Community Approaches to Addressing Health Disparities

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INTRODUCTION

A major national enterprise has grown up since the IOM Report devoted to documenting health disparities; understanding their clinical, service, and social determinants; and mounting specific projects that address particular combinations of health status and racial and ethnic populations. This work has given extraordinary visibility to the existence of significant and stubborn disparities and mobilized an impressive number of university centers, provider groups, and community partners. Significant federal and private foundation funding has mapped onto this agenda. A great deal of innovation and adaptation has been spawned in this field, most notably the establishment and federal support for a broad body of community based participatory research. Important state policy initiatives, such as the recently enacted Massachusetts Health Reform, have specific governance and accountability for disparities reductions.

Despite the number and variety of health disparities initiatives, there is growing restlessness that this enterprise is not yielding effective and scalable approaches, and, most importantly, evidence of significant outcomes (Lurie, 2006). For example, the CDC’s recent interim report on Healthy People 2010 worried that among the 195 disparities objectives there has only been measurable improvements in 24 categories, declines in 14, and no change in 157 (CDC, 2007).
A number of concerns underlie this restlessness:

- That many initiatives do not embody the kind of community voice, support, and participation that is necessary for sustainable long-term results.
- That many initiatives are divorced from other significant community development strategies that have the potential to influence the known determinants of health disparities (e.g. housing, safety, education, civic engagement).
- That many initiatives are not built on a platform of governance, management, and adequate stable financing that assures a continuity of response from prevention, to early detection, to treatment, to evaluation.

In simple terms, these initiatives have developed along two different paths. One broad approach to disparity reduction involves essential clinical services and interventions, generally developed by health status or diagnostic categories, and supported by categorically clinical funding streams. Thus, a huge number of specific health disparities programs have emerged to address asthma, diabetes, breast and cervical cancer, cardiovascular disease, and other conditions. These programs have the advantage of being targeted to known disparities, can be tailored to provider and community resources, and have the potential to pursue evidence based strategies. Often these programs are mounted by academic medical centers, health systems, or other provider organizations.

At the other end of the spectrum, an alternative set of community programs and policies proceed instead to address the socioeconomic “fundamentals” of community development and health. These initiatives, generally not on the radar of disparities researchers, are designed to enhance the strengths and assets that already exist in communities; increase human, physical, and social capital;
and navigate complex processes of economic change (such as gentrification) in communities. These programs fall under the rubric of community building, community economic development, comprehensive community collaborations, and others in the so called community development field. Examples include the Local Initiatives Support Corporation (LISC), Community Builders, etc.

For our purposes, however, many of these community development approaches have significant health aspirations (sometimes explicit and sometimes implicit), often command huge investments and resources, as well as involve the same institutions – churches, schools, hospitals – and community leaders as community based disparities programs. There is much to be learned about the overall impacts of these approaches, as well as their specific health consequences.

The thesis of this review for the Institute of Medicine is that the “action” in community approaches to addressing health disparities lies in better understanding, design, and implementation of “hybrid” approaches to community development and health disparities. We define hybrid approaches as those derived from a combination of clinical, community and other heterogeneous sources, such as public health and policy. The best of these approaches have the virtue of empowering and mobilizing community resources and residents, but at the same time implementing systematic, sustainable and clinically sound approaches to health behavior, screening, prevention and promotion, and treatment. Admittedly, the knowledge base for this assertion is thin; in fact, we believe one of the key frontiers in this field lies in creating an evidence-based approach, yielding results for community development that build off of the knowledge base about both community and health disparities; that is more purposeful about evaluation; and accomplishes better sharing and translation of information across disciplines and stakeholders.
DISPARITIES IN A COMMUNITY CONTEXT

Although many concepts and constructs of community abound, this paper treats communities as largely geographical or spatial units, though only as the best proxy for capturing a set of social relations and social institutions.\textsuperscript{1} This means that we are largely concerned with so-called place based approaches to health disparities and aligned with the literature on neighborhood or area effects on health (Diez Roux, 2001, Sampson, 2003).

A large literature focused on the role of socioeconomic and community factors on health outcomes has grown up in social science, public health, and the field of community organization and development. The backdrop to this literature on community effects is an even larger literature on the socioeconomic determinants of racial and ethnic health disparities. The pathways by which socioeconomic position and resources affect health status are well understood in concept, but more difficult to attribute empirically. Education, for example, provides opportunities for certain occupational pathways, which in turn produce different income streams, occupational exposure to health hazards, wherewithal to engage in positive health behaviors, and access to communities and social networks that are believed to reinforce health behaviors. Perceptions of racial discrimination, for example, have been linked across a large body of studies to health behavior, physical health, and mental health, though the precise mechanisms for how discrimination translates into physical or behavioral outcomes via stress or other pathway is less well established empirically (Williams, 2003).

\textsuperscript{1} For a complete discussion and review of different concepts of community see Robert Chaskin (1997).
The state of the evidence about these socioeconomic pathways to health disparities is crucial to the justification of community approaches. If policy and programs can in fact systematically affect social variables such as education, employment, or housing; and these improvements translate into health outcomes, then we have the beginnings of a model for influencing significant health disparities at the community level. However, the empirical understanding of how these socioeconomic mechanisms work at the community level is still quite limited. Nonetheless, many observers believe that research and policy experimentation specifically devoted to these influencing these indirect socioeconomic pathways to health disparities should proceed apace. Alegria (2003), for example, has argued that interventions in schooling, housing, and income support (EITC) are empirically defensible and justified in the field of mental health disparities. Adler and Newman’s conclusion about the role of social capital in generating health outcomes is similar: “The literature on social capital has not yet explained why neighborhoods with similar demographics differ on social cohesion and trust, or established whether social capital is stable. But the associational evidence between social trust and health outcomes is striking and suggests that these are complementary frontiers worthy of exploration for addressing health issues along with raising income or educational attainment.” (Adler & Newman, p. 67).

The literature on community effects on health disparities demonstrates that many community factors contribute to differential health outcomes by race and ethnicity, over and above individual characteristics (Bigby, in press). A recent annotated bibliography of this literature by itself runs 93 pages long. The sources of these community influences are numerous and complex, including risks created by the built environment such as lead in housing, access to the “ingredients” of healthy living such as affordable healthy foods, lack of community resources such as parks and green

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2 For a review of this literature see Rebecca Flournoy and Irene Yen, The Influence of Community Factors on Health (PolicyLink 2004).
spaces that promote activity, ambient levels of stressors such as violence that may have physical and psychological sequela, and disadvantages in access and in quality of health services and public health supports.

Despite the extent of this literature, again there is relatively little rigorous empirical evidence that demonstrates the mechanisms by which community characteristics or the ways in which community interventions produce observable differences in health outcomes. In part, this stems from the daunting statistical and data requirements for sorting out the multiple influences on health – the selection of individuals (with given health characteristics) into neighborhoods in the first place, the necessity for broad and multiple levels of data, and the substantial need for statistical variation across communities and groups especially in non-experimental data (Duncan and Raudenbush, 2001, Karachi and Berkman, 2003).

The most intriguing recent empirical evidence of community level effects per se comes from the Move to Opportunity (MTO) demonstration, in which 4600 families in public housing in five cities were randomly assigned to different treatment groups of housing options and community environments. Adults in the experiment showed significant improvements in mental health and reductions in obesity with moves to new and higher income communities; teenage girls showed improvements in mental health and reductions in risky behavior. Interestingly, teenage boys exhibited increases in risky behaviors relative to the control group. (Liebman, Latz, and Kling, 2004). Residents in individual MTO sites have shown substantial declines in specific health outcomes such as injuries and asthma attacks needing medical attention. In other studies, such as movers to new communities from distressed public housing, the so-called HOPE VI studies, however, have not yet shown improvements in health status, despite extraordinarily high rates of
chronic and mental health conditions at baseline in this population. (Manjarrez, Popkin, and

The critical role of community level factors in addressing health disparities has led some
commentators to argue that communities should become the “unit of analysis” for interventions, and
community development should become the broad framework for implementing approaches
(Robinson, 2005). Failure to make communities the unit of analysis means that a number of
opportunities to design innovative and effective approaches are lost. First, most disparities of
interest have important “non-health” community predispositions – environment, levels of
community violence, etc. Second, many disparities represent mixtures of social and health factors
that cannot be easily disentangled into a simple clinical intervention. High rates of obesity and
diabetes in communities reflect such a complex bundle of medical, health behavior, mental health,
community resources, and access to health care. Third, many interventions require the active
participation of community residents in order to be effective; this participation cannot be imposed.
Fourth, many disadvantaged communities simultaneously exhibit health disparities because of the
coexistence of poverty, racial concentration and segregation, lack of access to health and other key
supports. In the City of Chicago, for example, a relatively small number of disadvantaged
neighborhoods on the South and West Sides exhibit the highest rates of asthma, cancer, heart
disease, sexually transmitted infections, diabetes, deaths from injuries and violence, and other
critical health outcomes. Even in the face of this overlapping epidemiology, “siloed” approaches to
health disparities miss the opportunity to marshal large scale community participation and resources
to design approaches that sweep at least across interrelated health related conditions – e.g.,
substance use, violence, high risk sexual behavior -- in a community.
A MULTILEVEL FRAMEWORK

As shown in Figure 1 below, there have historically been two paths toward addressing health needs of individuals in communities. In the clinical setting, interventions improve healthcare processes and outcomes, but there is limited evidence of their impact on health disparities. In the community setting, interventions improve community status, but there is limited evidence of their impact on health. Policy and public health interventions can influence health through clinical or community settings, and may address health directly.

Over the last decade, in recognition of the inadequate improvements in minority health, clinical, policy, public health and community leaders have begun to consider what we will call a hybrid approach to health improvement, namely integrating features of clinical, community and other (i.e., public health) approaches to address both biological and social determinants of health. These hybrid approaches can be focused in communities or in clinical settings, but expertise of both is brought to bear on the problem, the solution, the evaluation, and plans for dissemination and
sustainability. We compare their features in Table 1. Following the table, we provide an overview of clinical and community approaches to disparities. We then discuss the issues and opportunities for advancing hybrid approaches. Finally, we conclude with a set of ideas about how hybrid approaches might be organized and implemented at scale.

Table 1: Characteristics of Clinical, Hybrid and Community Interventions to Improve Health

<table>
<thead>
<tr>
<th>Level</th>
<th>Clinical</th>
<th>Hybrid</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention Locus</td>
<td>Health care settings and related organizations</td>
<td>Centered clinically or in the community, but combine efforts from both disciplines.</td>
<td>Neighborhoods, or non-geographically defined communities</td>
</tr>
<tr>
<td>Theory for health improvement</td>
<td>Evidence-base of impact of clinical interventions on health.</td>
<td>Simultaneously addressing clinical and community factors will have more direct and lasting impact.</td>
<td>Improve community factors (social, economic, environmental, political) and health will also improve.</td>
</tr>
<tr>
<td></td>
<td>Proven impact on health.</td>
<td>Sustainable designs.</td>
<td>Sustainable designs.</td>
</tr>
<tr>
<td></td>
<td>Enhance clinical resources and capacity.</td>
<td>Enhance community and clinical resources and capacity.</td>
<td>Enhance community resources and capacity.</td>
</tr>
<tr>
<td></td>
<td>Employ narrow clinical perspective.</td>
<td>Interventions often local, may be challenging to scale up.</td>
<td>Target-efficiency problem (target broad, timeframe long, not specific for health)</td>
</tr>
<tr>
<td></td>
<td>Challenges for sustain-ability and effectiveness (beyond efficacy)</td>
<td>Time consuming, intensive to initiate.</td>
<td></td>
</tr>
<tr>
<td>Feasibility of implementation</td>
<td>Feasible in tightly controlled settings.</td>
<td>Feasible with adequate development time and collaboration.</td>
<td>Feasible with adequate infrastructure, resources and large scale collaborations.</td>
</tr>
<tr>
<td>Challenges of translation/replication</td>
<td>Translation to routine practice may be difficult.</td>
<td>Replication may be difficult due to strong local influences.</td>
<td>Both may be difficult given size and scope.</td>
</tr>
</tbody>
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**CLINICALLY DRIVEN APPROACHES**

Without question, the effective therapies developed and tested using basic science, clinical and health services research and have significantly contributed to the improving life expectancy of
Americans of all racial and ethnic backgrounds. Yet, these diagnostic and therapeutic breakthroughs and unprecedented healthcare spending, have not resulted in elimination of healthcare or health disparities for the majority of health conditions, even among populations with equal access to care. Several shortcomings of the current approach may help explain this disconnect. Below are building blocks of clinically-oriented research to improve health. After each, are descriptions of potential missteps that may occur if clinical interventions are conducted in isolation from the wider sociocultural context where patients spend the vast majority of their lives.

Table 2: Steps in Isolated Clinical Research Addressing Health Disparities and their Pitfalls

<table>
<thead>
<tr>
<th>Research Step</th>
<th>Pitfall if Lack Community Partnership</th>
<th>Potential Impact of Pitfall</th>
</tr>
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<tbody>
<tr>
<td>Identify Concerns</td>
<td>Look through narrow clinical lens. Patient/community ideas and priorities not taken into account.</td>
<td>Identified reasons for health disparities do not adequately explain disparities.</td>
</tr>
<tr>
<td></td>
<td>Do not look at social determinants of health.</td>
<td>Overlook novel areas for assessment and intervention.</td>
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<tr>
<td>Design Study</td>
<td>Design lacks combination of cultural and evaluative competence. Target population may not be interested in participating, study may not be relevant.</td>
<td>Increased likelihood of negative study.</td>
</tr>
<tr>
<td>Identify Sites, Recruit Patients</td>
<td>Inconvenient locations for patients. Sites chosen do not include epicenters of illness (site convenient, not relevant) Steps not taken to build trust. Recruitment strategies not motivational.</td>
<td>Poor recruitment/response rates. Fail to target the most appropriate population.</td>
</tr>
<tr>
<td>Assess Processes</td>
<td>Labeled successes may not impact outcomes. Omit qualitative evaluations. Do not solicit evaluations by subjects.</td>
<td>Increased screening, contact with healthcare or surveillance, not clear if improved health. Unable to identify or act on study shortcomings.</td>
</tr>
<tr>
<td>Assess Outcomes</td>
<td>Find no outcome improvement due to earlier flaws.</td>
<td>Missed opportunity. “Blame the victim,” lack of improvement is patient’s fault.</td>
</tr>
<tr>
<td>Disseminate Impact</td>
<td>Disseminate scientifically but not to community. Community does not have ability to act on results. Results not used to inform/influence policy</td>
<td>Reinforce “drive-by research” attitude held by community. Lost opportunity to capitalize on benefits beyond the specific project.</td>
</tr>
<tr>
<td>Sustain Intervention</td>
<td>Interventions not designed with sustainability in mind.</td>
<td>Benefit disappears along with funding.</td>
</tr>
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Two examples of the incomplete impact of clinical research merit further description-- breast cancer treatment, and diabetes prevention. Breast cancer is an area where disparities in processes, namely screening, often using community-centered education, appear to be narrowing, yet disparities in breast cancer deaths persist (Wier et al., 2003, Smith-Bindman et al., 2006, Earp et al., 2002, Erwin et al. 1999, Deitrich et al. 2006,). Minority women with early-stage breast cancer are far less likely to receive necessary adjuvant treatments, even when equally referred to oncologists (Bickell et al, 2006). Perhaps the simpler process (mammography) is easier to address than is breast cancer treatment, which requires a multidisciplinary approach. Perhaps women of color also face disproportionate non-clinical barriers to treatment.

Diabetes is another area in which clinicians and clinical researchers are making strides and yet persons of color do not appear to reap sufficient benefits. Minority individuals are more likely to develop and die from diabetes, and disparities in death between Whites and Blacks/Latinos are widening (Mokdad et al. 2001,). If prevention efforts are not developed and widely implemented, one in two Black and Latino children born this decade will develop diabetes, as opposed to one in four Whites (Narayan et al. 2003). Several clinically based programs, most notably the large, multisite Diabetes Prevention Program found that weight loss among overweight adults with prediabetes can prevent or delay diabetes (Knowler et al. 2002,). In this Program, weigh loss even eliminated racial and ethnic disparities in incident diabetes. Despite this unusually promising result, the program has been expanded, nor continued, even at the sites where its effectiveness was proven. Less expensive methods are needed to achieve the degree of weight loss and diabetes prevention seen in this costly, time-consuming efficacy trial. (Eddy et al. 2005,)
COMPREHENSIVE COMMUNITY DEVELOPMENT APPROACHES

Community development and community building approaches emphasize the development of community capacity and community connections as the means to producing better outcomes such as economic opportunity, safety, housing conditions, and health status (Chaskin, Brown, Venkatesh, and Vidal, 2001). Community building approaches tend to emphasize local leadership development, promotion of collaborations, strengthening the capacity of community based organizations, strengthening of social capital, and generation of new resources for housing and economic development.

A classic example of a comprehensive community development approach based on a community building philosophy would be initiatives supported by the Local Initiatives Support Corporation (LISC):

*LISC helps resident-led, community-based development organizations transform distressed communities and neighborhoods into healthy ones – good places to live, do business, work and raise families. By providing capital, technical expertise, training and information, LISC supports the development of local leadership and the creation of affordable housing, commercial, industrial and community facilities, businesses and jobs.*

These community building programs, individually and collectively represent substantial commitments of public and private resources, as well as community leadership and effort. LISC alone claims to have mobilized over $7.8 billion for projects in 300 urban and rural communities (LISC 2006). Development banks, such as ShoreBank, or commercial banks with large community development portfolios, represent significant sources of capital and expertise. Bank of America, for
example, expects to invest $750 billion in community economic development over the next ten years. Major foundations, such as Ford, McArthur, and Kellogg have also built their strategy and funding priorities around these comprehensive community development initiatives, in most cases leveraging an additional set of federal and state development resources. These sums dwarf the scale of most disparities interventions, yet there seems to be little effort devoted to capture and leverage these resources to strategically improve environment and community capacity in ways that produce measurable health outcomes.

On the whole, these comprehensive community building initiatives and the national health disparities agenda have proceeded on largely separate tracks. While the connections of community building initiatives and the efforts of public health and disparities programs operating in communities may seem self-evident, a recent review by Kieffer and Reischman (2004) concludes that the “reality is that many public health interventions are not coupled with community building strategies; and many groups undertaking community building do not include measures of improved public health as an outcome of their activities” (2004, p.2).

The implications of this disconnect are significant. Health disparities initiatives by themselves cannot command the level of resources and community attention necessary to impact the myriad of physical, social, and economic factors that underlie community health outcomes. Since community leadership and institutions are critical to the success of any health intervention, it may be necessary for community-health interventions to become aligned with these larger community development efforts to be able to capture the necessary time and attention.
There are a number of good reasons why community health approaches to disparities reduction have not been built upon this platform of comprehensive community building. First, these approaches tend to emphasize community process over interventions and implementation. In this world, collaborations, connections, relationship building, partnerships, and process often take precedence over specific interventions and implementation. Second, these approaches vest enormous control with community residents and stakeholders to define their own assets and approaches, whatever the views of experts may be. Particular health disparities may or may not rise to the top of the community hierarchy of priorities and needs for attention and resources. Third, by the very nature of comprehensive community approaches, these initiatives may have low target efficiency for a particular health condition. Efforts to improve employment, education, safety, and other community factors may have marginal or indirect effects on a particular health condition of interest. Finally, these comprehensive collaborations are often slow and halting in their progress and observable outcomes.

HYBRID APPROACHES (Mixed approaches)

Hybrid approaches imply that community and clinical and other resources are both deployed and coordinated in developing and implementing programs to address health disparities. Interventions can be centered or grounded in one of five disciplines or areas: clinical, public health, policy, community and research. We review existing approaches from these perspectives below.
Clinically-Centered Hybrid Approaches

These approaches invite community, public health, policy and research experts into the clinical setting, in order to make clinical care more responsive to vulnerable populations (i.e., low-income individuals, or persons of color), and to make clinical interventions more effective in improving their health. Two approaches are gaining favor: systems redesign to make systems more culturally competent and effective, and health management and support to facilitate patient self-management and navigation.

Health Systems Redesign

Health systems leaders can look outside their clinical boundaries to find expertise and models to improve the care they deliver. Efforts are well underway to make health centers meet current standards for culturally and linguistically appropriate services (CLAS). Some translate materials into common languages and offer brief cultural sensitivity trainings. More comprehensive efforts also aim to include a well-trained and diverse staff, and gain a deeper understanding of the populations they serve, and use this understanding and active community input, create a welcoming, educational, health promoting clinical environment (National Standards for Culturally and Linguistically Appropriate Services in Health Care, 2001, Horowitz, 2000). Data on the impact of CLAS on health outcomes is scarce, though providing such basic services should not be considered controversial.

Broader approaches to providing healthcare in communities of color have been underway for decades. The community health center model that emerged as part of the war on poverty in fact
targeted the roots of poverty by combining the resources of local communities with federal funds to establish neighborhood clinics. Governed by community boards, and providing access regardless of ability to pay, there is some evidence that patients in these centers receive more timely screening and preventive services.

To combat the continued heavy burden of chronic illnesses at these centers, the Health Disparities Collaboratives of the Health Resources and Services Administration (HRSA) employed Wagner’s Chronic Care Model, a system that encourages high quality disease management (Wagner, 1998, (Landon et.al. 2007.). The collaboratives significantly improved the processes of care for two of the three conditions studied (diabetes and asthma), but there was no improvement in the clinical outcomes studied. The authors’ reflect, “achieving improvements in both longer-term and intermediate outcomes may require more intensive interventions in order to overcome environmental factors that pose particular challenges for patients.” As shown in the figure below, this model asserts that to improve the health of the population, health systems organizations reach out to form community alliances and partnerships with state programs, local agencies, schools, faith organizations and businesses, a step those implementing the model may not have focused on adequately.
Health Management and Support

Health management and support reforms are often built around new professional and para professional roles that connect with community residents. Examples include; clinical disease managers, community health workers who are usually employed by health systems, and more independent peer educators. Each straddles the clinical and community realms with the goal of helping patients better manage their health.

- *Disease managers* or nurse case managers work with patients who have specific, often chronic health problems, and use information systems to track and monitor patients, and clinical guidelines for care to improve both clinical and self-management (Norris, Nichols, Caspersen 2002). Initially developed to cut costs and resources, a new generation of these programs are culturally tailored to better educate, motivate and support patients (Sisk et.al. 2006). The programs have some strong effectiveness data in their favor, but current non-
managed care payment structures that do not lead to cost savings for health systems if these relatively costly managers prevent hospitalizations, may make it difficult to sustain these programs beyond the studies that prove their beneficial impact (Carryerou, 2006).

- **Community health workers** (CHWs) are lay community members who work with the local health care system, and usually share ethnicity, language, socioeconomic status and life experiences with the community members they serve (HRSA, 2007). They can be members of the care delivery team (largely subordinate to a lead provider); navigators who assist individuals and families in negotiating complex service systems and bolster their clients’ confidence when dealing with providers; screeners and health educators, often working with hard-to-reach populations; outreach-workers, who reach individuals and families eligible for benefits or services and persuade them to apply for help or come to a provider location for care; advocates for individual and community health needs; and organizers who become active in a community over a specific health issue, promoting self-directed change and community development. There are myriad evaluations of CHWs and the meta-analyses of these studies. CHW trials reveal significantly increased access to healthcare, improved asthma symptoms and decreased use of urgent care, blood pressure control, breast feeding, and decreased high risk sexual behavior (HRSA, 1998, Andrews, Peres, Williams 2003, Krieger, 2004, Brownstein et. al., 2005, National Fund for Medical Education 2006, Lewin et. al. 2005, Lavery et.al. 2005, A Final Report of the National Community Health Advisor Study, 1998). The CHW workforce is likely to increase in the forthcoming years (HRSA, 2007).

- **Peer educators** are distinguished from CHW’s, as they are more independent of the healthcare system. Lay-led, community-based peer group sessions are an effective and cost-effective method to improve patients’ self-management skills, health outcomes, and
hospitalization rates. They use trained lay leaders with backgrounds and health problems similar to those of the participants, incorporating evidence of the effectiveness of role models in increasing patients’ confidence in their ability to manage their conditions, and recognizing patient education should be inexpensive and widely available, and that lay leaders from the community can impart information that may not be accepted from outsiders. These programs have significant health benefits in diabetes, asthma, seniors with heart disease, and with heterogeneous groups of persons with chronic conditions (Lorig 1992, 1999, 2001, Center for the Advancement of Health 1996, Fries et.al.1998, Brown 1999, Ladenuso et. al. 1996, Mazzuca et. al. 1986).

**Policy-Centered/Driven Hybrid Approaches**

The two best examples of policy-driven hybrid approach to community health disparities are the Federal CDC REACH 2010 program and the California Healthy Communities Campaign.

**REACH 2010**: The Centers for Disease Control and Prevention launched the REACH 2010 initiative in 1999 to address disparities in six priority areas: cardiovascular disease, immunizations, breast and cervical cancer screening, diabetes, HIV/AIDS, and infant mortality. Six racial and ethnic groups were designated for these programs: African Americans, American Indians, Alaska Natives, Asian Americans, Hispanic Americans, and Pacific Islanders. By 2004, 40 separate projects were being supported under this initiative and evaluation results had begun to be disseminated.
Overall, the REACH 2010 projects emphasized local leadership and resident participation, prevention and education, and community based participatory research. A variety of interventions and community approaches have been supported under the REACH framework. Bronx Health REACH, for example, involved 40 community-based organizations with a heavy emphasis on faith-based approaches to reducing rates of diabetes and related cardiovascular morbidity and mortality. In Oklahoma, the REACH project seeks to increase levels of physical activity with the ultimate goal of affecting diabetes and cardiovascular disease among tribal communities.

The theory of REACH’s community participation and health outcomes is best depicted in their “logic model” which traces the connections between community awareness, coalition and community organization, community changes processes, health behavior changes, and health outcomes. In practices REACH projects are expected to define the community coalitions and capacity, design and intervention and tactics that have the basis to affect the targeted health outcome, produce community and community systems change, and produce a significant amount of behavioral change, and ultimately reduce the observed disparity of interest.

Recently, data are beginning to appear on the effects of the REACH 2010 projects. Findings from the REACH Risk Factor Survey indicate significant gains in the proportion of African Americans and Hispanics in REACH communities screened for cholesterol, the proportion of American Indians in REACH communities taking medications for high blood pressure, and the proportion of Asian American men in REACH communities who do not smoke (CDC, 2007).

For the purposes of this paper, the REACH projects represent a hybrid approach that attempts to take account of community coalitions and input, but with a systematic goal of reducing particular health disparities. In general, the REACH projects have involved a limited range of community
participants and limited control over health provider and community development resources. Most important, these approaches tend to tackle one condition at a time, and given resources and time, they eschew a larger approach to community development and change.

**California Healthy Communities**: At the state level, the most ambitious and integrative approach to health disparities reductions is the California Campaign to Eliminate Racial and Ethnic Disparities, and its affiliates the Prevention Institute and DRA project. The Campaign is directed at nine medical issues, cardiovascular disease, breast cancer, cervical cancer, diabetes, HIV/AIDS, infant mortality, asthma, mental health, and trauma. Philosophically, the campaign is dedicated to tackling fundamental causes of injury and illness. Its “logic model” envisions a progression to disparities which begins with root causes, behavioral and environmental factors, and access to quality health services. The Campaign seeks to be encompassing of a wide variety of actors, including public health, social services, education, cultural organizations, and community based organizations.

The Campaign represents an impressive assembly of funding, collaborations, and knowledge resources. Funding has come from the California Endowment, the California Wellness Foundation, Kaiser Permanente, as well as numerous other smaller grants and contracts. The principle leadership and collaboration has come from the American Public Health Association, the Prevention Institute, and the California Health and Human Services Agency. Leaders of the California Campaign liken it to some of the biggest and most visible campaigns of the modern era – the Marshall Plan and the Manhattan Project – as examples of the scale and unity of purpose that will be necessary to produce meaningful change in California’s health status. Recently, leadership of the Campaign has given considerable attention to social movements as a framework for mobilizing the political will and social change necessary to achieve the desired large-scale outcomes.
The California Campaign reflects many of the ingredients for a scalable disparities approach, significant funding, a powerful strategic focus, widespread collaboration, and a commitment to applying the knowledge base about effective interventions and community process. However, as even the leaders of this Campaign acknowledge, there is still a long way to go to produce a cohesive approach that capitalizes on other disparities experience, as well as involves the other sectors -- such as urban and community planning, housing, etc. – that have significant roles in addressing disparities at the community level. It remains to be seen how well this kind of highly orchestrated and systematic approach to disparities reduction will fare in giving communities voice, and engaging the community in meaningful change processes to produce the kinds of large scale statistical results that are envisioned in the campaign.
Research-Centered Hybrid Approaches in the Community

Researchers are now quite comfortable using secondary data analyses to study health disparities. It would be interesting for them to partner with community development, environmental development and urban planning leaders, to conduct community targeted secondary analyses, merging clinical and community level data to study impacts of development on health. These partnerships may help build the mutual understanding, trust and respect between the various stakeholders needed to work on prospective projects to improve health.

Beyond the relative absence of evaluation findings from the wide range of existing disparities interventions, even less work has been done to estimate the economic value of these initiatives either as a guide for resource allocation or for policy advocacy. A model of this work is the recent cost-effectiveness analysis of improved quality of diabetes care in Federally Qualified Neighborhood Health Care Centers (Huang, et. al., 2007). This analysis suggests that systematic improvements in diabetes care would be cost-effective for society because overall health effects (lifetime incidence of blindness, kidney disease, heart disease) offset the costs of health services improvements.

This form of economic analysis is just the beginning of a necessary agenda to value community based interventions to reduce disparities. In many respects, cost benefit or cost effectiveness analysis of this form of clinical service is the easiest case; broader based or hybrid approaches will require much more effort and sophistication to capture the full range of social costs and benefits. Indeed, many of the effects represent externalities in the economic sense, and will not be typically priced or valued in traditional economic markets. Reducing incidence of high lead levels, for
example, yields a host of developmental, educational, and community benefits than extend beyond the simple accounting of health care costs and benefits. In traditional cost benefit analysis, these outcomes typically fall in the domain of externalities, not priced or valued in direct market exchanges, but they may represent the paramount economic benefit of community level investments.

Being able to account for the return on investment of health disparities interventions is more akin to the literature and practice of social return on investment, where effects on the environment and the social opportunities of beneficiaries are central concerns (Olsen, 2003). Especially in cases where disparities approaches have the character of hybrid clinical and community development initiatives, considerable attention will need to be paid to developing methodology, collecting data, and reporting results in forms that are appropriate to the task.

VI. Creating a New Cadre of Community Based Researchers

In this young field, there is only emerging evidence of the health benefits accrued with a community focus. Little is known about relative effectiveness of different organizational strategies to build the enterprises needed for this work. Building a cadre of professional and lay experts to conduct and evaluate interventions will take time, yet there is tremendous opportunity for leadership development, such as the new emphasis in the Robert Wood Johnson Clinical Scholars Program.

Critical to the advance and credibility of this field will be the involvement of new investigators and an expansion of the pool of community-based researchers. Venues to train new community and academically-based investigators in CBPR are expanding. There are also many reviews, guides and
literature syntheses available to guide individuals through the steps to conducting CBPR. (http://depts.washington.edu/ccph/index.html) To build new opportunities and expertise in the field, areas to consider include:

- Creating formal liaison centers to allow community representatives to better understand research, better define their concerns and find researchers they can work with, and for researchers to learn about CBPR and link with community representatives.
- Clearer mechanisms for academic advancement to legitimize CBPR and to ensure talented researchers are supported to remain in the field (Commission on Community-Engaged Scholarship in the Health Professions, 2005).
- Institutional sponsorship of community-academic partnerships at the highest level.
- Identification of mentors for community and academic partners locally and nationally (Community Campus Partnerships on Health maintains a database of community partners for this purpose).
- Creating an information clearinghouse on disparities that networks individuals, programs and opportunities, houses databases with information on local and regional health and health disparities and relevant community characteristics and lists community-based disparities reduction programs and links to their evaluations.
- Finding new mechanisms to increase interaction amongst social scientists, medical investigators, public health, and community development scholars in the pursuit of a community level knowledge base leading to effective interventions.

VII. Taking Advantage of Large Scale Translational Research Opportunities (Bench to Bedside to Barrio)
Historically, translational research has focused on “bench to bedside” (Zerhouni, 2003).

Acknowledging the slow trajectory toward eliminating health disparities and the failure of those few programs that show promise to be sustained or disseminated, the a new term has emerged in translational research circles, “Bench to Bedside to Barrio.” Regional and national efforts have started bringing together federal and private funders with academic and community leaders to identify barriers to and enablers of effective community-academic research partnerships and to develop and disseminate guidelines and best practices for conducting community-based clinical and translational research in minority communities. They help coordinate support for developing and maintaining of core research infrastructure to enable community participation, developing research protocols that work effectively in community settings, and building community buy-in and trust to enhance recruitment and retention of research participants.

(http://www.ncrr.nih.gov/research_infrastructure)

The best funded and most visible of such programs are the new Clinical and Translational Science Awards (CTSA), a new consortium to transform how clinical and translational research is conducted, ultimately enabling researchers to provide new treatments more efficiently and quickly to patients. The consortium will link about 60 institutions to encourage development of new research methods, tools and approaches, improve training and mentoring, assemble interdisciplinary research teams and forge new partnerships with private and public healthcare organizations.

According to the CTSA literature (www.ctsaweb.org/commengage.html), “CTSAs represent a new culture of translational healthcare research in which community engagement is key to success.”

The CTSA Community Engagement Steering Committee (one of eight subcommittees to coordinate institution topic-specific efforts with the national CTSA consortium) is charged with
ensuring the successful implementation of a broad community engagement plan among the CTSA sites by sharing knowledge, expertise and resources, and effectively engaging communities in the translational research process via bidirectional dialogues. Their aims are to (1) find ways to get bench scientists & clinicians interested in priorities identified by communities (2) identify effective strategies to convince academic institutions that community engagement is important and deserves a supportive atmosphere (including adequate budgetary resources and influencing the NIH culture to value community engagement and CBPR, collaborative budgeting strategies) and (3) develop milestones for community engagement and research, including establishing boards, leveraging partnerships for funding, developing a registry of community generated research ideas and needs, and developing outcomes and metrics for this research.

VIII. Taking Advantage of Public Health

Ever since the IOM report, the Future of Public Health, public health professionals and organizations have been looking to lead and participate in disparities initiatives in a meaningful way. The IOM Report defined a mission for public health of “assuring conditions in which people can be healthy,” with its “aim to generate organized community effort … by applying scientific and technical knowledge to prevent disease and promote health” (IOM, 1988). The Committee recommended a host of activities that would position public health agencies and professionals in the middle of policy development, data collection and research, and capacity building to affect health status. Included in this agenda were issues of indigent health care, mental health, and environmental health. Schools of public health figured prominently in this agenda, and they were expected to cross boundaries with medicine, the social sciences, and other disciplines with the ultimate goal of
generating new and effective interventions. Public health was envisioned to play a strong policy role with extensive interaction with government, social service agencies, and “street-level” contacts.

Without question, considerable progress has been made in the last 20 years in realizing this vision for public health, and many examples exist of the kind of collaborative, integrated approach that was envisioned by the IOM process. The CDC’s STEPS program, directed at high priority disparities issues of obesity, diabetes, and asthma, for example, embodies most of the principles of this IOM report. It seeks to implement and integrated approach at the community level that involves schools, employers, and other stakeholders; it attempts to affect policy; attempts to affect fundamental health behaviors, and incorporates a strong evaluative component. However, in the scheme of disparities challenges, STEPS is a relatively modest public health initiative, allocating $44 million in FY2005 for 40 community projects.

While the agenda articulated in 1988 would seem to place public health departments, schools, and professionals at the heart of the disparities, few observers would conclude that public health has played the kind of overall leadership, integrative function, and applied community role that is necessary to effectuate significant changes in health disparities. Much has happened during this period, including funding challenges, the demand for homeland security and bioterrorism roles for public health, and other claims on public health’s mission and priorities. Many movements are afoot to bring public health into a more central role, including a great deal of discussion about the role of public health in influencing the built environment in health disparities. The California Campaign represents an initiative that embodies both the philosophical commitment to prevention of a public health perspective, as well as the professional and organizational leadership of APHA. The research opportunities provided in CTSAs, Disparities Centers, and other large-scale initiatives may be...
important factors in bringing at least academic public health into a stronger and more applied community role in reducing health disparities.

IX. Solving Organization, Finance, and Policy for Hybrid Approaches:

Efforts to mount a systematic approach to racial and ethnic disparities at the community level are hampered by governance, funding, and management challenges of the health delivery system utilized by racial and ethnic minorities.

- Governance. Especially since the demise of health planning in the 1980s, most areas of the country have no accountable party and no organized mechanism for governing health resources across the spectrum of public health, hospital system, community health centers, and the myriad of private health providers and resources that are necessary for building effective health disparities collaborations. Governance of health is fragmented into different levels of administration (e.g. city, county, state); “fiefdoms” of health provision (e.g. public health versus hospitals); as well as different geographic jurisdictions. St. Louis, for example, is an agglomeration of 97 municipalities and complex web of city, county, and state (both Illinois and Missouri) jurisdictions.\(^3\) It is hard to overestimate the significance of these kinds of political, administrative, and even statistical fragmentations for mounting strategic approaches to disparities. This lack of overarching governance means that the most basic elements of a strategic approach – collecting data, creating a continuity of screening, prevention, and care – are dauntingly difficult administratively.

\(^3\) See for example, Terry Jones, Fragmented by Design.
Funding. Health care interventions to address disparities are financed through a bewildering array of public and private resources. Some of these resources flow from categorical grants and contracts specifically targeted to fund a program or agency dedicated to a particular health outcome such as infant mortality. HRSA funding of specific Health Start programs, such as programs to improve the systems of care for pregnant women experiencing domestic or family violence would be an example of highly targeted discrete funding stream. Some of the financing flows to public and private providers, such as payments (grants or fee for service) to Federally Qualified Health Centers or other community based clinics. Some of the relevant resources flow through either traditional Medicaid or Medicaid waiver schemes. Some of the resources flow through County or City public hospital and clinic systems. Some services and costs are simply unfunded, meaning that cross subsidies from charity care, disproportionate share, or philanthropic sources need to be found. An example of the consequences of this patchwork of financing can be seen in programs to reduce racial and ethnic disparities in breast cancer: projects have been successful in motivating women to be screened, but have often struggled to find and pay for mammography services, as well as timely follow up care. This follows directly from the fragmentation of financing and services. The providers and payment for community health promotion are often disconnected from the providers and payment for mammography and advanced cancer care.

Many disparities interventions are funded through research mechanisms whose short timeframes (usually 2-5 years) often preclude the development of substantive partnerships, and do not allow for sustaining partnerships or successful interventions. This stuttering funding can lead to only transient improvements in health for small populations, and mounting distrust of community members who view such endeavors as academic fodder.
In order to create the combination of resources, as well as continuity of service for community residents, much greater attention will need to be paid to the governance and financing of disparities approaches. At a minimum, this means that some form of regional data collection, coordination, and accountability for disparities interventions much be accomplished. It also means that payers and providers will need to be vested in the financing and outcomes of disparities initiatives. The Massachusetts health reform provides this kind of recognition of the integral role of financing and governance, but it too has been criticized for not backing up the rhetoric of a disparities priority with hard sources of funding.

Critical to commanding the resources and instruments to address the environmental, housing, educational, employment, and social service correlates of health disparities will be a recognition that larger scale public policy is a key element of the disparities agenda. The best spokesperson for this perspective has been Margaret Alegria, who has argued that much of the action in hybrid approaches lies in understanding of and policy reform of such programs as the Earned Income Tax Credit and Special Education (2003). Key policy areas that will affect the course of disparities approaches include public housing transformation, changes in the Community Reinvestment Act Provisions, welfare reform, immigration policy, Medicaid and health care coverage. Typically, advocates and investigators do not see such large scale social policy issues as part of the set of disparities levers and concerns, but the resources involved and implications for communities dominate many of the research driven projects that have come to define the disparities field.

**MODELS AND IDEAS FOR HYBRID COMMUNITY APPROACHES**
In order to bring these hybrid approaches to scale, new community infrastructure and resources will need to be developed. Current approaches are typically small in scale, do not leverage significant resources, and do not capitalize on information and technical expertise. Creating scalable community approaches will require solutions to the financing problems inherent in many disparities initiatives. Community approaches that can be evaluated and demonstrate statistical impact on disparities will also need to account for much larger populations and bring much greater analytic sophistication than most current community examples. Four models or heuristics are presented to give examples of how new hybrid approaches might be configured in ways that address many of the shortcomings identified in this paper.

- **Regional Health Authorities.** A number of regional authorities already exist at different levels of aggregation. The Westside Health Authority in Chicago, for example, has led a number of community development and health disparities initiatives with full community participation and advocacy. The Regional Health Commission in St. Louis, addresses a range of data, provider, and policy functions from the perspective of the region as a whole. Regional Health Authorities effectively configured for addressing disparities would need to capture a financing stream (most likely though a Medicaid assessment or all payer program), and adopt a dedicated focus on disparities reductions for particular communities to be effective.

- **Community Development Banks/ Corporations.** While improvement of community health is one of the stated initiatives of many comprehensive community development initiatives, in practice the goals and resources are more tightly defined by housing and economic development measures. However, these institutions and investments represent large flows of capital and often intensive community involvement. The Bank of America, for example, will
invest $750 billion in the next 10 years in community development. Many of these investments occur in exactly the same communities with high prevalence of health disparities conditions. To organize this combined health/community development approach new partnerships would need to be struck with institutions such as Shorebank, LISC, Bank of America; the Department of Housing and Urban Development; as well as other regional investors and developers. Many of these initiatives are organized around community development corporations that provide an initial infrastructure and governance of these collaborations.

- **University/Community Partnerships.** A number of successful university/community partnerships have been built in recent years, some with the formal support of HUD and other federal agencies. The major examples, the University of Pennsylvania and the University of Chicago, have largely focused on community economic development and urban schools. While there certainly are examples of academic medical centers and schools of public health that have significant community partnerships, they have not been organized and disciplined by a systematic approach to addressing disparities in particular communities. The emergence of CPBR, the emphasis on CTSAs, the community interest of academic public health, and the community training needs of many medical schools, makes this an opportune time to consider scaling up and organizing university/community partnerships for specifically for addressing disparities. To the extent that these partnerships can leverage the health care delivery system at major academic centers, there is also the potential to create more seamless structures of financing and health care service in these neighborhoods. These urban community models have the potential for not only addressing urban disparities, but also utilizing university networks in rural health as well.
• **CBPR Practice Networks.** As this paper describes, one of the exciting developments in addressing disparities have been the projects and community relationships stimulated by CBPR. Despite the apparent early successes of this movement, it is operating at small scales and with little opportunity for cross-fertilization, data development, and comparative analysis. A structure that organizes and supports this movement across community sites has the potential to create a multiplier from these projects. A potential model for collaboration, data collection, and technical assistance are the national practice networks that are emerging in other areas of health services research. The extension of this idea to communities would involve the creation of comprehensive practice network structures and data/information systems at the community level. Even better a consortium of community-based practice networks would allow better systematic and comparative evaluation of community-based disparities initiatives.

• **Provider Networks or Systems to Address Disparities.** Many of the current priority conditions have a heavy reliance on improvements in access and quality of health services in low income and minority neighborhoods. As a practical matter, to create sufficient funding and sufficient “market penetration” to create a statistical impact will require multiple health care plans, systems, and providers operating in consort. Versions of these arrangements have been created in cities to address ambulatory care provision, indigent care, and special service needs such as trauma care. These networks of systems typically require dedicated payment streams, and some governance from the local health departments, state public health, or other public agent. Payment streams have included Medicaid provider assessment schemes, use of Disproportionate Share dollars, or allocations of city, county, or state revenues. A model for organizing these networks to address place based disparities would be the creation of special health disparities districts, analogous to medical districts, that would provide
incentive for health plans to create new community based programs as well as access and quality improvement in relevant services.

SUMMARY AND RECOMMENDATIONS

The central problem for building community approaches to reducing health disparities is to knit together community, provider, funding, and academic resources at such scale that there is the potential to have statistical effects on population health outcomes. Many of the initiatives to date have demonstrated good will, effective community collaborations, and reasoned approaches to addressing disparities, but they tend to be fragmented, small in scale, and inadequately or transiently funded. If one considers realistically the magnitude of behavioral change and service provision that is necessary to have a statistical impact on disparities, at the community level much less nationally, it will require a level of commitment and organization that far outstrips current models of intervention. In effect, the disparities initiatives need to be upsized from a cottage industry to substantial organization and scale.

Hybrid approaches to improving health outcomes and reducing disparities have the advantage or being clinically centered in the community, but leveraging the community participation, resources, and environmental agenda that is associated with broader community development strategies. In principle these hybrid approaches have greater potential for sustainability and scale. They have the disadvantage of being diffuse, community process oriented, and difficult to target narrowly on specific disparities interventions. Many varieties of these hybrid approaches exist, such as REACH 2010 and CBPR projects, but little empirical evidence about outcomes and little analysis of strategies is available for making these approaches successful, scalable, and sustainable.
Our analysis of current hybrid community approaches has identified a number of issues that need to be addressed to advance these clinical and community models. The goal of these hybrid models should be to be simultaneously clinically excellent as well as community responsive initiatives. Significant adaptation will need to occur in the clinical enterprise in order to have mutuality and successful collaboration in the community. Innovation in the forms and utilization of data will be necessary. New commitments to community level evaluation, including some version of social return on investment, will be necessary to learn from and advocate for these community level initiatives. A new cadre of appropriately trained community based researchers, with expertise in the community disciplines and experience with the cultural, social, and political realities of working in communities will need to be trained. CTSA opportunities will need to be seized, so that that the community side of this roadmap is highly responsive to community values and interests, and not merely an appendage to the traditional clinical research enterprise. The resources of public health – both governmental and academic– will need to be reassessed and more effectively deployed to advance this agenda of hybrid approaches. Finally, solutions to the organizational and financing gaps in disparities programs will need to be fashioned.

There are currently a large number of alternative community disciplines, professionals, and organizations laying claim to the community development and disparities agenda. Community health, community building, community organization and planning, urban planning, public health, environmental health, social work, and others, all see themselves as primary professional leaders in this movement. From the perspective of communities, academic centers, health providers, social service organizations, public health agencies, faith based organizations, and a host of advocacy organizations are all seeking to partner and mount their own versions of disparities programming.
Meanwhile, some of the largest players in community development, the banks and developers, are often outside of the discussion, financing, and implementation of disparities programs. Community collaborations (CBPR) show great promise in the struggle to eliminate disparities. They can identify root causes of disparities, build on local assets, devise novel, clinically and environmentally sensible designs with sustainability in mind, inspire robust research participation, and disseminate results so they inform policy and inspire further introspection and change. They are also community organizing and development initiatives in their own right. However, models for partnership in the literature describe years of planning, building relationships and crafting fair rules of engagement before research and interventions begin in earnest. While these processes must not be overlooked and local adaptation may be necessary for many interventions, the CBPR community must challenge itself to move from “CBP” to CBPR with more efficiency, and to find models that are proven to improve health, and that can be exported to other communities or within the community, to address other health related issues.

The solution is not to choose one or another of these community players as primary. Rather, new mechanisms which bring together some of these stakeholders in partnership with community residents and with focus on substantial disparities programming will be necessary. Examples we have considered include regional health authorities, community development corporations, university/community partnerships, CBPR practice networks, and new forms of health plan districts or networks.

Our analysis has produced a beginning agenda for the Institute of Medicine Panel to pursue in building better linkage between community development and clinical services – hybrid approaches – in the name of reducing disparities.
• Convene community development organizations and funders, along with health disparities academic and practice leadership to design hybrid approaches.

• Promote the creation of an evidence-based clearinghouse for information and technical assistance in community development for reduction in health disparities (such a clearinghouse could be mounted under the auspices of public, association, university or foundation organizations).

• Convene the major health systems to address staffing, programming, disease management, and community partnerships approaches to disparities.

• Influence the major existing clinical/research mechanisms – CBPR, CTSAs, REACH 2020 – to leverage the full spectrum of community resources, beyond the traditional scope of the clinical and research requirements of these mechanisms.

• Commission a set of briefing papers that describe replicable models of community finance (e.g. DSH payment approaches), governance (e.g. health authorities), and communications innovations for effective and sustainable disparities reduction in communities.

• Re-examine the framework and recommendations of the IOM Future of Public Health with the goal of re-invigorating a public health agenda in community and health disparities.

• Convince a leading public health, health services, or community development journal to publish a special issue on methods for evaluating community interventions and initiatives to reduce disparities – geographical and Health Impact Analysis, cost benefit and social return on investment analysis, multilevel and social network methods – as well as qualitative approaches.

• Engage a leading foundation in supporting the training and professional development of a new cadre of community savvy academic leaders in the field of health disparities.
Identify and encourage a set of universities with the academic mission, resources, and community context to seriously and systematically build hybrid approaches that bring the same sophistication to community engagement and partnership as they brought to other dimensions of translational science.
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