants have special impact on an enormous number of people that have a cascading effect on everyone (for example lost days at work or school). If it's bad now, wait 10 years. A long diffusion time [for biomonitoring devices] increases disparities. But this is not as important as social determinants.
- If we compare health consequences of social determinants in the US to those in developing countries, the profile is similar. If they [Congressmen] knew that the life expectancy in some low-income minority populations is similar to 3rd world countries, it might spark interest and make them see that this is a serious issue.
- Thinking about the audience and what's likely to be more adoptable, we have to look at the difference between social determinants and biomonitoring. The difference is like primary vs. secondary prevention. Research favors interventions at the secondary level. That's where the Chronic Care Model started.

- Social determinants and biomonitoring may not be mutually exclusive. Biomonitoring can become low cost. The cell phone 20 years ago was very expensive, now they give them away. Biomonitoring has the opportunity to be cost effective. Biomonitoring may be able to improve school performance. It cannot, however, address all of the social ills that exist.

- Others felt that research has not supported secondary prevention as being better than primary prevention.

- There is a difference between effective treatments, where they exist, vs. monitoring. The more information that gets out there to the people who are in the basket of those affected by social determinants and the less we do as a nation to help them, the more disparate and hopeless they will become. This could lead to a dangerous/frustrated situation. It is better to not educate people if you're not going to do anything.

- On the flip side, if the population is better educated about the disparities, don't you increase the probability that they could increase social pressure to get something done about it?

- There are a lot of advocates out there that haven't yet learned how important the social determinants are for health.

## DRA Project Next Steps

In discussing next steps DRA Partners noted how useful the DRA Project is in not being bogged down in the bureaucracy and allowing Partners to spend time focused on "what could and should be". Partners also appreciated the opportunity to meet those doing breakthrough work and to collaborate for long term changes.

Participants filled in personal forms on the question of where they will commit their energy for 2008 and beyond. The DRA Project will work Partners to pursue the specific next steps across the DRA Project efforts. Some of the commitments voiced to the full group include: disseminating the DRA Project results on line to their 150,000 members; making the measurement tools on social determinants more robust; considering research on CAM and the military in relation to health disparities; involving the National Association of Community Health Centers; distributing the DRA Project's report on Healthy Eating and Active Living.

The next DRA Partners meeting will be September 29, 2008.

## Appendix DRA Partner Meeting March 31, 2008 Attendees

Mariela Alarcon-Yohe MPH
Program Director
Directors of Health Promotion and Education

Penny Bailer
Executive Director
City Year Detroit

Ivonne Fuller Bertrand NRPP MPA
Associate Executive Director
National Medical Association

Clem Bezold PhD
Chairman and Founder
Institute for Alternative Futures

Linda Blount MPH
National Vice President, Office of Health Disparities, Office of the Chief Medical Officer
American Cancer Society

Ahmed Calvo MD MPH
Acting Deputy Director, Center for Quality
DHHS/HRSA

Renee Carter MD
Wellstone Fellow
Families USA

David Ellis
Corporate Director, Planning and Future Studies
Detroit Medical Center

Joyce D.K. Essien MD MBA
Director
Center for Public Health Practice at Emory University-Rollins School of Public Health
Emory University

Matthew Fritts MPH
Senior Research Associate
Samueli Institute

Roland Garcia PhD
Program Director, Center to Reduce Cancer Health Disparities
DHHS/NIH/NCI/OD/CRCHD/DRB

Kelly J. Gourdin
Program Coordinator, Optimal Healing Environments (OHE) Program
Samueli Institute for Information Biology

Miryam C. Granthon MPH
Public Health Analyst
DHHS/OS/OPHS/OMH
Division on Data and Policy

Marielle Haywood-Posey
Senior Associate Director
The Brady Center to Prevent Gun Violence
National Constituencies and Community Mobilization

Alicia Horton
Director, NCCM
The Brady Center to Prevent Gun Violence

Cecelia M. Horwitz MBA
Executive Director
Center for Future Health at the University of Rochester

Colleen Kigin
Chief of Staff
Center for Integration of Medicine and Innovative Technology (CIMIT)

Maribel Martinez
Program Manager, Center Eliminate Health Disparities
University of Texas-Medical Branch
Office of the President

Mike Mawby
Chief Government Affairs Officer
Novo Nordisk Inc.
Julia S. Moorhead
Coordinator of Alliance Development
Biotechnology Industry Organization

Rebecca Myers LSW
Special Assistant to the Executive Director
National Association of Social Workers

J. R. Peter Nelson PhD
Executive Director
Joseph P. Addabbo Family Health Center, Inc

Carmen Rita Nevarez MD MPH
Vice President for External Relations and
Medical Director
Public Health Institute

Jonathan C. Peck
President
Institute for Alternative Futures

Bianca Pullen
Bill Emerson National Hunger Fellow
Joint Center for Political and Economic Studies
Health Policy Institute

Ann Ritter, Esq.
Policy & Program Strategist
National Nursing Centers Consortium

Rochelle Rollins PhD MPH
Acting Director, Division of Policy and Data
DHHS/OS/OPHS/OMH

Summer E. Rosenstock
Intern
Institute for Alternative Futures

William R. Rowley MD
Senior Futurist and CFO
Institute for Alternative Futures

J. Tyler Ruthven
Intern
Institute for Alternative Futures

Joshua Seidman PhD
President
Center for Information Therapy

Melissa Sileo MSW, LCSW
Education Resource Specialist
Lance Armstrong Foundation

Byron Sogie-Thomas MS
Director, Office of Health Policy and
Government Relations
National Medical Association

Stephanie Ann Stevens
Intern
Institute for Alternative Futures

Tasha Tilghman-Bryant
Project Associate
C-Change

Jonathan N. Tobin PhD
President/CEO
Clinical Directors Network, Inc. (CDN)

Armin D. Weinberg PhD
Co-Founder
Intercultural Cancer Council
Baylor College of Medicine

Shannon White MPH
Public Health Advisor
DHHS/CDC/CCHP/NCCDPHP/DACH/CHAPS