Institute for Alternative Futures

DRA Partners Meeting Summary

September, 2007

September 2007 DRA Partners Meeting Summary

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Introduction

On September 25th, 2007, over 50 representatives of DRA Partners and affiliated experts met in Alexandria, Virginia to discuss disparity reducing advances at the fourth DRA Partners meeting. The logic behind the DRA Project is that health disparities in the U.S. are significant, yet they are not perceived as such by most in the U.S. We believe the pursuit of equity and fairness is a movement, like civil rights, anti-slavery and women's rights, that will take time and support, but can be made faster.

Commitments to Health Equity are growing, including the World Health Organization's Health For All vision, The U.S. Healthy People 2010 goal of eliminating health disparities, and the Institute of Medicine's Crossing the Chasm & Unequal Treatment Reports. Disparity reducing advances are available now and even more will be available in the years ahead – and these advances can be identified and accelerated. The DRA Project, using the DRA Partner Network and those we affect, can do this – accelerate Disparity Reducing Advances.

Dr. Clem Bezold, Director of the DRA Project, noted in the introduction to the September 2007 Partners meeting, a disparity reducing advance (DRA) can be: a movement, policy, technology, or health care delivery approach that leads to more equitable health. The DRA Project and its Partner network are working diligently on eight priority areas (4 in the Public Health arena and 4 in the Health Care arena) for reducing health disparities in the United States. The DRA Project identified these eight priority areas for reducing health disparities during previous DRA Partners meetings.

The four initiatives in the Public Health priority areas focusing on using community based prevention to reduce disparities are:

- Refocusing on the Community and Social Determinants of Health
- Healthy Eating and Active Living (HEAL) Initiatives
- Obesity Prevention in Schools
- REACH U.S. [Racial and Ethnic Approaches to Community Health Across the U.S.]

The four initiatives in the Health Care priority areas focus on reducing health disparities by providing continuous, appropriate care are:

- Expanded Care Model
- Integrative Primary Care
- Navigators
- Continuous Passive Biomonitoring

Accelerating these disparity reducing advances can be accomplished by:

- Spreading awareness of them
- Supporting, enhancing movements
- Ensuring testing & development focused on low income populations & their providers
- Shortening the diffusion time of innovations

The agenda for this meeting included a discussion of three of the 8 efforts: as well as discussion of the overall DRA Project and input to the Healthy People 2020 objectives.

The morning sessions focused on the Expanded Care Model as well as Healthy Eating & Active Living. In the afternoon, the meeting discussed both Patient and Virtual Navigators. The DRA Project staff focused the ending session on two policy briefings that are under development for the DRA Project. The DRA Project is preparing for a policy briefing on Capitol Hill around the DRA Project Public Health efforts in the first week of December 2007. These efforts include refocusing on the social determinants of health, promoting healthy eating and active living, school wellness and the Centers for Disease Control and Prevention's REACH U.S. initiative. In early 2008, the DRA Project will conduct a session on key aspects of the DRA's health care focused efforts.

The 2007 September Partners meeting had two main objectives:

1. To better understand and connect with the task of accelerating disparity reducing advances – making the targets more clear and the actions more effective; and
2. To refine our targets and strengthen commitments to accelerate these specific disparity reducing advances:
    a. The Expanded Care Model,
    b. Healthy Eating, Active Living (HEAL) Initiatives
    c. Patient Navigators & Virtual Navigation

Status Report of the DRA Efforts Discussed September 25

The Expanded Care Model

The DRA Project has identified the HRSA Health Disparities Collaboratives as a significant disparity reducing advance. HRSA concurs and wants the DRA Project to work with them to advance and support the next stage of the Collaboratives and the underlying chronic care model. The next stage is called the Expanded Care Model. Ahmed Calvo, MD, Medical Director of the Health Disparities Collaboratives at HRSA, explained the origins and directions of the Expanded Care Model. Dr. Calvo noted that the prevalent system of health care delivery often has doctors practicing in a vacuum, complying with guidelines in their caregiving only 20% of the time, with 40% of the resources going to waste and inefficiency. The work of health centers, particularly through the Collaboratives is changing this.

The Expanded Care Model grows out of this experience. It focuses on primary health care. This approach has shown significant improvements for patients, though the financial implications of the quality improvement emphasis are still being analyzed. The expanded care model is about empowering patients for self - care, coupled with mobilizing population data and community resources to facilitate the patients' ability to care for themselves in coordination with a proactive team of care providers that has simultaneously committed to coordination of all these activities. All of the relevant components of regular care delivery are organized together to try to optimize and activate both the patient and the care team. The expanded care model promotes a culture of effectively and efficiently delivering safe, high quality care, which is grounded on evidence - based methods. Evidence - based literature has begun to

accumulate for the value of the chronic care model (on which the expanded care model is based). There is also the opportunity to integrate complementary and alternative medicines or modalities (CAM) into the Expanded Care Model.

Tom Curtin, the Chief Medical Officer of the National Association of Community Health Centers (NACHC) responded that some of our leading health centers have been moving toward the expanded care model on their own. They naturally used the original collaborative approach that was focused on one disease at a time to enhance their care for multiple diseases. A team aspect of the Expanded Care Model is consistent with the way that most Community Health Centers (CHCs) operate. It is critical that health center leadership understands the value of the components of the model. NACHC has a natural distribution mechanism in its website where health centers share their processes. This website has enormous number of hits from NACHC members. Also it is important to realize that the Expanded Care Model will be focused within each health center on their unique community. Each community health center has its own community based board of directors that keeps the centers grounded in the community and its needs.

Another question focused on the need to take this health focus to schools and to very young children. Tom Curtin agreed and noted that they look to the community partners including “churches and other community partners”. Some of the health centers have used this type of model to work with churches to encourage breast feeding – and they have proved more effective than doctors and staff alone in encouraging this.

Peter Nelson - is the CEO of the Joseph Addabbo Family Health Center in Queens New York, one of the most diverse communities in the planet - with 137 languages spoken. Nelson put the Expanded Care Model in context of the role of his Community Health Centers (CHCs). 20 years of research shows that federally qualified health centers are among the best medical care today, though CHC’s are unappreciated and relatively unknown. When CHC patients go into hospitals these patients get 30% better results, including lower mortality rates and consume 45% less medical resources in the process. While CHC physicians are not better than private practice doctors (though all CHC doctors are board certified and are highly regulated in terms of the quality of their practice) there is a fundamental difference in the practice. CHCs have a team approach among the CHC staff, doctors, nurse practitioners, and other staff. And CHCs routinely venture into the community to expand their partners (for example working with local clergy to do Post Traumatic Stress Syndrome counseling). CHCs venture into areas that hospitals often don’t. The Addabbo Family Health Center is applying the Expanded Care Model already and is tracking health benefits. CHCs need better tools for tracking costs. Peter Nelson believes that there are significant costs savings involved in this approach and we need to show that. Addabbo thinks that it now achieves cost savings of 30% over prevalent health care systems and believes that this can be increased to 45 to 50%. CHCs are working on pilots to show this now.

Joyce Essien of CDC and Emory raised questions about whether the Expanded Care Model deals adequately with health rather than care or treatment and with systems particularly over the life cycle. Ahmed Calvo argued that the collaborative approach to cancer screening used a systems approach to move beyond treatment and do more effective early detection. He

acknowledged that the collaborative missed a life cycle focus and as a consequence did not focus explicitly on elders. The U.S. Department of Health and Human Services, via HRSA, working with the Agency on Aging (AoA), Centers for Medicare and Medicaid (CMS), the Centers for Disease Control and Prevention (CDC), and the Agency for Healthcare Research and Quality (AHRQ) has now begun a Hispanic Elders Initiative in several cities to use the Expanded Care Model and other related models, particularly to improve diabetes outcomes.

The DRA Project will work with HRSA to refine and promote the Extended Care Model including the addition of complementary and alternative approaches to appropriate self care and treatment. We will seek to publish a paper, a draft of which was distributed at the meeting, which compares the Expanded Care Model to the operations of patient-centered medical homes; and will seek to have a symposium on the Expanded Care Model in 2008.

Reducing Disparities though Healthy Eating and Active Living Initiatives

Sarah Strunk, Director of Active Living by Design, a national program of the Robert Wood Johnson, noted that this report represents a significant opportunity to highlight the growth of these initiatives and the evolution of some as disparity focused efforts. A movement is brewing in parallel to these initiatives that we should support. She added that it is important to identify those programs and elements that go beyond an individual focus and address broader community conditions that can be accomplished through policy and environmental change. In addition, she cautioned against framing the movement too strongly around obesity because of the risk of stigmatization and because there are likely to be additional pressing problems in target communities that they might choose to pursue over obesity prevention alone. It may be important to learn to frame these initiatives in a variety of ways, as they have the potential to address important issues such as crime and safety, economic development, etc. in addition to health disparities. The DRA Project and its Partners can be significant in promoting healthy eating/active living initiatives to reduce health disparities, she noted, because we include the public sector, health care providers, and other sectors. We can also recruit additional local advocates, faith based organizations and additional non-profit groups.

Ms. Strunk encouraged everyone to consider their approach to community problems and the opportunity that this view of healthy eating and active living represents for their community. In addition, each of our DRA Project Partners was encouraged to use this perspective on themselves, asking what healthy eating and active living principles they can apply to and for themselves as organizational leaders. “Each of us at this DRA Partners meeting have an important role within our organization about policy changes,” she noted, encouraging participants to ask themselves questions like: Are there are stair wells in your building clean and well lit? Does break time at meetings only include soda and cookies? Are breaks long enough to encourage activity? Are there showers in your facility that facilitate bike commuting to the office or exercise during the day? Attendees were encouraged to consider these and other changes that would make life more conducive to health in their organizations.

Andrea Hegedus, of the REACH U.S. Program at the Center for Disease Control, argued that the DRA Project report makes two major statements. First, we are moving from the medical

model into the larger community focus for health. However, she added, it is difficult to translate what we know to community based work. While these HEAL programs, other than REACH and Place Matters, do not focus as predominantly on disparities, there is still evidence of a community movement that is pushing forward. "It is possible to change behavior," Hegedus observed, "but how can we take what we learn and say to other programs that it's not rocket science and train them to support changes in their behavior?" The second theme of the report, Hegedus continued, is that there is a need to change to an evidence-based approach. While this is not necessarily appropriate for all community work, we must first understand how change is made, and what meaningful change is for the community, if we are to have a lasting impact. There is a need to gather evidence that change is possible.

Sarah Strunk cautioned that this healthy eating/active living initiative can be extremely intimating because you have to change policy. It is hard work and it is messy. People tend to become daunted as they have to work with city council members, other policy–makers and schools. Funding these efforts can also be a challenge, but their energy can be significant. RWJF will give out about $5 million to its 25 ALbD communities over five years. Yet those communities in their first four years have raised an additional $132 million on their own for these healthy eating, active living efforts.

Andrea Hegedus noted that, in the REACH U.S. program, community is defined in many ways, but that it does take a coordinated effort adding that "all our work is built around coalitions. It's hard work, not as easy as it sounds. But it does work in different ways in different communities. Success stories, such as those at CDC REACH U.S. website, take the mystery out of being successful. Policy issues can be digested in smaller chunks."

Participants observed that many DRA Partners can be more involved in HEAL Initiatives, that it is challenging, that celebrities can be involved to support the efforts, and that social workers are often already involved in this space. A number of DRA Partners attending the meeting indicated that they are already involved in collaborations designed to promote healthier eating and physical activity and a number of organizations went on to offer help with the distribution of the final DRA Project report on healthy eating and active living efforts.

Navigators

The DRA Project should consider how navigator efforts can be made sustainable, and how emerging information technology can assist patients and navigators to be more effective in reducing disparities.

Virtual Navigation:

DRA Project Forecast:

> *By 2017, Virtual Navigation has grown, but not removed all disparities. Cell phones will have helped to reduce the Digital Divide. Internet penetration will still be lower for the poor, but most lower income people will have access to virtual navigation. There will be Personal Health Records (PHRs) for most people and we will see gains in screening and detection, and data on PHRs. Increased numbers of risk factors will be routinely*

considered in care. Biomonitoring data will be included in PHR& Electronic Medical Records (EMRs). Language translation will be widely available and tailored to literacy level. Information therapy will be common in health care. Many individuals will get their care in "virtual space".

The preliminary DRA Virtual Navigation Recommendations were: To use these forecasts with leaders to ensure that the advances work effectively among marginalized populations, to work with HRSA/health centers to understand & optimize evolution of virtual navigation in their systems, to work with associations and organizations of people of color and involve them in development, to identify ways to reduce the Digital Divide, to ensure navigation tools are embedded with PHR/EHRs and provide focused, usable information.

The question is which of the preliminary recommendations in the area of virtual navigation should the DRA Project pursue?

Josh Seidman, Center for Information Therapy – Was in agreement that we need to embed navigation tools into Personal Health Records and develop links to the patients Electronic Medical Record. We also need to contextualize the data so it is understandable to the patient and useable for their clinician. Navigation is also part of the growing social media – increased cell phone use, text messaging, IM are part of this. Home monitoring and health coaching by telephone is also growing.

David Ellis – Patients have increasingly been going online to navigate their health (i.e. Web MD, etc…). Second Life is a 3-D interactive online environment – a "virtual world" -- that represents a sort of Web 3.0 and already today provides interesting opportunities for virtual navigation. Of particular interest is the maturation of artificial intelligence to the point where AI avatars may soon be able to perform the role of patient navigator. The Detroit Medical Center is currently developing such a concept.

In the discussion, health literacy was raised as an issue. Roland Garcia from NCI pointed out that cancer patient literacy can be at a fourth grade level even though they claim to have graduated from high school. And many lack access to computers. Yet computers are becoming more available. And Alex Gerwer of Siemens noted that we can import the lessons from the $100 computer being developed for low income nations. Language translation in the virtual navigator will be common and in the near future can also adjust to the appropriate literacy level of the user.

We will work with DRA partners, health IT systems and navigators to explore the intersection of virtual navigation and human health navigators & work to enhance navigators and navigation.

Patient Navigator Functions & Sustainability of Navigator Programs:

A panel of DRA Partners involved in human navigator programs discussed the current issues and concerns of non-standardization of skills and training of those who currently work as navigators in clinical and community settings around the country. Currently theses include:

Patient Navigators, Nurses, Nurse Practitioners, Social Workers, Clinical Social Workers, Community Health Workers, Lay Health Advocates, and Promotores de Salud. Along with the uncertainty of minimal standards, the concern of financial and human resource sustainability was discussed.

Clem Bezold introduced the array of functions patient navigators perform that the DRA Project had developed in conjunction with DRA Project Partners. What does (or should) a trained un-paid volunteer do as opposed to a community health worker or to a licensed professional? Given this set of functions and a better understanding of what types of navigators effectively perform which of these functions; can we develop principles for more cost effective and sustainable navigator programs?

Roland Garcia, NCI, stated that two groups who do navigation are missing, namely the survivors and advocates. In terms of NCI's research, NCI opted to not encourage the use of volunteers, since this was a clinical intervention study. Many of the NCI navigators have some college, and several have degrees. It had been agreed by the PIs that a minimum level of education would be a high school diploma. All of the navigators are a member of the health care team.

Angelina Esparza, ACS, stated that they have 84 programs for newly-diagnosis cancer patients and medically underserved. ACS Patient Navigator Programs will help patients reach appropriate ACS programs and other appropriate referrals. She agreed that survivors were missing, and bring a unique view to the table as navigators as they are survivors as well and can share their experiences. There are also other disciplines and ancillary health care providers who play navigator roles, such as social work technicians, health educators, nurses, etc.

Missing from the current DRA Navigator Activity list is: patient empowerment, issues related to survivorship and caregivers, patient education and long term management of chronic disease. DRA should look into creating a survey to better categorize navigator functions across navigator programs.

In order to assure a Reimbursable and Sustainable program, we must first define the services, education, and knowledge attainment of the navigators and competency for success at performing these identified functions.

ACS has plans to have their navigators keep activities diaries. If ACS and the other navigator programs did similar data gathering we would have a better sense of how best to deploy navigators.

Jonathan N. Tobin, Ph.D., Clinical Directors Network (CDN) – The Dartmouth-CDN/NCI Prevention Care Manager (PCM) patient navigator project was a randomized controlled trial of telephone-based education and outreach that showed dramatic increases for cancer screenings (breast, cervix and colo-rectal cancers) in NYC-based Community Health Centers. The feedback was unanimous from the Community Health Centers - while they embraced the significant increase in screenings in all three areas, they said they do not have the resources

to implement and sustain the prevention activity, which would require expenditures to hire patient navigators. After the success of the initial project, CDN wanted to replicate initial clinical trial in partnership with health plans (Medicaid HMOs) that fund insured patients in Community Health Centers. NCI awarded Dartmouth and CDN a grant to conduct a pilot study in one Medicaid HMO to test the feasibility of such a study. The key findings from this second clinical trial include 1) demonstration of effective translation of the intervention from the Community Health Center to the Health Plan setting 2) replication of results for colo-rectal cancer screening 3) determination of availability of established telephone outreach programs at Health Plans that could be re-trained to provide patient navigation services. CDN and Dartmouth are now conducting a full-scale NCI-supported randomized clinical trial with four NYC-area Health Plans and twelve Community Health Centers. Although effectiveness was similar between the Community Health Center-based and Health Plan-based studies, challenges in the Health Plan setting differ in some important ways from those identified in the Community Health Center. The rationale that applies to Community Health does not always apply in the managed care world. For example, the average rate of retention in Medicaid in New York State for adult women over twelve months was 51%, indicating high levels of membership turnover. This turnover decreases the incentives for each plan to invest in clinical preventive services for diseases that may not occur for many years, as many patients will no longer be insured by the plan when their disease will require coverage. Strategies that increase the appeal of participation included helping Health Plans to meet the NY State annual requirement to participate in research and quality improvement activities. Another appeal for the plan was to demonstrate that they could use existing staff who provide telephone outreach, in more effective ways, such as supporting prevention for members.

Armin Weinberg, Intercultural Cancer Council – You need to know where you are going so you know when you get there. Yet, for many in minority and underserved communities they neither know where to go or once there, how to achieve access. Therefore, a key element of support that navigation can provide is the assurance that they will indeed efficiently understand where they are going, get where they are supposed to be, and benefit from the services that are provided to meet their needs. Another equally important principal is to consider the source of the navigation. Think about penetration down to the community, about other organizations that are out there doing effective everyday services for these individuals in their community. Is this where the "navigators" will work, or start? I would suggest that some of these are missing here at the table today… they are the community-based education, faith based education, local organizations. When looking for information, people go to neighborhood centers and church related activities. One good example is the lessons learned from Katrina through an Office of Minority Health supported project called Project Reconnect (iccnetwork.org). What we learned:

1. Volunteers, people we were trying to help turned to family or friends.
2. Penetrate as far down into the community as we can.
3. People needed to feel a level of trust. Family became important because of trust issues.
4. Principles and Principals… talking about both.

It was clear that although many national, state, local resources were mobilized the trusted source for helping those who were displaced often came from small faith-based and community-based organizations.

Comments:

After hearing the panel, there was agreement that there needs to be standardized education. The question is - how are they to be trained above and beyond the level of education and/or training regardless of professional position (nurse, social worker, etc...)? What is the level of knowledge of cancer disease and treatment navigators should have? What are the core competencies of navigator training?

Jonathan Tobin, CDN, offered some other points to consider. Patient navigators need a basic knowledge of cancer screening. They need to know the instrumental issues related to the health care system (where to go for mammograms, what is a gastroenterologist?) along with skills to provide motivation and support. Becoming a patient navigator could also be viewed as an entry point of higher education and professional/career development for some, thereby bringing more people into employment in a health care setting. Let's not overlook potential opportunity. He also expressed concern that a proliferation of virtual and real patient navigators (i.e. a different one for cancer, one for diabetes, etc…) would create too many care managers, and an increase in the frequency of medical errors could arise at handoffs. We must also consider what natural barriers that exist such as HIPPA. We must do it in a way that doesn't create new silos of care.

Angelina Esparza, ACS**,** noted that it is a challenge to assure proper training and preparation of navigators across programs and at various experience and educational levels. In some cases navigators can be GED graduates and others foreign trained physicians.

Another view was that patient navigators should be able to question or critique the system, because the system is essentially unnavigable. Besides having the navigator navigate through the system, the navigator needs to be empowered to navigate through and change the system, whenever possible.

Other Comments

Another concern raised from the view of the health centers was that malpractice insurance does not cover a navigator unless they are an employee, which eliminates all use of volunteers and thereby increases costs. The question is - how can they be covered by malpractice? What are their credentials? These navigators would have to be paid in order to sustain them.

The DRA Project will work with DRA Navigator Partners to Survey their Patient Navigators on who performs what specific functions (i.e. lay volunteers or licensed staff) and the implications for effectiveness, efficiency, and sustainability of the programs.

Status Report of the DRA efforts not discussed in detail at the meeting:

The DRA project is making steady progress across all eight priority areas. Deeper in the report, the DRA Project discusses the three priority areas discussed at the Partners Meeting. This section provides an overview of the status of the other five priority areas.

In the **Public Health** priority areas, the DRA Project is currently working on:

1. **Refocusing on the Social Determinants -** The DRA Project is working to increase understanding by key individuals of the role of social determinants of health. We are encouraging use and involvement in the PBS Mini Series "Unnatural Causes." Organizations can sign up to sponsor a viewing at www.unnaturalcauses.org. DRA is also working to facilitate a "design meeting" for the movement.
2. **Promoting Obesity Prevention in Schools** – There are exciting developments in the City Year Detroit effort to promote health using integrated school-based teams. The DRA Project has a draft report identifying the range of options for school focused wellness or obesity prevention.
3. **REACH U.S.** – The DRA Project is working with CDC to promote awareness of this effort, which focuses on increasing activity and healthy eating in minority communities. Preliminary lessons from REACH will be part of the DRA policy briefings.

Health Care priority areas not focused on at the September Partners meeting:

1. **Integrative Primary Care** – DRA Partners continue to express interest in considering the current use of complementary and alternative health approaches, particularly in community health centers. We are hoping to encourage a meeting on this topic as well as to integrate a focus on complementary and alternative modalities into the Expanded Care Model.

2. **Continuous Passive Biomonitoring** – The DRA Project is encouraging the work of the Medical Automation Research Center and other technology developers to apply their work in low income communities and communities of color. The DRA Project is looking for the involvement of Partners and other colleagues in helping to implement the recommendation for disparity reducing biomonitoring, particularly in standard settings and in the federal government.

Healthy People 2020

Linda Harris, of the Department of Health and Human Services' (DHHS) Office of Disease Prevention and Health Promotion, briefed DRA Partners on the Healthy People 2020 development process and invited Partners to get involved in formulating the 2020 objectives, particularly as they relate to disparities and health information. Many of the DRA Project

discussions, such as the Expanded Care Model and the Navigator are directly involved in health information. Dr. Harris invited the DRA Partners to consider making the navigator system a part of identifying a disparities reduction informatics objective that we could work to put in place over the next decade.

The discussion further considered the uses of the Healthy People 2020 Objectives, their focus and whether the overarching goal of to "eliminate health disparities" would remain. Attendees voted an emphatic "yes" on this point. It was further argued that in considering information and communication objectives, a focus using a socio-ecological model, which includes more than health care and health status data and metrics is important.

DRA Project Policy Briefings

DRA Partners heard plans for upcoming DRA Policy Briefings that will carry messages from the DRA Project to the Washington DC policy community, particularly on Capitol Hill. Partners provided key input and will receive additional information moving forward.

A December 2007 session centering on the DRA Project's Public Health efforts (refocusing on the social determinants, using healthy eating active living initiatives & school focused wellness efforts to reduce disparities, and CDC's REACH U.S.) will be followed by a session on key aspects of the DRA's health care focused efforts in early 2008.

Next Steps for DRA Project

DRA Partners provided their comments and commitments to the various DRA efforts during the course of the day on their "green sheets" for the meeting. In part, this discussion has considered the breadth of the DRA Project's activities. Some have advised focusing on a smaller set of targets, while others have noted the breadth and difficulty of the effort to refocus on the social determinants.

While the DRA Project scope is broad, as Ahmed Calvo pointed out, there is clear evidence that activities that are too focused ultimately don't change anything. Disparities are multivariate and require a broad response. Others pointed out that there could be benefits to tying DRA Project efforts together; arguing that some efforts seem to be in silos themselves. Still others called for a restating of the causes of disparities as the introduction to our work.

Beyond this, the DRA Project elicited a great deal of programmatic feedback from participants. Several partners have raised concerns that mental health and disparities are not adequately reflected in the DRA efforts. Some attendees expressed the desire for more discussion of what is needed to create a movement. Laying the Groundwork for a Movement to Reduce Health Disparities, produced in April 2007 by the Prevention Institute for the DRA Project.

Other participants pointed out that where the movement related to social determinants is involved, there is a need to create new leadership, teach others, and equip communities for this. The DRA Project has endorsed the PBS mini-series ***Unnatural Causes***, which explores the social determinants of health, as an important tool in this area (see

www.unnaturalcauses.org). Further, the organization Synergy is trying to create such movements at the local level in some of the more mature REACH communities.

Input for future DRA Meetings included suggestions to consider greater interaction, modeling our own behavior, and using web or internet based meetings. Some argued that the DRA Project should pick specific areas, such as obesity or smoking or health care and talk about the evidence for reducing disparities – and use that to help distinguish whether the Project should be focusing on topics such as navigation or prevention.

Some partners asked about the range of topics and work the DRA Project is covering. The DRA Project is an alliance to provide strategic intelligence and leveraged action in accelerating disparity reducing advances. Bezold noted that in 2006 we considered a range of topics and gave partners the opportunity to choose ones they both thought important and were committed to working on. For example, Cell phones as a disparity reducing advance, was an intriguing topic and will require major effort (as with most of the DRA Project topics). However, Partners did not step forward to support the cell phone initiative, so the DRA Project is monitoring that area but is not currently devoting substantial resources to it.

Given the DRA Project's limited resources, it is seen as crucial that the efforts continue to work toward contributions at a strategic level – encouraging attention to key issues and networking among those in the field. **Given the diversity of viewpoints, a survey of DRA Partners on current activities and priorities was discussed and will be considered**.

Another option raised for DRA Project consideration is scenarios that include a warning regarding what happens "if we don't change". It was speculated that these could be used to get national attention to where the country is heading and what the available options might be. Since scenario development is an ongoing part of IAF's work, including scenarios on diabetes, outlining what will happen if we do not change and what is needed to reverse the national epidemic of diabetes, **DRA Project scenarios are a reasonable option to consider**. It may be possible to use David Eddy's work with Archimedes in developing these scenarios.

It was also recommended to develop one page summaries of all of the DRA Project reports and get those in the hands of policy makers and campaign staffs.

Finally, Dr. Bezold summarized the immediate next steps for the DRA Project, including the summary of this meeting as well as releasing reports on healthy eating activity living, school based wellness, the expanded care model, and the policy briefings. He went on to urge partners to provide support for moving forward with any commitments to efforts that they may be involved in before the next DRA Partners meeting, scheduled for March 31, 2008. In the meantime, DRA Partners are also invited to get involved with the public impact campaign of the ***Unnatural Causes*** miniseries and use the DRA Project's monthly newsletter to share their activities and relevant news among the DRA network.