Institute for Alternative Futures

# DRA Partners Meeting Summary

September, 2006

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Executive Summary 3

Introduction 7

Considering the Question 8

Exploring a Range of Advances 10

Conclusion 23

Appendix A: DRA Sponsors and Partners 24

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# EXECUTIVE SUMMARY

Representatives from a spectrum of leading health, voluntary, and government organizations gathered in Alexandria, Virginia on September 13th to eliminate health disparities. They met under the aegis of the Disparity Reducing Advances (DRA) Project, IAF's multi-year, multi-stakeholder project to identify and accelerate advances that can reduce disparities in healthcare. The DRA Project is a three year project supported by a network of organizations and individuals dedicated to eliminating health disparities. This DRA Network of Partners and Sponsors is listed in the Appendix of this report.

## Focusing on Promising Strategies: The DRA Project Portfolio

The DRA Project Portfolio is a collection of strategies identified and supported by the network of DRA Partners. Working groups will be formed around these initiatives and more will be formed as the DRA Project continues to identify and accelerate promising disparity reducing advances. The meeting identified four initiatives for reducing disparities using community based prevention and four initiatives for reducing 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 DRA Project will continue to explore new advances to reduce health disparities throughout 2006 and 2007.

## Community Based Prevention Working Groups

The greatest leverage over the long term in reducing disparities is to focus on prevention and the social determinants of health and disparities. Upstream prevention can have a wide ranging, positive impact on a range of health disparities including the big three of diabetes, heart disease and cancer. In this area the DRA Project will pursue four key efforts:

- **Refocusing on the Social Determinants of Health:** This working group will form a "Marshall Plan" for preventing health disparities by focusing on the social determinants of health. The Prevention Institute will be a key partner in identifying those leveragable activities that will form the basis of this "Marshall Plan" for preventing health disparities. The Prevention Institute is national center dedicated to improving community health and well being by building momentum for effective primary prevention.

- **REACH 2010 Lessons:** This working group will network with a major program at the Centers for Disease Control and Prevention (CDC), REACH 2010, to identify what is working in community based programs to reduce health disparities. The Racial and Ethnic Approaches to Community Health (REACH) is the CDC's cornerstone initiative aimed at eliminating disparities in health status experienced by ethnic minority populations. The lessons learned from this working group will inform our DRA Partner Network and the second round of REACH 2010 activities.
- **Healthy Eating and Active Living (HEAL) Lessons:** HEAL are the keys to preventing obesity as well as health disparities in diabetes, heart disease and cancer. This group will work with Active Living by Design (ALbD) and five other national programs to identify and disseminate lessons learned from the many nationwide HEAL programs, particularly in relation to reducing health disparities. ALbD works with partnerships across the nation to increase routine physical activity and healthy eating through changes in community design.
- **Obesity Prevention in Schools:** The Detroit City Year Project is using teams of AmeriCorps volunteers to reduce obesity in Detroit's public schools. The DRA Project will work to get the Detroit City Year Project additional funding to complete and evaluate their findings and to share and compare these lessons with other school focused programs.

## Continuous, Appropriate Care Working Groups

The fragmented and episodic nature of health care for underserved communities leads to poor outcomes across a range of conditions. The four working groups identified below will work on innovative strategies designed to tackle this difficult problem by providing continuous appropriate care that includes prevention.

- **Planned Care Model:** One of the most important ways to reduce health disparities is to have low income and marginalized populations receive quality health care with preventative services. This working group will work with Health Resources and Services Administration (HRSA) to focus on the whole person through the "planned care model." DRA will partner with HRSA's Health Disparity Collaboratives. The Collaboratives were developed by HRSA to transform primary health care practices to improve healthcare and eliminate health disparities.
- **Integrated Primary Care:** The inclusion of evidence based methods of complimentary and alternative care could reduce health disparities by making care more accessible, culturally

appropriate and affordable. This working group will work with the Samueli Institute and other DRA Partners to look for ways to integrate complimentary and alternative methods of care into primary care for underserved populations.

- **Consumer-Patient Navigation:** The DRA Project will work with the many DRA Partners currently running consumer-patient navigation projects to focus on ways to advance the evidence base, share best practices and consider how emerging information technology can assist patients and navigators to be more effective. These partners include the National Cancer Institute, the American Cancer Society, the Intercultural Cancer Council, the Clinical Directors Network and Florida Hospital.
- **Continuous, Passive 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 the treatment or progression of disease. This working group will work in partnership with BodyMedia and the Medical Automation Research Center (MARC) to design and develop pilot projects to use these new technologies to reduce health disparities. BodyMedia provides continuous body monitoring solutions for individuals and healthcare practitioners. MARC, at the University of Virginia Health Sciences Center, is a research, development and consulting organization focusing on monitoring and automation.

In addition to the eight working groups listed above, the DRA Project will continue to monitor and promote other disparity reducing advances.

- **Tobacco Control:** Tobacco Control is critical for reducing health disparities, particularly as smoking becomes more concentrated in low income populations. The DRA Project will work with the Campaign for Tobacco Free Kids to ensure optimal tobacco control strategies among DRA Project Partners.
- **Advances in Modeling:** There is great promise that advances in modeling can provide a more effective basis for targeting disparity reducing activities. The DRA Project will work with leading experts in modeling such as Joyce Essien, David Eddy, the American Diabetes Association, and others to identify and promote these advances.
- **Cancer Blood Tests:** There is great hope and great uncertainty in the development of new cancer blood tests for screening and treatment. The DRA Project will monitor the development of these and related tests for potential breakthroughs.

The working groups were identified through a process of research, evaluation and input from the DRA Partner Network. Throughout the second half of 2005 and beginning of 2006, the DRA Project conducted extensive research on new advances in healthcare. The most promising of these advances were further developed and considered at the September Partner Meeting. Those leading possibilities which DRA Partners have committed to form the portfolio listed above.

## Considering the Question: What are the Most Important Advances?

The DRA Project Portfolio grew out of our analysis of the most important disparity reducing advances and DRA Project Partner commitments. If pressed to choose one "most important" strategy for reducing health disparities, preventing and reversing obesity in poor and marginalized communities would be at the top of the list. Obesity is a major risk factor that cuts across several high disparity diseases including diabetes, heart disease and cancer. Tackling the epidemic of obesity that is rolling across many of our communities requires new strategies for community based prevention. And continuous, appropriate health care is vital for preventing and reversing obesity. In addition to preventing or reversing obesity the DRA Project identified the approaches need to reduce disparities in key diseases: heart diseases, cancer and diabetes. Many of the same strategies which are successful in reducing disparities in these diseases are the same strategies for preventing and reversing obesity. These include dealing with poverty, education, healthy eating and active living, and appropriate health care. Looking at strategies that cut across multiple risk factors and high disparity diseases creates significant leverage in eliminating health disparities.

# SEPTEMBER 2006 DRA MEETING SUMMARY

## Introduction

Health disparities are a widespread problem in communities across the nation. Healthcare disparities occur in a range of chronic and infectious diseases, and affect racial, ethnic and income groups. From the neglected inner city to the isolated hills of Appalachia, poor health is endemic. The root causes of these disparities are difficult to identify. They arise from a range of factors from poverty and a lack of education to a lack of access to quality health care and the ways these communities are structured. However, many of these disparities could be prevented by providing continuous, appropriate care and championing community based prevention.

Representatives from a spectrum of leading health, voluntary, and government organizations gathered in Alexandria, Virginia on September 13th to eliminate health disparities. They met under the aegis of the Disparity Reducing Advances (DRA) Project, IAF's multi-year, multi-stakeholder project to identify and accelerate advances that can reduce disparities in healthcare. The DRA Project is a three year project supported by a network of organizations and individuals dedicated to eliminating health disparities. The DRA Project is supported by grants from the National Cancer Institute, the Agency for Healthcare Research and Quality, the Robert Wood Johnson Foundation, the Centers for Disease Control and Prevention, the American Cancer Society, the University of Texas Medical Branch and Florida Hospital. A complete list of sponsors and partners involved with the DRA Project is located in the Appendix.

The meeting in September focused on a range of opportunities identified at the first Partner meeting in April 2006. Seven exploratory committees were formed in the wake of the first partner meeting in April and their findings and recommendations were presented. Other topics of interest were also presented by DRA Partners. Throughout the meeting, the DRA Partners were asked to commit to activities to advance these opportunities.

These commitments were collected and organized to form working groups around key strategies for reducing health disparities. Four working groups were developed to focus on strategies for reducing disparities using community based prevention and four working groups were formed to focus on

strategies for reducing disparities by providing continuous, appropriate care. These working groups form the core of the DRA Project Portfolio. As the project progresses, IAF will monitor other key advances and actively research new advances for eliminating health disparities.

## Considering the Question: What are the Most Important Advances?

The DRA Project has received input from leading researchers and modelers in the field of healthcare. The DRA Project has also looked at the major reports and scientific literature in health disparities. Over the summer of 2006, we considered the "most important" disparity reducing advances. With input from DRA Partners, other experts and the leading papers in the field, this report provides a preliminary set of answers to the question of "most important". A central caveat is that the state of evidence does not allow real numeric rankings of importance. Instead we have reviewed the insights from a variety of settings, some using limited clinical evidence, most based on thoughtful judgment.

To give a sense of direction and options on what is important, rather than to claim that we have "the answer" on what is most important, we developed three related views of the answer, based on the extensive literature, particularly key reports from the local, state, and national level (see the "most important" disparity reducing advances report, available at www.altfutures.com/dra):

- The single most important strategy would be to prevent and reverse obesity in poor and marginalized populations. Obesity is an underlying factor in several diseases where disparities are high: including diabetes, cardiovascular disease and many types of cancer.
- The second view of what is most important for reducing health disparities, identifies the approaches needed to prevent and reverse obesity in poor and marginalized populations, focusing on the general social and economic environment, the specific food and activity components that contribute to the "obesogenic environment" in the U.S., individual and family activity, and health care's response to obesity.
- The third view asks the question differently. It considers what would be most important to reduce disparities in three key high disparity diseases – heart disease, diabetes and cancer. There is remarkable overlap among what is needed across the three diseases (see the chart #1 below) and what is required to prevent and reverse obesity.

| Chart #1<br><br>**Important Disparity Reducing Advances: Heart Disease, Diabetes and Cancer** | | | |
|---|---|---|---|
| | **Heart Disease** | **Diabetes** | **Cancer** |
| **Social and Economic Environment** | Reduce or Eliminate Poverty | Reduce or Eliminate Poverty | Reduce or Eliminate Poverty |
| | Education | Education | Education |
| | Employment | Employment | Employment |
| | Healthcare Access | Healthcare Access | Healthcare Access |
| | Obesogenic Environment Reversal | Obesogenic Environment Reversal | Obesogenic Environment Reversal |
| | Sustainable Agriculture | Sustainable Agriculture | Appropriate Food Choices |
| | Safe, Active Living Environments | Safe, Active Living Environments | Support for Physical Activities |
| | Culturally Appropriate Healthy Diet Alternatives | Culturally Appropriate Healthy Diet Alternatives | Culturally Appropriate Healthy Diet Alternatives |
| | Tobacco Control | Tobacco Control | Tobacco Control |
| **Individual and Family** | Family Cohesion | | |
| | Stress | | |
| | Emotional Support | | |
| | Food/Diet | Food/Diet | Food/Diet |
| | Physical Activity | Physical Activity | Physical Activity |
| | Weight Control | Weight Control | Weight Control |
| | Tobacco Control | Tobacco Control | Tobacco Control |
| | Alcohol Control | Alcohol Control | Alcohol Control |
| | Monitoring Blood Pressure & Cholesterol | Monitoring Glucose Level | |
| | Maintaining Treatment Regimen | Maintaining Treatment Regimen | Maintaining Treatment Regimen |
| **Healthcare** | Access to Care; reimbursement for meds and supplies at reasonable cost | Access to Care; reimbursement for meds and supplies at reasonable cost | Access to Care; reimbursement for meds and supplies at reasonable cost |
| | Early Diagnosis | Early Diagnosis | Early Diagnosis |
| | Quality Primary and Specialty Care | Quality Primary and Specialty Care | Quality Cancer Care |
| | Planned Care Model | Planned Care Model | Planned Care Model |
| | Simplifying Compliance | Simplifying Compliance | Simplifying Compliance |
| | Polypill | Polypill | |
| | Emergency Room Access | | Patient Navigation |
| | CPR & Defibrillation | | |

At the September 2006 meeting there was a significant discussion among the DRA Partners on what constitutes the "most important" advances for reducing health disparities. There was general assent that the factors listed in chart #1 were relevant and that much of the needed effort is "upstream" of health

care.  Discussion on the three views raised the issue of obesity as stigma.  Some DRA Partners recommend focusing on diet and physical activity as positive targets, rather than the "O" word.

In addition to the focus on the "most important", the discussion also focused on the significant modeling efforts by DRA Partners.  The "most important" disparity reducing advances report summarized some of the work of DRA Partners Joyce Essien and David Nerenz.  Joyce Essien is the Director of the Center for Public Health Practice at Emory University.  David Nerenz is the Director of the Center for Health Services Research at the Henry Ford Health System.  There are preliminary results from Nerenz that, among treatment approaches, controlling lipids in diabetes patients yields the greatest reduction in health disparities.  There are other community focus models, including those stimulated by CDC's REACH 2010 that should contribute to identifying priorities for reducing disparities.  For next steps the DRA Project will work with these modelers, as well as David Eddy, Senior Advisor to Kaiser Permanente, to understand the contribution of these models to understanding the relative importance of key prevention and treatment approaches for reducing health disparities.

Besides the three main diseases listed in chart #1, the DRA Partners raised other topics that the DRA Project should focus on.  These include: universal access to health care, pre-natal care, at risk children, dental health, violent injuries, evaluation strategies that look at social determinants, and the role of the free market in influencing health.

## Exploring a Range of Advances: Results of the Seven Exploratory Committees

The DRA Project is an ongoing effort that builds on the learning of previous meetings and activities. The September 2006 meeting was the second meeting of the DRA network of sponsors and partners and built on the work of the first meeting in April of 2006.  A significant amount of time at the September 2006 meeting was spent discussing the results of the seven exploratory committees formed after the first meeting.  Each of the committee created a number of recommendations for reducing health disparities. During the September meeting, the DRA Partners were asked to commit to the recommendations proposed or propose new ones.  There was significant buy-in by the DRA Partners in attendance.  Their commitments formed the backbone of the DRA Project Portfolio.

For those partners who could not attend the DRA Partners Meeting, below is a short overview of the discussions at the September 2006 meeting. The overviews cover the seven exploratory committees as well as additional topics discussed. These additional topics were led by partners in the DRA Network. Reports for the committees as well as slides from the meeting will be placed on the project website (www.altfutures.com/DRA).

## Community-focused Approaches to Prevention

Community focused approaches to health was the leading choice for further exploration by the attendees of the April 2006 DRA Partners meeting. The attendees recognized the importance of taking a broader look at health to identify and address some of the social determinants that lead to disparities in health. The committee charged with exploring this topic further relied heavily on the expertise of one of the DRA Partners: The Prevention Institute. The Prevention Institute, a leader in identifying and promoting community strategies for health and prevention, prepared the committee report for this topic: *The Imperative of Reducing Health Disparities through Prevention: Challenges, Implications, and Opportunities*.

Larry Cohen, executive director of the Prevention Institute, also led the discussion of this topic at the September 2006 meeting. He described 13 community factors that underlie health and lead to health disparities in underserved communities as well as 10 key disparity reducing strategies on which public health practitioners, advocates, and decision makers should be focused: Primary Prevention, Underlying Determinants of Health, The Built Environment, Sustainable Agriculture, Economic Development, Social Norm Changes, Community-based Participatory Efforts, Comprehensive Approaches, Interdisciplinary Collaboration and Community Resilience. Five of these emerging strategies are particularly appropriate for the DRA Project—the built environment, sustainable agriculture, economic development, social norms change, and community-based participatory efforts. These strategies affect multiple community health factors and can prevent a range of high disparity health problems. No one strategy will, in isolation, solve the disparities crisis. However, together they do represent a comprehensive approach to prevention across multiple diseases. As Cohen noted, a good solution solves multiple problems.

Sarah Strunk, director of the Active Living by Design Program, reinforced the Prevention Institute framework, and noted that rural areas would need greater attention. Other DRA Partners identified parallel opportunities to learn from community networks. Andrea Hegedus from REACH (Racial and Ethnic Approaches to Community Health) 2010 proposed a collaboration between REACH and the DRA Network to disseminate findings about what works in different racial and ethnic communities from the REACH 2010 evaluations. Joyce Essien pointed out that prior efforts at community modeling provide much value, but to get those applied, there is a need to recognize that we are "doing international health work in the USA", and that disparity reduction will require reframing so that people understand that their health is related to the health of others in the community.

## Using Cell Phones to Reduce Health Disparities

Cell phones can provide a platform for supporting health and treatment among poor and underserved populations with positive health messages and helping them navigate the healthcare system. Cell phones can also be biomonitors, recording information or conveying biomonitoring data from an individual to data storehouses or to their health care provider. Cell phones and biomonitoring, by themselves, will not reduce health disparities. But, if they help to provide better management of disease by patients and their doctors, and if they reinforce healthy behavior, their impact could be significant.

A number of opportunities and ideas for using cell phones for reducing health disparities were discussed. One topic discussed was the development of health information that could be included with free music, video and game downloads to get positive health information to teenagers and to reinforce healthy behavior. And there was much overlap with the opportunities to consider the role of cell phones in pilot testing of continuous passive biomonitoring. The DRA Project will consider developing the scenarios and strategies for cell phones to play a role in reducing health disparities and, if appropriate, additional DRA Partners can be recruited.

## Enhanced Consumer Navigation of the Healthcare System

One of the most persistent disparities in the healthcare system is the inability of poor and minority patients to navigate the maze of rules, regulations and institutions to access the care they rightly deserve. This is a separate issue from access to care in the first place. It focuses on the disparities resulting from

the inability of patients and health care providers to ensure that patients are able to receive appropriate care. For poor and marginalized patients, where treatment is complex and specialized, such as cancer treatment, and where patients have multiple, uncoordinated providers for different chronic conditions, initial disparities in incidence of disease parallel the inability of patients to navigate healthcare systems.

The conversation at the September 2006 meeting revolved around two main items: identifying and improving the healthcare system to make separate navigation programs unnecessary and developing the public support needed to maintain and expand navigation programs. Advances in technology combined with better training of existing staff in healthcare systems was seen as a solution to the problem by some of the partners. Others believed focusing on patient navigator programs for underserved populations was also vital to reducing healthcare disparities. The key to accelerating these programs is the development of an evidence base that proves their efficacy. The Center to Reduce Cancer Health Disparities (CRCHD) is developing this evidence base through their Patient Navigator Program and the Centers for Medicare and Medicaid Services (CMS) is looking at the cost-benefit of patient navigator programs while the American Cancer Society (ACS) is evaluating telephone navigators.

DRA Project Partners actively involved in developing or testing navigator programs include the CRCHD at the National Cancer Institute, the American Cancer Society, the Intercultural Cancer Council, the Clinical Directors Network, and Florida Hospital. A group of these and other DRA Project Partners will work to advance the evidence base, share best practices, and consider how emerging information technology and information systems can assist patients and navigators to be more effective.

## Continuous, Passive Biomonitoring for Health and Prevention

Continuous, passive biomonitoring can be worn or used in the home to monitor patients in free living environments. Combined with software for health coaching, these monitors can improve health and help manage disease. For reducing health disparities, there are two particular areas where continuous, passive biomonitoring might play a key role: preventing the incidence of high disparity diseases and helping patients manage existing high disparity diseases.

John (Ivo) Stivoric, Chief Technology Office of BodyMedia, presented recent developments in using personal biomonitoring. He also discussed the use of personal biomonitoring for weight loss as well as

for monitoring and managing diabetic patients, noting that using the monitoring system led to improvements in the control of the patients' diabetes.

The meeting conversation turned to expanding the use of biomonitoring to show the link between behavior and disease. A number of partners expressed interest in exploring continuous, passive biomonitoring through pilot studies in low income, underserved populations. Two high disparity chronic conditions, obesity and diabetes, were seen as promising targets for research. Several community health centers and other DRA Project Partners will design and develop additional pilots using BodyMedia's Bodybugg system as well as the Noninvasive Analysis of Physiological Signals (NAPS) system developed by the Medical Automation Research Center (MARC) of the University of Virginia.

## Automated Control of Insulin Levels

A significant amount of research time and dollars is being spent to develop a robust, automated system for controlling insulin levels. Such a system holds promise for improving patient control over diabetes and reducing complications from the disease. Since diabetes is a disease for which there are high disparities in both prevalence and outcomes, automated control of insulin levels could be promising advance for reducing health disparities.

However, on further evaluation, the committee considering this topic did not find automated control of insulin levels a good candidate for reducing disparities. The committee discussed a number of other promising advances for diabetes that would be worth pursuing through the DRA Project. A polypill that could be used to control diabetes was seen as the most promising of these other options for reducing disparities related to diabetes. The diabetes polypill would include generic versions of metformin, aspirin, a statin, and an ACE inhibitor. A key challenge to overcome for the development of a polypill is the dosing requirements for the different component drugs, particularly the ACE inhibitor, which may vary across patients with differing levels of heart disease complications. Another promising advance discussed by the committee is to perform more quantitative assessments of the patterns of disparities in diabetes to better target disparity reducing possibilities.

## Early Detection of Cancer Using Blood Screening

Effective, easy to use screening tests detecting early cancer could make a big difference in beginning treatment early in the course of disease. Early treatment of cancer increases the likelihood of success. This promise is not lost on the biotechnology companies that develop new diagnostics. Even though there is ongoing work in identifying gene and protein patterns associated with cancer, much more research is necessary to identify and validate specific profiles for identifying early cancers. Genetic and proteomic blood tests for cancer screening and diagnosis are in early stages of development and will likely be in the market place within 10 years (plus or minus a few). At this stage, it is advisable to keep a close eye on innovations in this sector and then work to expand access to them in the market as they prove safe and effective.

With these comments in mind, IAF developed three time horizons for accelerating the disparity reducing potential of blood testing for the early detection of cancer. A more detailed description of DRA Project activities in each of these horizons is available in the Report of the Early Detection of Cancer Using Blood Testing Committee at www.altfutures.com/DRA.

- Horizon 1 (1-3 years) – near term – Review Currently Available Approaches; Monitor and Shape Emerging Potentials
- Horizon 2 (4-6 years) – mid term – Position Strategy and Resources to Leverage Promising Advances
- Horizon 3 (7-10 years) – long term – Uncover Possibilities and Create Options

The discussion on this topic at the meeting largely confirmed the committee's report. Jerome Yates, National Vice President of Research at the American Cancer Society, pointed to the promise of the HPV vaccine as a disparity reducing advance. The HPV vaccine, which was recently approved for use by the Food and Drug Administration, could eliminate 80% of cervical cancer if it is widely used in at-risk populations. The attendees also discussed the importance of ongoing cancer disparity surveillance in reducing health disparities and the need to use existing data on cancer disparities to better target disparity reducing advances.

The DRA Project will monitor these developments in the cancer blood test area and related areas and stimulate readiness of health care providers, particularly community health, to use them and for funders

to be clear on the standards for reimbursement. In the process, the DRA Project will work to compress the normal diffusion time of tests that can make important differences in cancer detection and survival. The DRA Project will also monitor parallel advances in other forms of monitoring for early stage cancer and precancer, e.g. breath, saliva and other forms of testing in addition to blood tests.

## Community and National Biomonitoring to Support Upstream Change

Today's surveillance and biomonitoring systems are providing an increasing awareness of risk factors, health conditions, and disease states in communities and among at-risk populations. These monitoring systems will grow in their scope and sophistication as they are coupled with other important advances over the next ten years. These advances include the deployment of more sophisticated electronic medical records, regional and national health information systems, new biomonitoring devices and biomarker tests. As these systems evolve and improve, we will be able to target individuals and communities for "upstream" prevention.

The DRA Project will consider some of these opportunities as it pursues other efforts in the initial portfolio. The DRA Project will remain open to DRA Partners taking the lead in developing other efforts to use biomonitoring as well as community and national information gathering to move upstream with prevention.

## Other Key Opportunities for Reducing Health Disparities

**Obesity Prevention in Schools:** Obesity is a rising problem among young children, especially in underserved communities. Penny Bailer and Sharon Milberger presented one ongoing community approach to reducing the epidemic of obesity in schools: City Year Detroit. City Year is a collaborative effort between AmeriCorps and local communities that provide AmeriCorps volunteers to local schools. In Detroit, only one semester of physical education is required over 12 years of schooling. City Year Detroit fills that gap with after school programs that focus on after-school exercise and other community prevention strategies.

**Integrated Primary Care:** Wayne Jonas, director of the Samueli Institute for Information Biology, discussed the integration of alternative medicine into primary care. The conversation focused on the

potential benefits of integrating alternative medicine into primary care and the possible use of alternative medicine providers as primary care providers. There was general agreement that the evidence for efficacy for many of these treatments would need to be proven and that there would need to be safeguards to ensure that underserved populations don't receive an alternative medicine treatment as second class treatment. Another topic of conversation was the importance of patient empowerment. Patient empowerment can often dramatically enhance the efficacy of therapy. Alternative therapies, especially prayer, can be an important part of empowering poor and minority patients.

**Tobacco Control:** In part because of the success in reducing smoking rates in the US since the 1970s, tobacco use is disproportionately focused in lower income and some minority populations. Many middle class Americans don't see tobacco use as a problem because they don't see or experience tobacco use in their daily lives. Tobacco control was added to the DRA Project horizon when Matt Myer, director of the Campaign for Tobacco Free Kids, pointed out its importance for reducing health disparities. The DRA Project can play an important role in tobacco control by raising awareness of the issue, particularly encouraging the tobacco control efforts of DRA Partners, coordinating strategies for tobacco control and adding a futures perspective to the issue.

## The DRA Project Portfolio

The DRA Project Portfolio is a collection of initiatives identified and supported by the network of DRA Partners. These initiatives came directly from DRA Project Partners during the September 2006 meeting. Working groups will be formed around these initiatives. The meeting identified four initiatives for reducing disparities using community based prevention and four initiatives for reducing 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 DRA Project will continue to explore new advances to reduce health disparities throughout 2006 and 2007 and will form additional working groups as promising advances emerge.

The DRA Project Portfolio crosses a range of categories from public health and prevention to treatment. It also covers advances that are appropriate in the near term to long term advances that may not fully materialize for another decade. Near term advances, such as tobacco control, are advances that are well

understood and should be widely implemented. Mid-term advances are those that show early stage promise and should be piloted and tested now for widespread application in four to six years. Long-term advances, such as blood tests for early stage cancer, show incredible promise in early stage research, but may not be ready for widespread use for more than a decade.

## Community Based Prevention Working Groups

The greatest leverage over the long term in reducing disparities is to focus on prevention and the social determinants of health and disparities. Upstream prevention can have a wide ranging, positive impact on a range of health disparities including the big three of diabetes, heart disease and cancer. The social determinants of health working group will focus on this opportunity. The REACH 2010 and HEAL lessons working groups will look at the success of programs that address the social determinants of health while the obesity prevention in schools working group will support one promising approach to preventing obesity, a key risk factor in health disparities.

## Refocusing on the Social Determinants of Health

This working group will form a "Marshall Plan" for preventing health disparities by focusing on the social determinants of health. This effort will convene key leaders to developing an overarching roadmap for preventing health disparities that incorporates the social determinants of health. Some promising strategies for dealing with the social determinants of health include focusing on the built environment, sustainable agriculture, economic development, social norms change, and community-based participatory efforts.

The Prevention Institute will be a key partner in identifying those leveragable activities that will form the basis of this "Marshall Plan" for preventing health disparities. The Prevention Institute is national center dedicated to improving community health and well being by building momentum for effective primary prevention.

## REACH 2010 Lessons

This working group will network with a major program at the Centers for Disease Control and Prevention (CDC), REACH 2010, to identify what is working in community based programs to reduce health disparities. The Racial and Ethnic Approaches to Community Health (REACH) is the CDC's cornerstone initiative aimed at eliminating disparities in health status experienced by ethnic minority populations. The lessons learned from this working group will inform our DRA Partner Network and the second round of REACH 2010 activities.

## Healthy Eating and Active Living Lessons

Healthy Eating and Active Living (HEAL) are key approaches to preventing obesity are well as reducing health disparities in diabetes, heart disease and cancer. This group will work with Active Living by Design and five other national programs to identify and disseminate lessons learned from the many nationwide HEAL programs, particularly in relation to reducing health disparities. Active Living by Design (ALbD) works with partnerships across the nation to increase routine physical activity and healthy eating through changes in community design.

## Obesity Prevention in Schools

The Detroit City Year Project is using teams of AmeriCorps volunteers to reduce obesity in Detroit's public schools. The DRA Project will work to get the Detroit City Year Project additional funding to complete and evaluate their findings and to share and compare these lessons with other school focused programs.

## Continuous, Appropriate Care Working Groups

The fragmented and episodic nature of health care for underserved communities leads to poor outcomes across a range of conditions. The four working groups identified below will work on innovative strategies designed to tackle this difficult problem. These strategies address the problem of fragmented and episodic care by providing continuous, appropriate care that includes prevention. The planned care and the integrative care models seek to provide appropriate care that is continuous across multiple

chronic diseases and incorporates prevention and other services. Consumer-patient navigator programs seek to provide continuous care from abnormal tests to treatments by helping patients navigate the confusing maze of contemporary healthcare. Continuous, passive biomonitoring seeks to integrate advances in monitoring capabilities into ongoing prevention and care activities.

### Planned Care Model

One of the most important ways to reduce health disparities is to have low income and marginalized populations receive quality health care with preventative services. Around the U.S., the most significant enhancements in quality among healthcare providers in low income communities have been the collaboratives in community health centers formed by the Health Resources and Services Administration (HRSA). The Planned Care Model currently in development by the Health Disparity Collaboratives provides care based on the "chronic care model". They have moved upstream to include a focus across all diseases and incorporate pre-disease screening. This working group will work with HRSA to promote the "planned care model."

### Integrated Primary Care

The integrative care model also seeks to go a step further than the "chronic care model" to incorporate complementary and alternative care that many patients receive outside the conventional medicine into an integrative whole. The inclusion of evidence based methods of complimentary and alternative care could reduce health disparities by making care more accessible, culturally appropriate and affordable. This working group will work with the Samueli Institute and other DRA Partners to look for ways to integrate complimentary and alternative methods of care into primary care for underserved populations.

### Consumer-Patient Navigation

One source of disparities is the inability to navigate the health care system, particularly for patients with complex treatment, such as cancer. Improving a patient's ability to navigate the health care system can improve screening rates for disease, reduce delays between an abnormal test and treatment and help patients identify funding for treatment. These activities can have a direct and measurable impact on outcomes.

The DRA Project will work with the many DRA Partners currently running consumer-patient navigation projects to focus on ways to advance the evidence base, share best practices and consider how emerging information technology can assist patients and navigators to be more effective. These partners include the National Cancer Institute, the American Cancer Society, the Intercultural Cancer Council, the Clinical Directors Network and Florida Hospital.

### Continuous, Passive Biomonitoring

New technology for monitoring patients in their homes and in their daily routines offer promise in conducting research, preventing disease, screening for risk factors and monitoring the treatment or progression of disease. This working group will work in partnership with BodyMedia and the Medical Automation Research Center (MARC) to design and develop pilot projects to use these new technologies to reduce health disparities. BodyMedia provides continuous body monitoring solutions for individuals and healthcare practitioners. MARC, at the University of Virginia Health Sciences Center, is a research, development and consulting organization focusing on monitoring and automation.

In addition to the eight working groups listed above, the DRA Project will continue to monitor and promote other disparity reducing advances.

**Tobacco Control:** Tobacco Control is critical for reducing health disparities, particularly as smoking becomes more concentrated in low income populations. The DRA Project will work with the Campaign for Tobacco Free Kids to ensure optimal tobacco control strategies among DRA Project Partners.

**Advances in Modeling:** There is great promise that advances in modeling can provide a more effective basis for targeting disparity reducing activities. The DRA Project will work with leading experts in modeling such as Joyce Essien, David Eddy, the American Diabetes Association, and others to identify and promote these advances.

**Cancer Blood Tests:** There is great promise in having blood tests that show the early stages of cancer, possibly even pre-cancer conditions within the next decade. The DRA Project will monitor the

development of these and related developments for potential breakthroughs and opportunities to speed their appropriate use and reimbursement.

## Conclusion

Eliminating health disparities requires focus and foresight. The DRA Project will continue to mobilize and organize support for disparity reducing advances. The core of this effort will be the DRA Project Portfolio of activities that support community based prevention and continuous, appropriate care to underserved populations. The DRA Project will also monitor advances in healthcare, science and technology for promising advances that can be accelerated to eliminate health disparities.

Together the DRA Partners represent a significant and growing network of organizations with the commitment, the skill and leadership to help reduce health disparities in the United States by accelerating relevant advances. The DRA Project will also facilitate the communication of new and promising advances in healthcare, science and technology for reducing health disparities.

We all can make a contribution, by ourselves, through our organizations, and through the networks and communities where we work. The DRA Project provides the forum for accelerating those advances that can create a meaningful difference. IAF hopes to see you at our next Partner meeting on April 11th, 2007 in Alexandria, VA.

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

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# Appendix: DRA Project Sponsors & Partners

**As of October, 2006**

## DRA Founding Sponsors

The National Cancer Institute
Center to Reduce Cancer Health Disparities

The Agency for Healthcare Research and Quality

## DRA Sponsors

Robert Wood Johnson Foundation

The Centers for Disease Control and Prevention

American Cancer Society

University of Texas Medical Branch

Florida Hospital

## DRA Partners

Active Living by Design

Alliance for Health Reform

American College of Nurse Practitioners

American Health Assessment Association

Bastyr University

BodyMedia, Inc.

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

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

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

Hill Health, New Haven, Connecticut

Institute for Alternative Futures

Institute for Community Health

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

Institute for Healthcare Improvement

Intercultural Cancer Council

Leadership by Design

Maryland Department of Health and Mental Hygiene

Medical Automation Research Center
University of Virginia

National College of Natural Medicine

Outside In clinic

Planetree

Prevention Institute

Resource Center for Health Policy
University of Washington

Samueli Institute for Information Biology