NIH SUMMIT THE SCIENCE OF ELIMINATING HEALTH DISPARITIES
DECEMBER 2008

NATIONAL CENTER ON MINORITY HEALTH AND HEALTH DISPARITIES

Summary *of* Summit Proceedings

ACKNOWLEDGEMENTS

The National Center on Minority Health and Health Disparities (NCMHD), acknowledges its many partners throughout the NIH and the federal government for their involvement in making the 2008 NIH *Science of Eliminating Health Disparities Summit* a success. NCMHD extends special gratitude to the members of the Summit Planning committee, the extramural planning committee, the global health committee, the abstract committee, the awards committee, and all the NCMHD staff and other NIH staff who contributed to the planning and execution of the summit. This report represents a synthesis of the findings from the summit convened by the NCMHD on December 16 – 18, 2008. This historic assembly convened the NIH, the academic research community and its community partners to address health disparities and provide recommendations that will shape future research.

Finally, we wish to acknowledge and thank the speakers, moderators and thousands of participants who attended the summit, for the overwhelming expression of interest and commitment to address the complex issues surrounding minority health and health disparities.

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FOREWORD

Why a trans-NIH health disparities summit? In 1985, Secretary of Health and Human Services, Margaret Heckler issued the *Black and Minority Health Report*, a landmark report from the United States Department of Health and Human Services (HHS) that highlighted the striking disparity in health status, between minority and non-minority Americans.

In 1990, then Secretary, Louis Sullivan, MD, responded to this report by calling upon the National Institutes of Health (NIH) to initiate measures that would improve the health status of minorities. Subsequently, the NIH administratively created the Office of Minority Programs (OMP) within the NIH Office of the Director.

By 1991, the OMP had established a 53-member Fact-Finding Team, representing various disciplines and populations, to convene a series of regional Town Hall meetings in communities around the country to answer the question, *"What is it that we are not doing that we ought to be doing?"* This, resulted in 13 recommendations that would later form the basis of the NIH Minority Health Initiative (MHI)—a collaboration with the NIH Institutes and Centers, led by the Office of Research on Minority Health (ORMH), which was established by the NIH Revitalization Act of 1993.

In November 2000, President William Jefferson Clinton signed into law, the *Minority Health and Health Disparities Research and Education Act of 2000*, which had been introduced in Congress by Senator Edward Kennedy. The law created the National Center on Minority Health and Health Disparities (NCMHD) to serve as the focal point for minority health and health disparities research at NIH. Public Law 106-525 gave NCMHD grant, funding authority and broadened its constituency base. It describes the roles and responsibilities of the Center as follows:

> "The general purpose of NCMHD is the conduct and support of research, training, and dissemination of information, and other programs with respect to minority health conditions and other populations with health disparities."
> "Coordination of Activities — The Director of the NCMHD shall act as the primary Federal official with responsibility for coordinating all minority health disparities research and other health
>
> (1) ... shall represent the health disparities research program of the National Institutes of Health, including the minority health disparities research program, at all relevant Executive branch task forces, committees and planning activities; and

> (2) ... shall maintain communications with all relevant Public Health Services agencies, including the Indian Health Service, and various other departments of the Federal Government to ensure the timely transmission of information concerning advances in minority health disparities research and other health disparities research between these various agencies for dissemination to affected communities and health care providers."

In addition, the legislation requires NCMHD to work in collaboration with the NIH Director, the NIH Institutes and Centers, and in consultation with its advisory council to establish a strategic plan and budget for minority health and health disparities research. The Institute of Medicine (IOM) established and later assessed the strategic plan and provided 10 recommendations. Among them, it suggested:

> "The NIH director, through the established authority of the NCMHD director, should assure continuous, effective coordination of the health disparities research program across the NIH including:
> Fostering of conferences and the use of committees and panels involving the NIH, extramural scientific communities, and others to inform and advise on initiatives and directions..."

The release of the IOM report *Examining the Health Disparities Research Plan of the National Institutes of Health: Unfinished Business*, provided the momentum and determination to move forward with a trans-NIH summit that would highlight the agency's accomplishments in the three principal areas of the NCMHD strategic plan – Research, Research Infrastructure, and Outreach. Specifically, the Summit would highlight the following:

Research – What scientific advances have increased our understanding of the causes and means to reduce and ultimately eliminate the disproportionate burden of diseases and conditions among health disparities groups and populations?

Research Infrastructure – What current opportunities and institutional capacity – e.g., environment, leadership, commitment to health disparities research – exist for research on health disparities?

Community Outreach – What progress has been made in the dissemination, translation and application of research findings to reduce and ultimately eliminate health disparities?

In addition to highlighting accomplishments in the three principal areas of research, research infrastructure and outreach, summit speakers and participants were asked to reexamine and redefine strategies toward eliminating health disparities and to provide recommendations for further research.

Most Americans would agree that, overall, we have made scientific progress in combating disease in general, as reflected by the dramatic increase in average life-span. In addition, there has been significant progress made in identifying, understanding and monitoring health disparities, diseases and conditions among groups. Adequate research, however, is needed to clarify the link between biological and non-biological determinants of adverse health outcomes, as well as to clarify the multi-factorial nature of health disparities. As t NCMHD continues to provide leadership to NIH for minority health and health disparities research, it recognizes the importance of redefining the paradigm for understanding and eliminating health disparities within a framework that integrates applied science, public health practice interventions and clinical practice and effective policy. The summit provided a forum for NCMHD to present this new framework of science, practice and policy needed to promote the integration of these three, frequently fragmented fields, and to help guide attention to key research needs and gaps.

Researchers are proving that health care is, but one, of several determinants of health and disparities. Other determinants of health and disparities that need recognition and attention include behavioral choices, and social, economic, and political environments. Our knowledge of the distinct fields of science, practice, and policy has improved. To affect change, we must, adopt a transdisciplinary approach across the determinants of health. Health disparities are an extraordinary moral and ethical dilemma for our nation. NCMHD is determined to change the discourse of this dilemma. We hope that the considerations and recommendations in this proceedings report will be useful tools for further action to reduce and eliminate health disparities and to ensure full productive and healthy lives for the next generation.

John Ruffin, PhD
Director
National Center on Minority Health and Health Disparities
Bethesda, MD

I. EXECUTIVE SUMMARY

In 1985, the United States Department of Health and Human Services (HHS) issued the landmark, *Black and Minority Health Report* which highlighted the marked disparity in health status between majority and minority Americans. The *Minority Health and Health Disparities Research and Education Act of 2000* established the National Center on Minority and Health Disparities (NCMHD) to promote minority health and to lead, coordinate, support, and assess the National Institutes of Health's (NIH) effort to reduce and ultimately eliminate health disparities. The Act charged NCMHD with conducting and supporting research and training, and with the dissemination of information related to health disparities among minorities and other under-served populations, in part by organizing conferences for government, scientific and medical communities.

Inequities in health care and health outcomes continue to be a primary concern for public health both nationally and globally. A number of factors, in addition to varying trends observed in health status, life expectancy, un- and underinsurance coverage, unemployment and poverty rates, shifts in US urban and rural demographic patterns and growth in diversity within minority and immigrant populations, represent a few of the complexities involved when addressing health disparities and challenge the efforts to accelerate progress in health equity.

Over the past 20 years, the National Institutes of Health (NIH) has played a leadership role in advancing health disparities research and in facilitating communication among stakeholders. Continuing in their leadership capacity, NIH, through NCMHD, sponsored the *NIH Summit: "The Science of Eliminating Health Disparities",* held from December 16 through 18, 2008. This historic assembly convened the NIH, the academic research community including policy researchers and community partners, ,in a forum that presented health disparities highlights, showcased best-practice models, and explored concepts, theories, data needs and applications to promote progress toward the elimination of health disparities. This summit provided a unique opportunity to examine conceptual challenges, redefine current strategies, and reach beyond traditional disciplinary boundaries to further the reduction of health disparities. To this end, NIH introduced a new framework for approaching health disparities that integrates science, policy, and practice to examine health disparities at the intersection of these often distinct and fragmented fields.

This monograph summarizes the priorities and recommendations of the Summit participants. Full details of the Summit outcomes can be found in the Conclusions and Recommendations of the Proceedings.

Audience

With over 4000 in attendance, NCMHD began the Summit commenced by announcing the new *Health Disparities Intramural Research Program* for state-of-the-art research which focuses on the links between biological and non-biological determinants of health within health disparity populations. NCMHD also introduced the *Science, Policy, and Practice* framework for addressing health disparities as an overarching, organizational construct to promote advances in and to identify ways to bridge science, practice and policy, as well as, shape future research.

- Science is essential for conveying new knowledge about health, determinants of disparities, disease progression and outcomes in different subgroups, risk factors and application of best evidence or translation of scientific findings to close the disparity gap.

- Practice is critical for applying the scientific knowledge, evidence and skills necessary for effective and quality health care delivery. It is achieving in-depth background knowledge, diagnostic expertise and effective critical appraisal skills to ensure the best care or intervention for the appropriate patient or subgroup. It, therefore, applies lesions learned from science to improve health care.

- Policy intervention is a critical facet of the science, research translation and practices aimed at eliminating health disparities. Science drives policy interventions as it provides the needed evidence for defining standards, regulations, or most importantly, legislation that may be integral to eliminating health disparities at the local, regional or national level.

The three-day summit was structured into three multi-topic plenary sessions and five distinct breakout session tracks, as well as oral and poster presentations. The third day closed with a town hall meeting forum.

Poster sessions highlighted the breadth of the outstanding work of seasoned and early-stage investigators in the areas of;

- Transformational research that show potential for reducing health disparities;

- Transdisciplinary research infrastructure, which typically builds on nontraditional partnerships;

- Translational community research that ensures that beneficial research information is effectively distributed to providers and communities through outreach; and

- Integrated best-practice models and programs.

Breakout session tracks and topics defined below provided a format for dynamic feedback by challenging participants to discuss current research and identify recommendations for future health disparities research.

- *Translating Science to Policy and Practice* explored translational efforts that bridge science to practice and policy in areas such as cultural competency, health literacy, community-based participatory research, social determinants of health, and gene-environment interactions.

- *Health Disparity Diseases and Conditions* focused on current research, as well as research gaps within priority health disparities diseases and conditions such as infant mortality, heart disease, diabetes, cancer, HIV/AIDS, and mental health. The session addressed challenges and opportunities for eliminating health disparities in these priority conditions were addressed, with an emphasis on identifying potential solutions or promising practices.

- *Health Disparity Target Populations* explored the challenges and opportunities in eliminating health disparities within health disparity populations, e.g., those consisting of racial and ethnic minorities, those of low socioeconomic status, or rural populations.

- *Building Capacity* acknowledged that in order to eliminate health disparities, we need to invest in developing the pipeline of researchers who can lead the next and future generations of health disparities research. This breakout session explored the challenges and opportunities in developing a pipeline, from training and education to the creation and maintenance of comprehensive centers that address health disparities.

- *Partnerships, Collaborations, and Opportunities* focused on opportunities for partnerships and collaborations with public and private partners. It also provided a venue for representatives from federal agencies and private organizations to showcase their health disparities portfolios and identify opportunities for collaboration.

Each breakout session identified current priorities and recommendations which were captured, organized, and qualitatively analyzed, with respect to the overarching paradigm of *Science, Practice and Policy*. This analysis resulted in three predominant themes:

- *Intersections Between Science, Policy, and Practice* identified broad and specific recommendations for bridging these three domains through community engagement and transdisciplinary approaches that linked biological and non-biological determinants of health.

- *Partnerships and Collaborations* identified many recommendations for fostering and maintaining robust partnerships. This category highlighted suggestions for various ongoing collaborative federal, state and local public health efforts, as well as public-private partnerships that included authentic community and academic research partnerships.

- *Training, Mentoring and Capacity-Building* identified recommendations for developing the health disparities research workforce through mentoring, infrastructure development and capacity-building.

Audience asking questions of the panel.

II. SUMMARY OF KEY RECOMMENDATIONS

In December 2008, under the leadership of the National Center on Minority Health and Health Disparities (NCMHD), the National Institutes of Health (NIH) sponsored its first trans-NIH summit: *"The Science of Eliminating Health Disparities."* The summit provided a unique forum for researchers, scientists (social, behavioral, environmental, and political), public health professionals, community leaders, health advocates, and stakeholders, with an interest in health disparities, to assess current advances in health disparities, examine gaps in research and data, explore conceptual frameworks and theories, and to provide recommendations for NIH to advance health disparities research through the translation of science into practice and effective policy.

The key issues that resulted from the summit were:

- The critical need for health and health care reform,
- The adoption of a life-course approach to address disparities and the social determinants of health,
- The integration of health disparities, not only within public health policies, but also within social, environmental, educational and institutional policies that are known to have a direct impact on health, and
- The need for partnerships, collaborations and community-engagement in health disparities research.

Participants called on NIH to enhance trans-NIH collaborations in health disparities research, develop stronger federal collaborations to advance the science and the translation to practice and policy, and provide effective methods to measure research outcomes.

Recommendations were analyzed and categorized into three key priority areas:

1. Development of a research framework at the intersection of science, practice and policy that includes the biological and non-biological determinants of health; 2) adoption
2. Adoption of a research process that recognizes and acknowledges the unique strengths of partnerships, collaborations, community engagement and transdisciplinary efforts
3. Development of an infrastructure to support a health disparities research workforce

III. SUMMIT STRUCTURE

The NIH Summit on "The Science of Eliminating Health Disparities" took place in National Harbor, Maryland, from December 16 to 18, 2008. A 67-member trans-NIH Summit Planning committee, a 9-member NIH Summit Extramural Committee and a 7-member Global Health committee planned and organized the various components of the summit structure. The Foundation for National Institutes of Health (FNIH) managed the summit speaker presentations and plenary session activities. A new framework that integrated science, practice, and policy was unveiled to examine and promote translational and transdisciplinary health disparities research. For the first time, the National Institutes of Health (NIH), the academic research community, and its community partners and policy researchers presented health disparities research highlights, showcased best-practice models, and explored concepts, theories, data needs and applications pertaining to health disparities science. The policy implications of health disparities science, and its applications, and promising practices were also discussed. The proceedings outlined in this report summarize the many valuable recommendations that emerged.

Summit Structure

Summit activities consisted of three multi-topic plenary sessions, four breakout sessions totaling 100 speaker panels, 328 poster presentations, and numerous presentations by exhibitors. Plenary speaker presentations focused on the intersections of science, policy, and practice, as well as health care reform issues. Summit planners organized scientific posters into four categories: transformational research, transdisciplinary research infrastructure, translational community outreach, and integrated best-practices.

- **Transformational Research** – Research that takes on an innovative and creative approach to advancing the understanding of the development and progression of diseases and disabilities that contribute to minority health and other health disparities and has the potential to close an important health disparity gap.

- **Transdisciplinary Research Infrastructure** – Research Infrastructure that builds on non-traditional partnerships across disciplines to increase minority health and health disparity research training, career development, and institutional research capacity and infrastructure.

- **Translational Community Outreach** – Outreach that expands the latest research advances in minority health and health disparities quickly into communities, ensuring that the public, health care professionals and research communities are informed and educated.

- **Integrated Best Practices** – Integrated models or programs that incorporate transformational research, transdisciplinary research infrastructure, and translational community outreach to reduce health disparities

Organizers invited researchers, scientists, practitioners and policy experts to present their work and encouraged them to consider the following questions when developing their presentations:

- How do we bridge science, practice, and policy to eliminate health disparities in this particular area?

- Over the past 10 years, what have been the three best advances from (your breakout session topics) toward eliminating health disparities?

- What are the three most important research focus-areas from your breakout session topic that NIH needs to pursue over the next 10 years to eliminate health disparities?

Each day began with plenary sessions that focused on a broad theme that provided a framework for continuing discussion.

Day 1: *Health Disparities and the Intersection of Science and Policy*
Charting a New Course for Health Disparities: Finding Your Niche

Day2: *Perspectives on Health Care Reform: Eliminating Health Disparities*
Health Disparities and the Intersection of Science and Practice
Health Disparities and the Intersection of Science, Practice and Policy
Policy Implications for Eliminating Health Disparities

Day 3: *Science and Industry*
The Role of Media and Policy in Eliminating Health Disparities
Town Hall Meeting

A total of 218 scientists, researchers, and public health practice and policy experts contributed to the breakout sessions that were organized into five "tracks". In addition to the three general questions posed to all speakers, additional specific questions were posed to participants for each track:

Track I: Translating Science to Policy and Practice

This track explored translational efforts that bridge science with practice and policy in areas such as cultural competency, health literacy, community-based participatory research, gene-environment interactions and social determinants of health. Key questions posed to participants were: 1) What efforts are being made to have the current science in this area reflect true practice and what more should we do? and 2) What efforts are being made to translate the current science in this area into effective policy and what more should we do?

Track II: Health Disparity Diseases and Conditions

Topics in this track focused on current studies and research gaps identified within priority health disparity-related diseases and conditions such as infant mortality, heart disease, diabetes, cancer, HIV/AIDS, and mental health. The challenges and opportunities in eliminating health disparities in these priority conditions were explored to identify potential solutions or promising practices. The key question posed to participants during this track was: What do we need to do to eliminate health disparities in this disease or condition?

Track III: Health Disparity Target Populations

This track explored the challenges and opportunities in eliminating health disparities within health disparity populations; i.e., racial and ethnic minorities, those of low socioeconomic status, and people living in rural areas. The key question posed to participants during this track was: What do we need to do to eliminate health disparities within this target population?

Track IV: Building Capacity

To eliminate health disparities, we need to build capacity and invest in developing a cadre of researchers who can lead and train future generations of health disparities research. This track explored the challenges and opportunities in building this capacity from training and education, and the creation and maintenance of comprehensive centers to address health disparities. The key question posed to participants during this track was: 1) What do we need to do to build capacity in this area?

Track V: Partnerships, Collaborations, and Opportunities

This track explored opportunities for partnerships and collaborations with public and private partners. It also provided a venue for representatives from the following agencies and organizations to showcase and share their health disparities portfolio. Two key questions posed to participants during this track were: 1) How can we learn from our partners, and 2) How can we build these collaborations further?

Scientific Poster Sessions

Scientific and poster sessions highlighted outstanding work achieved by seasoned and early-stage investigators. The Summit accepted 72 oral abstracts and 328 poster abstracts categorized into four areas of research.

Posters were organized into the following four categories:

Transformational Research

This category presented research that has provided an innovative and creative approach to advancing our understanding of the development and progression of diseases, conditions and disabilities that contribute to minority health and health disparities. This research has demonstrated a potential to close the health disparity gap.

Transdisciplinary Research Infrastructure

This category focused on research infrastructure that has been built upon nontraditional partnerships across disciplines to increase minority health and health disparity research training, career development, and institutional research capacity and infrastructure.

Translational Community Outreach

This category covered outreach, which has expanded the latest research advances in minority health and health disparities and have been quickly disseminated into communities, ensuring that the public, health care professionals and research communities are informed and educated.

Integrated Best Practices

This category reviewed integrated models or programs, which have incorporated transformational research, transdisciplinary research infrastructure, and translational community outreach to reduce health disparities.

The NIH Summit Abstract Review Committee reviewed and selected oral and poster abstracts for presentation based upon approach, conclusions, and relevance to the submission category.

IV. PLENARY SESSIONS

Summit Day One | December 16, 2008

Plenary Session I

The statements discussed in this summary reflect the ideas and views expressed in the presentations by invited plenary session speakers and guests.

Opening Ceremony

Introductory Remarks and Key Recommendations

The summit began with a plenary session addressing health disparities and the intersections of science and policy. The session's moderator, Mary Woolley of Research!America, presented the results of a survey commissioned by Research!America, which revealed that the 95% of the American public felt that research that helps them better understand and overcome health disparities is important. Dr. John Ruffin, NCMHD Director, then welcomed the participants and acknowledged prominent leaders who played an influential role in setting the course for the elimination of health disparities, including Drs. Louis Sullivan, Bernadine Healy, David Satcher, Harold Varmus and Ken Moritsugu. He also acknowledged the progress of the NIH community in advancing the health disparities agenda, establishing the NIH Health Disparities Strategic Plan and achieving steadfast scientific progress in translational and community-based research. Dr. Ruffin stressed the need for more partnerships between research institutions and community-based, faith-based, and minority institutions. He also emphasized the need for vision, leadership, commitment, creativity and passion to tackle the biological and non-biological factors that are the root causes of health disparities. He assured the audience that through transdisciplinary approaches, NCMHD would continue to explore the new paradigm for eliminating health disparities at the Intersections of Science, Practice and Policy.

Dr. John Ruffin

Dr. Varmus challenged participants to re-examine the obstacles faced in conducting health disparities research and providing health care in disadvantaged communities. He also encouraged the elimination of global health disparities and asked participants to support the IOM's recommendations for advancing the nation's effort in improving global health.

Dr. Raynard Kington provided a historical perspective on how far the science of understanding and eliminating health disparities has advanced since 1896, when Atlanta University conducted its first conference *"Conference for the study of the Negro Problem"*. He discussed the significant impact of W.E.B Du Bois, who shortly after obtaining his PhD from Harvard pioneered a sociological study in Philadelphia's seventh ward. Du Bois published his research "*The Philadelphia*

Negro: A Social Study". This book included a chapter on the social factors that led to the poor health status of African-Americans in this section of Philadelphia. He then sought to understand the "Science to Solve the Negro Problem," despite growing resistance from the scientific community and the belief that health disparities in African Americans were grounded almost exclusively in racism. Accordingly, Dr. Du Bois rejected these arguments and firmly held his conviction that progress could be made following scientific methods.

Dr. Kington discussed the ideas of John Trask (1916), an assistant surgeon general with the US Public Health Service, and Clark Tibbitts (1937), both of whom adopted social solutions to health disparities for poor blacks. He spoke of the growing diversity of minority populations and immigrants that has recently forced the scientific community to broaden its thinking about and approaches to understanding and addressing health disparities. Dr. Kington emphasized the large growth of Hispanic and Asian-American populations, the unique health challenges facing Native American tribal communities, and the growing heterogeneity among African-Americans, should enable us to gain a better understanding of the health disparities and that the research community should proceed with "vigilant humility and persistent humanity".

Dr. Raynard Kington, Dr. John Ruffin, Dr. Bernadine Healy, Dr. Mary Woolley, Dr. Joyce Hunter, and Dr. David Satcher

In conclusion, Dr. Kington announced the establishment of the intramural research program at NCMHD, describing it as follows:

> The NIH intramural program is a venue for high-risk, high-impact research and supports the agency's (NIH) ability to respond rapidly to public health emergencies, as well as to conduct long-term research on complicated problems such as health disparities. It also serves as an important vehicle for the international research collaborations needed to accomplish global health goals. The NCMHD Health Disparities Intramural Research Program will conduct state-of-the-art research focusing on the links between biological and non-biological determinants of health and health disparity populations. It will create training and mentorship opportunities to develop intramural researchers focused on health disparities research, including those from health disparities populations. It will contribute a pool of early-stage and seasoned investigators that will enhance the diversity of scientists and research disciplines which complement the intramural program at NIH."

Dr. Maya Angelou

Following Dr. Kington's speech, Dr. Maya Angelou presented an inspirational talk on her perspectives on minority health and health disparities. She encouraged the audience to be optimistic about the progress in disparities research. She suggested "health equity" is a preferable ways of referring to the problem of health disparities. These terms imply a perspective that,looks at the glass as half-full as opposed to "health inequity" and "health disparity", which suggest that the glass is half-empty.

Health Disparities and the Intersection of Science and Policy

The second part of the plenary session focused on health disparities at the intersection between science and policy. The moderator, Dr. David Satcher, stressed the need to continue to advance effective health and healthcare policies consistent with science.

Reducing Health Disparities in Our Society: Reshaping Opportunities through Science

Robert Otto Valdez, PhD, Robert Wood Johnson Foundation

Dr. Robert Valdez presented target areas for research and policy analysis efforts including the need for interdisciplinary research to address the highly complex issues of discrimination, poverty and limited access to basic necessities, and health care in resource-poor communities. Interdisciplinary science, according to Dr. Valdez, plays an increasingly important role in addressing the complex social issues, such as discrimination, poverty, and other forms of oppression that play out at the community level. He made the following recommendations:

a. Begin the implementation of effective policy efforts that support interdisciplinary fields that integrate the social and biological sciences. This would include the need for NIH and other researchers to move beyond the medical care system and focus on the relationship between the way individuals live their lives and the influence of the surrounding economic, social, political and physical environment. He referred to the recently released report of the RWJ Foundation Commission to Build a Healthier America that presented a conceptual framework integrating medical care, personal behavior, living and working conditions in homes and communities, and social and economic opportunities and resources to address health.

b. Focus future research and development on new tools for improving diagnostics and accelerating development of vaccines.

c. Address the equitable distribution of opportunity and resources.

Pursuing a National Policy for Preventing Hepatitis B-induced Liver Cancer: Implications for Eliminating Health Disparities

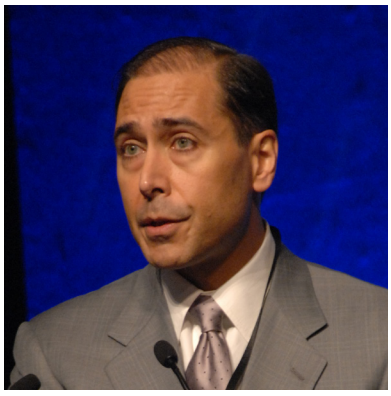
Moon Chen, PhD, MPH, University of California, Davis

Dr. Chen proposed a national policy for preventing hepatitis B–induced liver cancer by adapting the smallpox eradication model. He suggested that the eradication of smallpox is perhaps the only historical example where the elimination of a health disparity has been achieved. He also pointed out that this illustrates that not only must health care disparities such as access barriers be eliminated but that science, policy, and practice must all converge to facilitate disparities reduction and their ultimate elimination. The case of smallpox eradication also underscores the importance of disease detection, treatment, and prevention to work together to bring about the elimination of this unnecessary human scourge.

According to the World Health Organization, hepatitis B viral infection is considered second only to tobacco as the most common and known human carcinogen affecting more than 400 million people worldwide. While hepatitis B viral infection rates are relatively low in the US, its incidence is considerably higher among all racial and ethnic minorities compared to the incidence in non-Hispanic Whites. Thus adapting the smallpox model of vaccination and early detection offers the potential of preventing hepatitis B-induced liver cancer in subsequent generations and hence eliminating a significant health disparity for future generations.

Science, Policy, and Health Disparities in American Indians and Alaska Natives

Jeffrey Henderson, MD, MPH, Black Hills Center for American Indian Health



Dr. Jeffery Henderson

Dr. Henderson addressed the lack of knowledge about the tribal sovereignty and its importance. He addressed this issue specifically with regard to the intersection of science and policy in efforts to address health disparities that may exist in the American Indian or Alaska Native population. Dr. Henderson discussed Executive Order 1317entitled *Consultation and Coordination* with Native Indian tribes, which was signed by President Clinton in 2000. It highlighted the different responsibilities of the Federal Government when consulting with federally recognized American Indian tribes. A significant impact of the Order discussed by Dr. Henderson was how different branches and agencies within the Federal Government interact with American Indians and Alaska Natives. The Order also influences where researchers might focus in terms of research with respect to these populations.

Dr. Henderson urged all participants to consider how health equities and inequities should be addressed. He recommended:

a. Consideration and attention to the issues of funding, policy, practice, and partnerships with tribal people,

b. Increased partnerships with tribal people and develop interventions to improve the social conditions in which tribal people live, and

c. Adoption of a comprehensive approach that includes examining and addressing social and economic conditions and enhancing the overall health of tribal populations.

Health Inequality: Science, Policy, and Politics

Brian Smedley, PhD, The Joint Center for Political and Economic Studies

Dr. Smedley discussed the relationship between health, wealth, income, and sustained employment. He expressed that a strong belief in individual determinism can be problematic with respect to political will when addressing health disparities. Since 1985, when the Heckler Report was released, health inequality has persisted in America, and volumes of research studies have emerged. Although very little action has taken place at the federal level, some legislation has been created which has positively addressed health disparities, e.g., by creating the National Center on Minority Health and Health Disparities. Dr. Smedley pointed out the need for scholars, activists, and policy analysts working in interdisciplinary teams and using interdisciplinary models to improve political will. He discussed the importance of understanding residential segregation which shapes health, behavior, diet, and which also encourages a sedentary lifestyle. He explained how structural inequality, racism, and discrimination shape the context for health and why they should be priorities on the research agenda. Dr. Smedley recommended:

a. Efforts to engage scholars, activists, and policy analysts to help improve political will,

b. NIH lead, coordinate and develop strong interdisciplinary teams and interdisciplinary models to address health disparities, and

c. Inverting the lens, turning it around to" study conditions in society that create inequality, and perpetuate the kinds of systems that allow unequal treatment and advantages.

Charting a New Course for Health Disparities: Finding Your Niche

Kenneth Moritsugu, MD, MPH, Johnson and Johnson

Dr. Kenneth Moritsugu

Dr. Moritsugu discussed the definition of health care disparities, stating that they are differences in health status between one population and another, but he suggested that the definition is far too simplistic to describe the very complex and challenging issues. He discussed cultural, linguistic, racial, educational, and attitudinal differences that impose special barriers to reducing and eliminating health disparities. The list of these barriers also included geographic, professional, and socio-economic differences. According to Dr. Moritsugu, research should discover the roots of health disparities; identify scientific and social solutions, activities, practices, and interventions that will help eliminate health disparities; and develop policies that will enable and empower people and systems to assist in this endeavor. The health system must focus on the person at the center—the individual in the context of a community; because, the environment affects the ability of the individual to act and make good choices.

Dr. Moritsugu explained why charting a new course for eliminating health disparities should include the person at the center of the balanced triangle of research, practice, and policy. He recommended:

a. Focusing on relevant and robust research that translates effectively and efficiently for both the community and for the person. The research should focus on the whole person, mind, body, and spirit;

b. Including behavioral research as an integral part of the agenda; and

c. Encouraging NIH to lead and continue support for the expansion of basic scientific research that is devoted to finding solutions to health conditions that disproportionately affect racial and ethnic minorities.

Dr. Moritsugu concluded by stating that the challenges in health disparities are "long-standing and complex. We must "explore new courses" to forge new partnerships and to connect the dots between shared goals to reduce and eliminate health disparities.

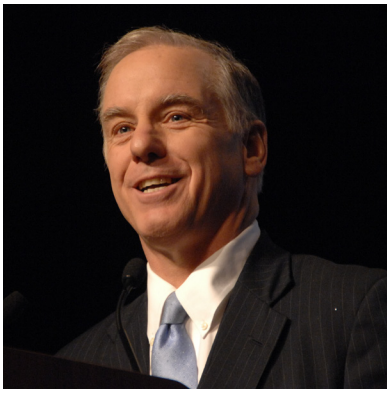
Summit Day Two | December 17, 2008

Plenary Session II

Health Disparities and the Intersection of Science and Practice

Health care Reform: Health care Disparities

Governor Howard Dean, MD, Chairman, Democratic National Committee



Governor
Howard Dean

The Honorable Howard Dean acknowledged the existence of health care disparities and addressed the importance of examining the entire perspective of health disparities. By understanding that racial, ethnic and most importantly socioeconomic disparities are national problems, researchers, scientists, policymakers and community members can affect health care at any point in the health care process," He advocated a focus on preventive care, and a wellness model of health care, as missed diagnosis or late-stage disease diagnosis and poorly managed care can result in expensive and avoidable complications.

Governor Dean also acknowledged that the expensive cost of managing health care disparities and noted that it imposes a tremendous strain on the country's financial system. He discussed the pioneering research work of John Wennberg and his colleagues at Dartmouth College that revealed variations in patterns and standards of medical practice and underuse of preventive care.

Governor Dean recommended:

a. Developing broad partnerships across multiple disciplines to addressing these disparities and ensure good health care for all Americans

b. Encouraging a focus on preventive care to improve the overall health of Americans, beginning with improvements in the education and health of all children; and

c. Using the transition from an "illness model" to a "wellness model" of health care, as part of our healthcare reform under President Obama.

Health Disparities: The Intersection of Science and Practice

Howard K. Koh, MD, MPH, Harvard School of Public Health

Dr. Howard K. Koh

Adopting a global perspective, Dr. Koh discussed eight millennium development goals which either directly or indirectly address the elimination of health disparities. These include eradicating extreme poverty and hunger, achieving universal primary education, promoting gender equality, and empowering women. He then addressed the question of how to translate research and science into practice, suggesting that, there must be a change in the way health is viewed. He indicated that a "broad population approach" which focuses on the "individual at the center, thus "the creation of a "public health symphony" is one solution. Dr. Koh presented that part of the challenge in moving forward is working together to "create the best possible public health symphony bringing together", all instruments, talents, and resources. Dr. Koh recommended that we:

a. Discuss health disparities in a language that is consistent with the World Health Organization's (WHO) constitution, which states, "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being."

b. Establish federal collaborations and public-private partnerships and involve political advocates.

Health Disparities and the Intersection of Science and Practice Community-Based Participatory Research (CBPR): What Predicts Outcomes?

Nina Wallerstein, DrPH, MPH, University of New Mexico, School of Medicine

Dr. Wallerstein discussed major challenges in moving science to practice when conducting intervention research. She suggested that Community-Based Participatory Research (CBPR) should be a transformative paradigm to enhance health equity and strengthen communities. It should include an interdisciplinary effort with community partners. Rather than adapting or adopting CBPR principles to enhance the recruitment of minorities into research studies, this CPBR as envisioned by Dr. Wallerstein, is aimed at democratizing science. She acknowledged the parallels of community and academia and discussed how the scientific needs of the community should be as important and similar to the scientific interest of academy.

Dr. Wallerstein suggested that the purpose of CBPR needs to be framed not only as a set of methods or methodologies, but rather as an orientation to a research process driven by collaboration. This research process includes qualitative, quantitative, and epidemiologic frameworks or concepts and serves as a springboard for action to improve health disparities.

The CBPR partnership incorporates an applied approach to influence changes in practice, (in clinical and in community settings), as well as and to influence changes in systems, programs, and policies. Dr. Wallerstein recommended:

a. Consideration of CBPR as an orientation to a research process between the researcher and the community research; that is driven by collaboration to help reduce health disparities, and

b. Support of interdisciplinary work with community partners.

Research to Practice: Moving from Disparities Research to Health Equity

Giselle Corbie-Smith, MD, MS, University of North Carolina at Chapel Hill

Dr. Corbie-Smith discussed how health disparities are associated with economic, social, structural, physical, and environmental inequities. She described how past interventions to address disparities have had a limited impact; have not been tailored to the concerns and cultures of participants; and have not included participants in the interventions, and the processes of design, implementation, and evaluation process. She further explained how the issue regarding disparities has created a need for more participatory and equitable approaches to research in order to eliminate racial and ethnic disparities through action.

Dr. Corbie-Smith explained how tradition in the sciences have sometimes focused on identifying problematic behaviors or defining communities in negative terms referred to as a "deficit approach" ignoring what is positive and what works well in particular subgroups. She discussed how the asset -based model, in contrast to deficit models highlights positive capabilities of individuals and strengths within communities to identify problems and create solutions. Dr. Corbie-Smith recommended that:

a. Health care professionals should integrate social capital in the workplace by reintegrating into the communities, and

b. Focus on research and community assets and strategies to build capacity within the context of research.

Health Disparity Research with Latino Populations: Advances and Future Directions

Mario De La Rosa, PhD, Florida International University

Dr. De La Rosa presented findings on the major biological, contextual, and interpersonal processes contributing to Hispanic health disparities. He highlighted the need for more

national studies to understand the notable health disparities affecting Latinos' health status. He emphasized the need for research studies linked to genetic, behavioral and community factors related to risks and protection against health disparities among Latino populations.

According to Dr. De La Rosa, research should be understood and conducted in the context of the community – i.e. where Latinos live. He suggested that future research should be expanded for Latinos. The science behind the reduction of Latino health disparities increasingly has been linked to community-based practice. He also emphasized mechanisms by which model interventions can target health risks and protective processes.

Dr. De La Rosa recommended:

a. Consideration of the "assets" Latinos already have that allow them to have better health outcomes, and

b. Encouragement of studies to understand significant differences and similarities between and within Latino subgroups.

Plenary Session IIa

Health Disparities and the Intersection of Science, Practice, and Policy

Policy Implications for Eliminating Health care Disparities

Elijah Cummings, Member of Congress, D-MD

The Honorable Elijah Cummings discussed: 1) the lack of health insurance for 47 million Americans, 2) the lack of health care access for 68 million Americans, and 3) the significant number of Americans who despite having health insurance are under-insured with limited or poor access to health care. He expressed concern about how people of color comprise more than half of America's uninsured population and the implications for obtaining health care. Congressman Cummings pointed out that health disparities and rates of premature death will get worse if we do not improve health care in our communities. He described the tragic story of Deamonte Driver, a 12-year old boy who died from complications of a tooth abscess, as a result of the lack of access to dental care, despite having insurance coverage, and he emphasized the critical need for improvement in oral health care and dental care access.

According to Congressman Cummings, there is an expressed vision and political will to address health disparities, and developing the policy road map to achieve this vision should be a top priority. He explained why healthcare reform efforts must be addressed in order to eliminate health disparities. Reforms should include: a) providing people with access to quality affordable health care regardless of their employment status, employer type, income, or education level; b) institutionalizing measures that improve upon and measure the quality of care provided to people of color; and c) eliminating discriminatory treatment in our health care system. Congressman Cummings recommended:

a. Adoption of broader policy measures that close the education, housing, environmental, and income disparities gap that contribute to health disparities, and

b. Encouragement of partnerships and active participation to eliminate health disparities

Moving Upstream: How Interventions that Address the Social Determinants of Health Can Improve Health and Reduce Disparities

David R. Williams, PhD, MPH, Harvard School of Public Health

Dr. Williams presented a growing body of scientific evidence on the influence of social determinants of health. He discussed the large racial gap in health status and higher death rates in the early years among African-Americans and American Indians compared to Whites. The relatively poor health status and higher death rates in these two populations persist in midlife, eventually reaching a point where the death rates are nearly twice those of whites He also spoke about the downward trajectory of the health status of immigrants with increasing length of stay in the U.S. He explained that disparities are longstanding, and he discussed the role socioeconomic status and level of education has on health. Dr. Williams emphasized the role of social policies––in the area of housing, employment, community development, transportation and income support ––and their relevance to making healthy choices. Dr. Williams focused on the importance of the social determinants of health and health status. He explained that individuals are affected not only by their current socioeconomic status but also by exposures throughout life, the inadequacies in income, deprivation in nutrition, and early and preventative medical care. He acknowledged the importance of improving access to care for all with an emphasis on prevention, and developing strategies to reduce inequalities. Finally, he discussed the work of the Robert Wood Johnson Commission to Build a Healthier America. In conclusion, Dr. Williams recommended:

a. "Moving upstream," and developing policies that will reduce inequalities in health that address non-medical factors. "All policy that affects health is health policy;"

b. Supporting investments in early childhood programs to reap decisive benefits for the well-being, the educational performance, and the educational success of children, as well as for their health;

c. Considering that improving health and reducing inequalities in health is not just about more health programs, it is about a new path to health;

d. Supporting Health officials to work collaboratively with other sectors of society to initiate and implement social policies that promote health and reduce inequalities in health

e. Committing to new strategies and "political will" to improve living and working conditions and eliminating health disparities; and

f. Utilizing all of our current knowledge in a "systemic and comprehensive manner" to tackle the issues in health care and eliminate health disparities.

Using Community-Based Participatory Research to Address Health Disparities

Meredith Minkler, DrPH, MPH, University of California, Berkeley

Dr. Minkler explained how the rationales for Community-Based Participatory Research (CBPR) involve speaking about the disconnect between academic research and the real concerns of people. She discussed the relevance of participatory research in addressing community problems, because it addresses local health disparities' concerns. According to Dr. Minkler, some of the best CBPR to address health disparities has been in the area of environmental justice.

Dr. Minkler declared that addressing policy and practice through CBPR requires relevant, credible data, and science that can stand up to careful scrutiny. CBPR should involve a variety of research methods and "quantitative" data, which are important for moving policy makers, and also should include people's stories captured in the "qualitative" data. Dr. Minkler recommended:

a. Address procedural justice through which people of color and people from other marginalized groups "get a seat at the policy table and remain at the table," and

b. NIH and the research community should build strong collaborations and alliances with stakeholders beyond formal partnerships.

A Patient Activation and Empowerment Intervention

Margarita Alegria, PhD, Harvard Medical School

Dr. Margarita Alegria

Dr. Alegria addressed communication in medical practices and the need for providers to work more with patients, and with minority patients in particular, to understand their health status. According to Dr. Alegria, a patient's signs and symptoms can vary among different cultures. She explained how diagnostic bias is reduced, while acknowledging that this bias can be important to determine appropriate treatment, obtain high quality care, and reduce service and outcome disparities. Dr. Alegria recommended:

a. Engaging the patient and build rapport, and

b. Preparing the patient to be empowered and knowledgeable about their health.

Creating, Maintaining, and Blurring Boundaries: The Intersections of Science, Policy, and Practice

David Takeuchi, PhD, University of Washington

Dr. Takeuchi described the boundaries between disciplines, within disciplines, and between scientists and communities and some of the rhetoric that is used to maintain them. He explained that scientists (and others) create boundaries as a means to reduce ambiguities in the field and secure resources and power for their disciplines and professions. Boundaries are social constructs that change over time and place. While they are inevitable, they can slow the progress of research, especially research that investigates disparities in health. He presented some thoughts on how boundaries can be blurred to facilitate more collaboration across multiple interests.

Dr. Takeuchi discussed the importance of establishing a "bigger boat", a bigger set of resources, and more collaborative efforts to resolve health disparities. He explained how boundaries are socially constructed and how society believes in the "rigidity" of these boundaries. He explained that one of the main attempts of boundaries is to distinguish between non-science and "legitimate" science. Dr. Takeuchi recommended:

a. Encouraging more discussions with scientists to understand the work of other disciplines, and

b. Establishing collaborations and relationships to address boundaries.

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Plenary Session III

Science and Industry

Evelyn Lewis, MD, MA, Pfizer, Inc.

Dr. Lewis discussed some of the efforts and strategies implemented by Pfizer to address health disparities, including several partnerships Pfizer has created to deliver prevention programs that involve physician and patient communication sessions, enhanced access to medicine, and data collection and dissemination. She stressed the importance of promoting physician-patient relationships, improving cultural sensitivity in the physician-patient relationship, and improving health communication. Dr. Lewis stated that the guiding principle for moving forward includes a foundation for all Americans, regardless of health status or income, to have affordable access to health coverage and quality healthcare that is also "culturally relevant quality health care. She expressed that the goal and top priority is to eliminate disparities in health, and health care access and quality. Dr. Lewis recommended:

a. Establishment of partnerships with NIH and other community organizations, and earning the trust of scientists, regulators, physicians, and patients;

b. Greater access to medicine which would further improve targeting of diverse populations to combat health disparities; and

c. Establishment of effective partnerships for delivering prevention programs.

Panelists for session on "Role of the Media in Eliminating Health Disparities."

Plenary Session: The Role of Media in Eliminating Health Disparities

Moderator: George Strait, NCMHD

Claudia Baquet, MD, MPH, University of Maryland School of Medicine
Brian Smedley, PhD, The Joint Center for Political and Economic Studies
Tim Johnson, MD, MPH, ABC News
Raj Shah, Chairman and CEO, Capital Technology Information Services
Elmer Huerta, MD, MPH, Washington Hospital Center
Hilton Hudson, MD Chairman, Health Literacy Foundation, Hilton Publishing Company, Cardiovascular Surgeon
David Satcher, MD, MPH, Satcher Health Leadership Institute

Brian Smedley, PhD, The Joint Center for Political and Economic Studies

Dr. Smedley discussed inequality and its negative impact on population health. Dr Smedley discussed the importance of having multiple sources of media to address health equity, and explained how media can empower communities to be more effective in addressing their problems. He explained how helping communities to organize, particularly through the Internet, is one of the most promising strategies and that government should facilitate this effort. Dr. Smedley outlined the responsibility of the media to highlight, in the context of general reporting, the fact that there are gross inequalities in health, access to health care, and health care quality. Dr. Smedley recommended that there should be full:

a. Accurate reporting by the media of inequalities in health care and the crisis in health infrastructure, and

b. Clear communication and reporting of the crisis in health infrastructure.

Raj Shah, Chairman and CEO, Capital Technology Information Services

Mr. Shah discussed the challenges in getting doctors with the correct skills and expertise to care for individual patients within health disparity settings. He added that, in terms of outreach, it is very important to start at the grassroots and work "directly with" the health disparity population. He explained how building a social network, independent of the standard networks, helps to develop a public and private partnerships needed for health disparities efforts and for grassroots efforts. He discussed the importance of fostering "local" blogs which would "extend healthcare" to "local" people, including young children, teens, and hard-to-reach populations in our society. Mr. Shah recommended that those concerned with health disparities should encourage use of the Internet, and local papers to educate the public about health disparities, with a focus on media coverage at the grassroots.

Hilton Hudson, MD, Chairman, Health Literacy Foundation, Hilton Publishing Company, Cardiovascular Surgeon

Dr. Hudson discussed the importance of addressing inequality in health, suggesting that it was the most important medical challenge. He explained that there is work to do in terms of getting everyone on board to support disparities as a core part of the research agenda, and shaping the rewards and incentives in academia for doing so. He also stressed the importance for media to be consistent in its message with a focus on success stories, including those that inform the underserved and health disparity populations that people can live longer with diseases. He stated that the media need to seek to report examples of true empowerment, and true success, and improve communication of health disparities.

Claudia Baquet, MD, MPH, University of Maryland School of Medicine

Dr. Baquet discussed the need for the intersection of science, research, and policy. She explained how the media could serve as a vehicle to disseminate the findings of research, updates, and clinical practice to the public. She also discussed some recent successes in providing data and information to communities, including the use of health information kiosks in community settings. Dr. Baquet suggested that the notion that communities which are most affected by disparities, are not interested in health or living healthy lives is untrue, and that the responsibility is not with the community but with the researcher to communicate complex concepts to the public. Dr. Baquet recommended:

a. Encouragement and promotion of programs which foster "research literacy" so that the public will appreciate the influence of research on community health;

b. That the media should be a driving force to disseminate health information

David Satcher, MD, MPH, Satcher Health Leadership Institute

Dr. Satcher discussed policy challenges in health care reform and in eliminating health disparities and the critical gap between science and policy. He spoke that one of the major challenges is to transform the health system so that it becomes a balanced community health system, and one that balances health promotion, disease prevention, early detection, and universal access to care. He further explained the role of media in closing the literacy gap and provided an example of how information kiosks, could help bridge the gaps in literacy and specifically health literacy, by providing prescriptions to a place where an individual can find out more about a particular disease. Dr. Satcher stressed that communication of scientific advances is probably the most critical issue in the gap between health disparities science and effective policy implementation Dr Satcher explained how the science could speak a different language when the community beliefs conflict and communication is not effective.

Policy is usually driven by advocacy and deeply held beliefs from advocacy groups, communities or lobbying organizations. Resources could also drive policies as with resources and support, you could compete to get policies through Congress. Different beliefs in science must be conveyed through effective communication in order to help alleviate this literacy gap – a determinant of health. Dr. Satcher recommended:

a. Encouragement of transdisciplinary research, and

b. Integration of disciplines to address social determinants of health, including health literacy

Elmer Huerta, MD, MPH, Washington Hospital Center

Dr. Huerta discussed the importance of media and its ability to empower people by consistently disseminating the information to them – "information saturation". He explained why health prevention should receive consistent media coverage as sports and weather, and stressed the need for consistency in reporting health prevention. Dr. Huerta urged society to "stop making a periodical" out of the delivery of health information. He cited community, regional and national campaigns for prostate cancer week as an example of "information saturation" for a short period of time, but is not repeated until the following year. He similarly cited breast cancer awareness month in October, when the community is saturated with messages about this breast cancer screening, and then nothing happens until the following year. Dr. Huerta went on to explain the need to dispel this mindset and provide health information to the public on a daily basis. Dr. Huerta recommended:

a. Focusing on the person, the neighborhood and the community rather than the condition,

b. Encouraging media coverage on health care prevention and health disparities on a daily basis, and

c. Encouraging communication with the public, using media, community organizations, and NIH.

Tim Johnson, MD, MPH, ABC News

Dr. Johnson discussed how traditional media is struggling with new media. He explained how ABC News created a section on its web site called "On-call" where the community can find answers to health questions. "On-call" provides answers to a list of 450 questions, and provides an option to click on "converse on-line with a real doctor" or "real nurse" icons and a doctor or nurse who will appear on the screen to answer questions. Dr. Johnson stressed the

importance of communication and honestly reporting what works and what does not work. Dr. Johnson recommended that we:

a. Encouraging honest communication of health issues and health disparities, and

b. Encouraging effective media coverage of health issues

Summary of Key Plenary Recommendations on the Integration of Science, Practice, and Policy for Health Disparities Research

Science

Key recommendations for bridging health disparities science with practice and policy were a) increase understanding and knowledge of "upstream" determinants of health and health inequality; b) increase calls for more participatory and equitable approaches to research to eliminate racial and ethnic health disparities through action; c) NIH lead and strengthen scientific partnership capacity and collaboration for health disparities research; and d) prioritize research on understanding, detecting and eliminating diseases that disproportionately affects the poor.

Practice

Key Recommendations for bridging practice with health disparities science were a) improve access to care and the quality of care, b) support interdisciplinary research with practice-based networks, c) emphasize prevention research, d) address cultural factors that affect patient-provider interactions, e) consider an individual and population-based approach to health, and f) reduce diagnostic bias in the initial clinical encounter.

Policy

Key Recommendations suggested for bridging policy with health disparities research were a) incorporate health-related policy considerations within sectors of society that impact opportunities of an individual to improve health; b) study the role of inequality and understand how historic and contemporary racism and racial inequality shape health; c) policymakers work with communities to address disparities, d) adopt collaborative approaches to understanding root causes of health disparities within communities and identify solutions; e) expanding the definition of health policy to go beyond health care policy; and f) address health disparities challenges that are rooted in social inequities.

V. BREAKOUT SESSIONS

Breakout session tracks and topics defined below provided a format for dynamic feedback, by challenging participants to identify and broaden "traditional" concepts and engage communities to better understand health disparities.

- *Translating Science to Practice and Policy* explored translational efforts that bridge science with practice and policy in areas such as cultural competency, health literacy, community-based participatory research (CBPR), social determinants of health, and gene-environment interactions.

- *Health Disparity Diseases and Conditions* focused on current research, as well as research gaps within priority health disparities diseases and conditions such as infant mortality, heart disease, diabetes, cancer, HIV/AIDS, and mental health. Challenges and opportunities in eliminating health disparities in these priority conditions were addressed, with an emphasis on identifying potential solutions and promising practices.

- *Health Disparity Target Populations* explored the challenges and opportunities in eliminating health disparities within health disparity populations such as racial and ethnic minorities, those with low socioeconomic status, and people living in rural areas populations.

- *Building Capacity* focused on the development of the "pipeline" of researchers who can lead and future generation of health disparities research. This breakout session explored the challenges and opportunities in building capacity, from training and education to the creation and maintenance of comprehensive centers that will address health disparities.

- *Partnerships, Collaborations, and Opportunities* explored opportunities for partnerships and collaborations between public and private entities. It also provided a venue for representatives from federal agencies and private organizations to showcase their health disparities portfolios and identify opportunities for collaboration.

The recommendations presented in the following breakout session tables below, provide the priority areas and recommendations for research submitted by the breakout session moderators and speakers.

Breakout Session Tracks and Recommendations

TRACK 1 – Translating Science to Practice and Policy

Translating Science to Practice and Policy	Priority Areas and Recommendations For Research
Clinical Trials – Diversity in Community Participation in Research and Clinical Trials D4	In terms of designing and conducting clinical trials: 1. Improve design to better address eligibility criteria. Clinical trials usually have very strict eligibility requirements that exclude individuals from diverse populations (such as the elderly, the very sick, and those with co-morbid conditions) 2. Require that investigators analyze and publish results by racial/ethnic groups (or other diverse groups). Improve design to adequately power studies for these populations. 3. Support infrastructures that involve community leaders in the design and conduct of clinical trials. Since infrastructures can cover a wide range- range of diseases investigators should take advantage of already established systems to maximize resources. 4. Build partnerships to share resources and lessons-learned across investigators and sponsors. 5. Enforce regulations/policies and make investigators accountable for their research plans pertaining to recruitment and publications. 6. Harmonize the regulations and policies of NIH, FDA, and other sponsors regarding inclusion and analysis of diverse populations in clinical trials. 7. Improve the NIH review process by changing the discussion of "inclusion" plans from human subjects' protection, which is not scored, to the science design review which is scored. 8. Address barriers to research participation, such as bias on the part of researchers and lack of knowledge about clinical trials among participants. 9. Educate physicians and providers about the importance of clinical trials and ensure that all patients have access to clinical trials
Community Health Centers C3	1. Improve access and reach of Community Health Centers (CHC) into the community given the large and unmet need for primary care. 2. Improve access and funding for clinical specialists, information technology and affordable medications. 3. Improve the dissemination of data/information regarding research to show that CHCs provide high quality care and have been very successful in eliminating health disparities.
Community Health Workers B2	1. Expand the use of community health workers (CHW) to include other venues and topical areas, including occupational health. 2. Invest in research to evaluate the short- and long-term value of health interventions delivered by community health workers. 3. There is a need for diversification of the roles of CHWs. 4. There is a need for additional resources to support long-term CHW interventions 5. Create a venue to share CHW and promotora interventions, and devise methods to adapt and standardize these interventions.

Translating Science to Practice and Policy	Priority Areas and Recommendations For Research
Cultural Competency A1	1. Go beyond the notion of working with health care practitioners to develop "competency" in particular cultures and convey the idea that understanding the patient's "frame of reference," in conceptualizing their illness, is needed. 2. Acknowledge that a good deal of cultural competence includes the importance of courtesy and the ability to listen and to elicit responses. . 3. Increase efforts to improve general health literacy for all patients in clinical settings
Discrimination, Racism and Stress B1, C1, D7	1. Explore and investigate the social processes that support structural racism and other social determinants of health. (e.g., transfer of wealth, influence, status and privilege) 2. Develop methods for disseminating and advocating best-practices to counter the problems and effects of racism. 3. Expand the current "anti-racism" paradigm to better understand discrimination against ethnic groups and immigrants. 4. Understand the social processes leading to environmental injustices and develop best-practices to address them with community-owned and managed research. 5. Extend the Clinical Translational Science Awards (CTSA) model to go from bench-to-bedside, to community, and then to policy. 6. Foster more NIH and non-federal collaborations supporting research that encourages non-traditional partnerships and innovative interventions. 7. Advocate for NIH to pioneer and create new innovation awards on social determinants of health; increase cross-institutional collaboration to address the social determinants of health research, recognizing that it underlies disease and conditions normally addressed by the separate institutions.
Data Collection methods Racial and Ethnic, Gender and SES Categorization A2	To date, the following reports have generated the importance of data and its role in addressing health and disparities. Institute of Medicine (IOM) Unequal Treatment; Agency for Health Care Research and Quality (AHRQ) National Healthcare Disparities Reports; National Center for Health Statistics (NCHS) Data Linkage Activities (mortality, social security, Medicare claims data) 1. Address the barriers to research participation, such as bias on the part of researchers, and lack of public knowledge about clinical trials. 2. Educate physicians and providers about the importance of clinical trials. 3. Provide better state and local data. 4. Identify the relationship between health data and "social determinants". 5. Provide better data on racial and ethnic subgroups. 6. Provide more "long-term" collected data. 7. Make data more accessible. 8. Other data considerations ♦ In recognition of the growing multiracial population: ♦ Incorporate Hispanic and Latino into one category ♦ Relax OMB data reporting standards which are too restrictive ♦ Measure results of programs aimed at reducing health disparities. ♦ Standardize data-collection across agencies. ♦ Consider factors that contribute to the complexities of the relationship between race and health in epidemiologic analysis such as measures of social and economic conditions.

Translating Science to Practice and Policy	Priority Areas and Recommendations For Research
Data-Collection methods Population and Individual Level Data C7	1. Separate determinants of health from those related to health disparities for study and application by identifying which of the determinants influence health status and when these determinants are contributing to disparities. 2. Increase focus on preventive services (e.g., cancer screening and vaccines) to individuals who are at greatest risk. (The health improvements achieved through preventive services often exclude those at greatest risk. 3. Revise healthcare policy and modify existing clinical guidelines to ensure that younger African-American and Hispanic women (who appear to be at greater risk for early onset breast cancer) get regular examination and testing according their level or risk and are then eligible under the BCCDP program or Medicaid for physician follow-up. 4. Encourage and fund more studies using multi-level and or ecological approaches that take into consideration the interactions between – variables that represent individual, family, community and neighborhood characteristics. 5. With the understanding that interventions are often ineffective for the group considered as a whole, but effective for subgroups defined by genetic susceptibility, biochemical/physiological features or other characteristics, NIH should encourage and fund more intra-group studies that investigate variations within population groups. 6. Continue funding of Centers of Excellence, like the NCI Center for Population Health and Health Disparities (CPHHD) program that foster interaction of researchers across disciplines and locations to better understand the complex nature of health disparities. This type of funding is necessary for approaching the complex issues in health disparities with a trans-disciplinary team and sufficient resources to do quality research. 7. Educate review groups on the importance of research in diverse communities at the population-level, and on the importance of combining biological investigation with understanding of health care and behavior, as well as the socio-economic and cultural environment. 8. Expand mentoring opportunities for under-represented, junior investigators, by pairing them with more experienced investigators at other institutions to expand their knowledge base and their professional networks. 9. Continue to support excellent meetings, similar to this one, for sharing of experiences and results to move forward in the effort reduce health disparities.

Translating Science to Practice and Policy	Priority Areas and Recommendations For Research
Faith-Based Initiatives B3, D8	1. Increase discussions about the comparative viability of faith-based and faith-placed incentives to ensure that these programs include individuals from a variety of religions and beliefs. 2. Clarify federal funding requirements for non-discrimination to allow support of faith-based health programming, provided that there is also support in the community for health programs that are open to the general public and that are not interwoven with faith-based messaging. 3. Support the introduction of health education curriculum into seminary training. Since congregants who have health problems often seek the advice of faith leaders, faith leaders should have a basic understanding of health care issues (especially health disparities) and be able to provide appropriate recommendations. 4. Provide funding to national, state, and local associations of faith-based organizations, support leadership development and use their members' ministries to support preventive health interventions.
Gene-Environment Interactions A5, C5	1. Develop effective genomic tools that can be readily translated into clinical practice and are applicable to diverse populations to improve health care decision-making. 2. Ensure equitable access to genomic medicine. Provide minority patients with access to genomic technology in clinical settings to increase the amount of information available for researchers to understand the role of genomics in health disparities. Therefore: 3. Concentrate research on individual genetic make-up rather than a population's designations or labels (e.g. racial or ethnic) 4. Develop more evidence-based guidelines for clinical practitioners that are specific to subgroups and not the general population to avoid clinical uncertainty about clinical decision-making._ 5. Ensure that environmental measures and environmental justice are a part of health disparities research. 6. Address the gene-environment knowledge gaps by promoting Gene-Environment Participatory Research, by taking an exploratory approach which informs the right risks/benefits to the right people and is guided by translational research (bench-to-bedside to trench) 7. Separate the fears and hype from the facts, in an effort to document how genomics may facilitate our understanding of disparities in health. 8. Develop international projects to permit systematic sampling of global populations and thus a more robust understanding of the scope and extent of human genetic. 9. Develop projects that will facilitate better understanding of phenotypes, with particular emphasis on the context-dependent nature of important risk factors. 10. Design Genomics/Genetics studies to include non-traditional risk factors (e.g., measurements of stress) in gene-by-environment models.

Translating Science to Practice and Policy	Priority Areas and Recommendations For Research
Global Health A6, B5 D5: Comparative Perspectives	1. Advocate for global health research collaborations to include capacity-building for foreign partners. 2. Expand the role of the Fogarty International Center in addressing disparities in training and research infrastructure. 3. Develop creative partnerships with NGOs to address gender violence and inequality. 4. Provide telemedicine and databases of "best-practices" and other knowledge-transfer systems) to support health care delivery systems in developing nations, and outsource specialized health. 5. Develop a database of "key professionals" in all health care fields and assist developing nations in networking. 6. Provide specific direction to developing nations on how to develop manpower and physical infrastructure such as laboratories and educational institutions that support the delivery of equitable health care.
Health Literacy A3, B4, C6, D6, D9	1. Support measurement of health literacy at the population and individual level. 2. Ensure that health literacy is considered in research that develops interventions and strategies to reduce health disparities. 3. Determine how best to design electronic health records and personal health records so they can be used effectively by individuals with low health literacy skills, and thus minimize the potential for amplifying disparities. 4. Study the role of health literacy in reducing disparities in health behaviors and adherence. 5. Identify the health system changes that can be implemented to make it less complex and easier to navigate. 6. Give physicians efficient tools to address health literacy in their busy practices. 7. Address health literacy in childhood through the education system with a focus on core skills and health-specific knowledge. 8. Teach physicians how to teach patients how to self-manage. 9. Increase participation of limited English proficiency (LEP) populations in studies of health literacy and increase the number of studies targeting LEP populations. 10. Clarify the determinants of health literacy and how it can be maintained and enhanced. Examine the variation in how it is defined and measured) and assess the role of context in health literacy fluctuations. 11. Determine which interventions can address provider and/or system deficits in language and cultural competency. 12. Study the impact of culturally representative and sensitive materials on health literacy to determine how useful and necessary they are.
Media A4	1. Investigate how best to use media in addressing health disparities.. 2. Incorporate media/outreach best -practices into the Summit proceedings. 3. Advocate for NIH grants to consider award requirements that state that the results of the research should be disseminated and made publicly available.

Translating Science to Practice and Policy	Priority Areas and Recommendations For Research
Patient Provider Communication D1	1. Urge NIH to partner with HRSA to fund policy-relevant research on improving workforce diversity and distribution to ensure equitable delivery of evidence-based care (i.e., translation of research benefits to improve health of communities, including underserved communities). 2. Implement patient-activation programs using culturally sensitive approaches such as community health workers, and care managers; increase interpreter services; improve scheduling; and increase time to build rapport and develop continuity of care. 3. Advocate that federal agencies (including NIH, and AHRQ,.) funding quality-of-care research ensure that equity is incorporated as an aspect of quality for all proposed projects. 4. Increase the number of underrepresented ethnic minorities among health professionals; require patient-centered communication and cross-cultural skills training in health professions' education and in, licensure and certification processes; and improve coverage for interpreter and care management service.
Quality Improvement D2	1. Raise awareness about quality of health care and make the case for action. 2. Identify quality improvement opportunities: populations, services or communities. 3. Implement better measures and methods for quality improvement.
Social Determinants of Health – WHO Commission Knowledge Networks C4	1. NIH should support research on the broad social and political processes that lead to or ameliorate social disparities in health. In the same way as the genome has been mapped, we need a mapping of the fundamental social determinants of health (or what one of our panelists, J. Popay, called "the socio-nome"). The social determinants of health are shaped by social and political processes, which must be understood in order to inform the development of effective interventions. 2. Because traditional criteria used in "evidence-based medicine," provide limited guidance to researchers and policy-makers, NIH should support and encourage research to guide the development of methods for increasing (and criteria for assessing) the quality of research on social processes in situations where randomized controlled trials are infeasible or unethical. 3. NIH should support and encourage research on the multiple aspects of employment conditions that contribute to health disparities (and often interact), including health effects of wage/salary levels and the organization of work.
Social Marketing D3	1. Promote greater interdisciplinary training opportunities to evolve a new scientific approach that includes disseminating information, communicating, and capacity-building. 2. Provide NIH funding to engage in large-scale social marketing messages for overall health and wellness for NIH areas of research. This activity should be continual, comprehensively focused, and multi-pronged, encompassing every disease and every channel of delivery. 3. Reinforce the executive charge to put all information, including scientific reports, in plain language formats that are accessible to the public.

Translating Science to Practice and Policy	Priority Areas and Recommendations For Research
Social Networks C2	1. Fund more research to explore social networks and their implications for health disparities. 2. Explore the influence of strong and weak social network ties - involve individuals and their social network relationships. 3. Understand that social networks are the building blocks of social capital. 4. Understand that social capital is the return or resource emerging from investment in relationships. 5. Understand that social network ties can be weak or strong. The size and shape of network can be markers of social capital. The strength of interpersonal relationships can have implications for socioeconomic outcomes such as employment and income.

TRACK 2 – Health Disparity Diseases and Conditions

Health Disparity Diseases and Conditions	Priority Areas and Recommendations For Research
Breast Cancer D10 A15	1. Give requisite attention to chronic diseases in breast cancer survivors, such as diabetes, to improve quality of life. 2. Endocrine stress responses should be considered when understanding the biology of health disparities in breast cancer as research suggests that there are hormone responses that mediate environmental effects on gene expression. 3. Recognize that breast cancer disparities are complex and multifactorial and that they are influenced by environmental and lifestyle factors and complicated by genetic, socioeconomic and cultural factors. 4. Investigate reasons for paradoxical patterns of lower incidence, higher mortality, and younger age at diagnosis in African Americans compared to white women? 5. Nutritional interventions among African Americans should emphasize the participant's individual motivation for learning how to eat healthily and make better food choices, rather than emphasizing the relationship between cancer/ illness and diet as a motivation for healthy eating.

Health Disparity Diseases and Conditions	Priority Areas and Recommendations For Research
Cardiovascular Disease and Stroke B7, B12, C10, D14	1. Continue and expand research to identify biologic, behavioral, social, and health system factors which lead to cardiovascular and stroke health disparities in primary, secondary and tertiary medical, community, and emergency health care settings. 2. Expand research to find effective means of improving patient-provider communication. Particular emphasis should be placed on determining effective communication methods by race, ethnicity, and language for individuals. Communication research needs to include how to effectively communicate with individuals with limited literacy and English language skills. 3. Expand research to understand and eliminate behavioral, social, and health system problems which contribute to cardiovascular and stroke health disparities. Research needs to include research of provider and organizational behavior. The contribution of health insurance to creating cardiovascular and stroke disparities needs further study. 4. Increase the rigor of disparities research. Support funding to improve research methods for measuring, quantifying, and understanding of health disparities. Efforts need to include improved and expanded data-collection. 5. Use the above findings systematically to implement and monitor clinical performance measures and quality improvement programs to ensure quality care across all patients, and identify gaps that may be amenable to system, provider and patient level intervention. Other suggestions for research: 6. Encourage and support collaborations between research and community organizations to understand and eliminate cardiovascular and stroke disparities. This effort may include community-specific development of education strategies and messaging to improve awareness. 7. Support ongoing research to determine incidence and prevalence of cardiovascular and stroke-related health disparities to monitor impact over time. 8. Think outside of the box. European countries are now thinking of health broadly, including improving architecture, neighborhoods and environments to improve disease prevention. Encourage broad collaborations to solve health disparities problems, especially at the level of social determinants. Has NIH considered partnering with the Department of Education or Department of Justice? 9. Test and evaluate new partnerships and team interventions to accelerate the translation of research findings to practice (such as applying up-to-date modes of communication tailored to local socio-economic communities as suggested by an attendee. 10. Identify and include critical social, cultural, and economic variables in studies designed to explore or to eliminate health disparities. 11. Promote additional research to optimize the use of cocoa flavanols as dietary supplements to improve cardiovascular outcomes. 12. Invest in minority-specific cohorts to expand understanding of risk factors (novel and conventional). 13. Build community engagement and cooperative/collaborative partnerships, which are essential to developing interventions projects and to implementing novel and innovative programs. 14. Provide research enrichment trainings to potential investigators and especially among underrepresented minorities.

Health Disparity Diseases and Conditions	Priority Areas and Recommendations For Research
Cancer A14, B11,	1. Coordinate cancer care from prevention to palliation to improved access. 2. Conduct team Science-community participatory translational research based on efficacy tests (clinical trials) and engaged population science, and to increase quality of outcome measurement. 3. Involve primary care providers in referral of patients for clinical trials for palliative care across the cancer continuum. 4. Convert the NCI Community Cancer Center Program (NCCCP) into a permanent program with additional funding because: a) it has community hospitals engaged in research and in reducing health disparities, b) it offers screening, diagnosis and treatment for those who cannot afford these services, funded by private enterprises, and c) it serves as a trusted partner in the community.
Cervical and Ovarian Cancer C11	1. Develop innovative mother-daughter programs through federal programs (e.g., Medicaid) to deliver cervical cancer prevention (vaccination and screening). 2. Expand the CDC Breast and Cervical Early Detection Program. 3. Develop effective Ovarian Cancer Screening tests 4. Understand racial disparities in ovarian cancer survivors.
Colon Cancer A10	1. Explore CT colonography for colorectal cancer screening in rural and medically underserved areas. 2. Consider funding research on alternative methods of colorectal cancer screening. 3. Explore opportunities for prospective enrollment of colon cancer patients in NIH-funded studies to unravel the genetic causes of the disease. 4. Address Policy and resources issues. 5. Address development and implementation of State Cancer Plans and support Cancer Registries 6. Work directly with under-represented communities. 7. Improve access to science and research – include all Americans in the science that can inform the research. Understanding who is at risk and direct scarce resources to those who are most at-risk. 8. Develop user-friendly messages to improve colorectal cancer screening rates. 9. Address colorectal cancer disparities from multiple levels (individual, provider, system, community, and policy). 10. Continue funding of high-quality research. 11. Because providing insurance alone will not eliminate CRC disparities, explore tailored navigation, system-delivery transformation and application of technology for colorectal cancer.

Health Disparity Diseases and Conditions	Priority Areas and Recommendations For Research
Diabetes and Obesity A13, B13, C14, D11	1. Improve access to care. 2. Support more CBPR funding with emphasis on identifying appropriate comparison groups. 3. Address social, cultural, and economic determinants of diabetes and obesity. 4. Implement more policies to emphasize health and prevention. 5. Consider health literacy interventions in diabetes and obesity prevention and management 6. Understand that team care is important. 7. Be where the patient/person is. 8. Support mid-level providers that are needed for chronic disease management. 9. Establish algorithms for chronic disease management. These will lead to lower costs of health care management. 10. Develop school-based intervention programs.
Hepatitis A12	1. Prioritize research to achieve full vaccination coverage of infants and young children, which despite present policies is still not universal. 2. Prioritize research on how to achieve population-level universal screening of at-risk adults and how to triage the various risk groups (i.e., those that are immune, those that are chronic carriers, and those that are still susceptible) into appropriate treatment, follow-up, vaccination, education, etc. 3. Develop vaccines for Hepatitis. C study, how to incorporate Hepatitis B/C education into school. 4. Promote coordination among researchers of the information and results of their studies so that the integral information among diverse groups, ethnicities, and races can be used for vaccine development.

Health Disparity Diseases and Conditions	Priority Areas and Recommendations For Research
HIV/AIDS A11, B14, C12	1. Examine the broader social context in which HIV infection occurs, such as poverty, racism, incarceration, to understand, and more importantly impact these disparities requires. HIV health disparities do not occur in a vacuum, but are a consequence of the social determinants of health. Therefore, examine the broader social contexts (e.g., poverty, racism, incarceration) in which HIV infection occurs. 2. Build linkages to the fields of economics and education in a multidisciplinary approach to decreasing HIV infection rates among racial and ethnic minorities. 3. Give greater attention to the impact of culture, gender, race, and class on seeking care, remaining in care and participating in clinical trials to determine what facilitates and prevents broader minority participation in clinical research and treatment. 4. Make adolescents a priority population for research and intervention 5. Promote use of technology as a way of delivering interventions. 6. Address better measurement of cultural factors. 7. Move away from "cultural" specific populations, and focuses on similarities rather than differences. 8. Promote structural interventions. 9. Make efforts from both top down and bottom up - can not just provide culturally-appropriate and linguistically appropriate services (though these are necessary), system change is also necessary. 10. Ensure that partnerships across community and researchers must be equal and will require building research capacity of CBOs, and perhaps give CABs more 'teeth'. 11. Research must begin with actual experiences and environmental factors (i.e., complexities of people's lives and geography).
Infant Mortality C9	1. Study the health outcomes over the lifespan that are impacted over the life-course, including early programming during pregnancy and cumulative pathways over life. 2. Study the societal factors related to life long minority status that underlie higher rates of poor pregnancy outcomes in minority populations 3. Health disparities research priorities should be incorporated more extensively into research priorities of NIH and other agencies. The interdisciplinary nature of this health disparity shows the need for new methodologies and interactions between disciplines that should be sought.
Immunization and Vaccination Rates B10, D13	1. Ensure that immunization recommendations are based on data regarding effectiveness and implementation practices? 2. Develop collaborations with media and opinion makers to improve public knowledge regarding the benefits of immunization. 3. Move focus of immunization coverage from efficacy to effectiveness. 4. Link health financing to science-based interventions that we know to be effective and cost effective. 5. Support the financing of adult vaccines-gaps and making better vaccines for some conditions (examples are flu and pneumococcal) 6. Utilize immunization registry and health IT more widely and link with protocol

Health Disparity Diseases and Conditions	Priority Areas and Recommendations For Research
Mental Health A9, B15, D12	1. Consider positive mental health interventions and cultural competence. 2. Consider environmental effects and interventions. 3. Incorporate the community, and listen to consumers. 4. Bring mental health into primary care. 5. Eliminate the divide between "health" and "mental health". 6. Organize workshops with key stakeholders, consumers, researchers, policymakers (without formal presentations) to discuss the appropriate mechanism to eliminate health disparities. 7. Identify the needs and wants of the population. 8. Design programs to address disparities within different racial and ethnic groups. 9. Develop model to improve the delivery of mental health services. 10. Improve access to and quality of mental health care.
Oral Health C8	1. Integrate an oral health focus in all research policy and practice initiatives supported by DHHS and evaluate the impact on improved quality of life, oral health, and general health. 2. Conduct oral health disparities research from a multidisciplinary and life-course perspective (this would cover the spectrum from basic biological sciences to translational/dissemination and community-based research). 3. Include oral health in primary provider and health systems and address oral health and quality of care to reduce health disparities.
Pregnancy Outcomes in Women B21	1. Train allied health professionals to provide counseling in conjunction with primary care (and agree to include mental health services in primary care-screening and care provision). 2. Conduct effectiveness studies that address women and pregnancy outcomes. 3. Involve community members (advisory board) in developing interventions.

Health Disparity Diseases and Conditions	Priority Areas and Recommendations For Research
Prostate Cancer B9	1. Promote funding and coordination of the discovery and validation of alternative molecular biomarkers associated with aggressive/lethal prostate cancer, including accrual of diverse patient specimens. 2. Educate men about the strengths and limitations of PSA screening and the inability of the PSA test to distinguish between indolent and aggressive tumors. The policy regarding prostate cancer screening is controversial and a marker that will identify lethal prostate cancer has not been identified. One recommendation is to educate men about the strengths and limitations of PSA screening and the inability of the PSA test to distinguish between indolent and aggressive tumors. A desired outcome would be increased physician–patient dialog about prostate cancer screening. But because much decision-making regarding screening is made outside of the physician–patient context, information regarding screening is often delivered in non-clinical settings. Education about the strengths and limitations of PSA screening is particularly relevant for the many men who do not have access to a physician. The goal of education would be that more informed decisions about prostate cancer screening and treatment will occur. 3. Institute a policy that provides more funding to train basic and population-based research scientists from disproportionately affected populations with the understanding that increasing trust among African-American men and their providers is an important area for consideration.
Respiratory B8	1. Adopt reimbursement policies that encourage the use of evidence-based interventions and practice guidelines (health care priorities, housing agencies, insurance, etc) in to addressing respiratory diseases such as asthma. 2. Support implementation studies and initiatives in asthma and other respiratory diseases, especially those that seek to empower individuals and communities (tailored interventions are important in this regard). 3. Support continuing research, studies, and initiatives to learn more about patient-health care provider interactions and enhanced communication for asthma health disparities. 4. As part of health care reform, expand the health care system (including reimbursement) to include health education and case management for respiratory diseases.

Health Disparity Diseases and Conditions	Priority Areas and Recommendations For Research
Substance Abuse B6, C13, D15	1. Consider and address the impact on health and disparities when setting substance abuse research priorities and identify measurable parameters and outcomes. 2. Involve the community in the planning stages of research, making it truly participatory. Researchers can learn from the community and vice versa. 3. Recognize that community collaboration can be empowering for community leaders as they advocate for policy changes based on research findings. 4. Use geospatial analysis to identify differential distribution resources in neighborhoods for policy-based discussions and activities to ameliorate problems identified (e.g., liquor stores in minority communities). 5. Ensure that adaptations of evidence-based interventions are culturally competent. 6. Pay more attention to research ethics and confidentiality, and the concerns of vulnerable populations. 7. Pay more attention to adolescent substance abuse during pregnancy. 8. Support more research on how patients/clients especially juveniles, are assigned to certain levels of care, e.g., residential treatment vs. outpatient (note that African-American youth are more likely to be assigned to higher levels of higher care). 9. Increase awareness of Hepatitis C transmission risks and the effectiveness of HCV treatment, among providers, patients and the broader community. 10. Continue research to develop and test tailored treatment programs for racial and ethnic minorities. 11. Support research on tobacco use prevention and cessation, and on the disproportionate impact of tobacco on related health disparity diseases and condition.
Substance Abuse: Tobacco use B16	1. Develop organizational capacity of community-based organizations (CBO) to translate the science into practice. 2. Examine the unintended consequences of tobacco taxes on youth (i.e., initiation of other tobacco products). 3. Support data-collection methods for disaggregated data to further examine tobacco-related disparities among sub-groups of racial and ethnic minorities.

TRACK 3 – Health Disparity Target Populations

Health Disparity Target Populations	Priority Areas and Recommendations For Research
African-American A16, D20	1. Broaden the public research paradigm to include social determinants. 2. Create a minimum health care standard for all Americans that define norms for intervention and treatment protocols. 3. Prevent and prohibit targeted marketing campaigns to groups with a high affinity to illnesses related harmful products (i.e., tobacco).

Health Disparity Target Populations	Priority Areas and Recommendations For Research
American Indian and Alaska Natives D16	General: 1. Implement more comprehensive, culturally-appropriate, and preventive interventions for tribal communities and families. 2. Increase funding for tribal communities. Tribal/community, clinical, and national leadership and governmental financial support are essential. 3. Conduct further research on effective preventive interventions. Regarding Stroke: ♦ Implement studies to obtain further data on controlling BP, glucose, and smoking cessation to prevent stroke. ♦ Obtain more data on stroke among American Indians, including the wide variations among Tribes and racial misclassification. Regarding Cancer: 4. Explore the cancer disparities in mortality that are: ♦ Primarily linked to delays between diagnosis and treatment ♦ Partly explained by advanced stages at first diagnosis ♦ Partly explained by cancer mortality from non-screenable types of cancer 5. Fund research to identify early detection methods for cancers that disproportionately affect American-Indian populations (such as gastric cancer and brain cancer) 6. Explore disparities in childhood cancers, cancers in young adults and rare cancers in Alaska Native tribes. 7. Conduct further studies to better understand the stigma associated with cancer, especially in American-Indian communities and the influence on: ♦ Screening and testing ♦ Entry into treatment ♦ Adherence to treatment ♦ Coping and Mental Health, esp. depression ♦ Longevity after diagnosis 8. Post Traumatic Stress Syndrome (Trauma and Pain): ♦ Explore the relationship between alterations in central and autonomic nervous system function and hormonal dysregulation and how these are associated with trauma, and risk for CVD. ♦ Explore how high rates of trauma exposure contribute to the increasing prevalence of CVD, as well as progression of diabetes and respiratory problems among American Indian ♦ Explore how pain affects help-seeking behavior, adherence to treatment recommendations, and the speed of surgical recovery among American Indians. 9. Improve the social conditions in which American-Indians and Alaska Natives live. Adopt a comprehensive approach that includes examining and addressing social and economic conditions to addressing health disparities and enhancing the health status of American Indian and Alaska Natives.

Health Disparity Target Populations	Priority Areas and Recommendations For Research
10. Asian-Americans A21, B18, C19	1. Address disparities in the number of NIH-funded studies focused on researching the health status of Asian–Americans, particularly through increasing the collection of ethnically-specific health data and appropriate measures that can be collected in routine national surveillance surveys to document trends in distinct Asian-American ethnic groups. 2. Encourage community-based participatory research (CBPR), including studies by community-based organizations in partnership with research institutions. 3. Institute longitudinal research studies of Asian-American ethnic groups on par with other longitudinal research studies of other racial/ethnic minority populations. 4. Support research on health care using the community–based research model. 5. Expand SCHIP to broaden access to health care and lift the 5-year waiting period. 6. Increase research in traditional medicines to provide evidence for payers to determine coverage. 7. Insist on aggregate and disaggregate data-collection on Asians.
Children and Adolescent Health B22, D18	1. Invest more in pediatric and adolescent health disparities research to change future direction to one that includes non-biologic and biological determinants of health 2. Invest in behavioral interventions with close supervision using community health workers that are trained and paid a living wage. 3. Involve families using the "family-centered care" model. 4. Make the non-specific and specific—train CHW to deliver evidence-based interventions for behavior change. 5. Increase research on social determinants of ambulatory care to improve prevention. 6. Increase use of touch-screen technology in primary care to improve efficiency money and improve outcomes. 7. Strengthen the training pipeline for young investigators to enter and contribute to pediatric HD. 8. Move research infrastructure and research into communities with disparities. 9. Conduct research based on age specific measurements among children and adolescents.

Health Disparity Target Populations	Priority Areas and Recommendations For Research
Elderly Populations B20	1. Incorporate the following areas into the life span research agenda: i) health promotion, ii) behavioral modification and iii) chronic disease etiologic studies focused on understanding biologic mechanisms and identifying molecular markers 2. Develop specific preventive medicine strategies. 3. Implement recruitment, retention and health education of older individuals who could be potential research participants in longitudinal studies and intervention studies. 4. Aging research should focus on every domain of health and not be limited to neurodegenerative disorders. 5. Support the training of aging researchers, especially clinical researchers. This is critically important. 6. Support for new researchers should be a highlighted concern in funding discussions. 7. Rapidly translate and disseminate findings that impact treatment algorithms.
Hispanic /Latino A20, C15	1. Implement disaggregation of data for different Hispanics sub-groups, making comparisons to the general population and to other populations. Do not always compare to the white population. 2. Promote research that includes the influence of the social and cultural environment including family 3. Help patient to understand and integrate into the health system. 4. Develop theory-based culturally relevant interventions. 5. Promote acculturation and culturally-appropriate interaction to increase participation and retention in clinical trials. 6. Engage everyone that is part of the solution. Strengthen community-based participatory approach. 7. Develop and test alcohol, cigarette, and drug abuse preventive interventions. The developmental process would include stages of intervention development, pilot testing, determining efficacy and effectiveness, and finally broad dissemination. 8. Address barriers to achieving access care by supporting reform and a national health care that would include everyone including immigrants 9. Find culturally-appropriate ways to educate providers and community members about preventive health care and to insure that health care providers are required to offer prevention services to all patients and to insure that health insurance and other third party payers reimburse appropriately for these services.

Health Disparity Target Populations	Priority Areas and Recommendations For Research
Immigrant Populations D17	1. Conduct research on educational strategies for immigrants for optimal use of the health care system, including preventative services 2. Conduct research on methodologies and standards of knowledge management to enhance translations of evidence for health care providers, community-based organizations, and policy makers. 3. Increase policy-relevant research concerning such areas as the context of health, ways to improve health care access, and natural experiments of policy interventions. 4. Develop data structures and systems that can account for the heterogeneity of immigrant populations. 5. Investigate the effect and implications of non-emergent and urgent care for immigrants. 6. Conduct research on the effective use of promoters to improve the health of immigrants.
Lesbian, Gay, Bisexual and Transgendered Populations B19	1. Collect population data with sexual orientation (identity and behavior) in national and regional surveys and surveillance activities in order to form policy. 2. Increase funding and test interventions (policies, programs, and processes) for diverse LGBTQ communities that address identified health disparities: cancer screening, smoking, alcohol use, sexually transmitted diseases, etc. Then disseminate these interventions to traditional partners by health departments and community-based organizations) and activists. 3. Explore and address socio-cultural predictors of health disparities: homophobia, stigma, victimization, etc. using creative approaches addressing social norms and perceptions that may not be similar to individual, behavior change approaches.
Low Socio-economic Status Populations B17	1. Examine spatial issues associated with factors and conditions that facilitate health and healthful behaviors in neighborhoods (i.e., proximity to health facilities, grocery stores, parks and recreation) and, negative health behaviors (i.e., proximity to liquor and tobacco outlet, unemployment). 2. Examine and evaluate the effectiveness of evidence-based practices in real-world settings. 3. Examine how social and public policies impact and improve or disadvantage health for low-income populations and communities (e.g., whether low-income older people are likely to enroll in Medicare). Focus on changing social norms regarding how people perceive and act toward people of lower socio-economic status. e.,.

Health Disparity Target Populations	Priority Areas and Recommendations For Research
Men D19	1. Encourage NCMHD to lead the effort in defining, updating and reporting (quantitatively and qualitatively) the health disparities experienced by men (compared to women), and sub-groups of men (according to ethnicity, SES, geographic region in comparison to all men). 2. Once these disparity groups of men have been identified (e.g., African-American men), NCMHD should develop announcements to attract high quality research that seeks to identify priority determinants for the disparities experienced by these men. 3. Advocate that NCMHD assist in the ongoing effort to establish policy to protect the health of men in the U.S (e.g., develop an Office of Men's Health within the National Institutes of Health (NIH) and/or the Department of Health and Human Services (DHHS).
Native Hawaiian and Pacific Islanders A17	1. Involve the Native Hawaiian and Other Pacific Islander communities in identifying priority issues, and in developing, implementing, and evaluating interventions in the research process, especially in the following areas: ♦ Implementation of translational model from practice to research. ♦ Assessment of the impact of culture on well-being. ♦ Development of prevention and early intervention strategies for mental illness and substance abuse. ♦ Development of interventions aimed at reversing cardio metabolic syndrome in this population. ♦ Development of approaches that will engage the Native Hawaiian and Other Pacific Islander communities through social support and community support interventions. ♦ Disaggregation of surveillance data of NHOPI from Asians to allow more accurate data for this population. 2. Increase funding of the Native Hawaiian and Other Pacific Islander research programs to: ♦ Implement the above recommendations. ♦ Provide resources to support capacity-building that fosters self-determination ♦ Implement social support and community support interventions ♦ Fund community-engagement infrastructure, which is needed to empower communities. ♦ Establish alternative funding streams (other than academic institutions) and CBPR criteria that support communities in sharing equally in the resources and the decision-making ♦ Fund all NHOPI health disparities – including (but not limited to) cancer, heart disease (the number one cause of mortality), mental health, substance abuse, obesity, diabetes, chronic lung disease, and other illnesses which produce health disparities in the NHOPI people.

Health Disparity Target Populations	Priority Areas and Recommendations For Research
Persons with Disabilities A19	1. Develop research to support the argument of social justice as the driver to bridge science, practice and policy. Scientists need to be better educated on policy-making. Scientific findings need to be translated into a political philosophy; use political philosophies to garner support. Specific recommendations: ♦ Review the IOM report recommending better funding in the disability field. ♦ Train clinicians on disability topics. ♦ Address critical issues of importance to persons with disabilities when drafting policies. 2. The separation of health and disability was the most important advance. Discontinued use of the medical model "in reference to" or "as the reference" for discussions about disability was another critical recent advance in the field. Specific recommendations: ♦ Address accessibility in all aspects of research and service activities. ♦ Focus on health "care rather than exclusively on finding cures" ♦ The research timeframe is often too long to address critical problems. Move from future focus to the here and now when conducting research and setting research priorities. 3. Examine the environmental and societal context of health disparities and disability. Adopt a multi-factorial focus to address topics across different research arenas and areas of expertise. Specific recommendations: ♦ Prepare a report on disability and present it to NIH to enhance awareness. ♦ Hold a conference on the intersection of disability and health disparities. ♦ Determine the economic argument for disability and health disparities research. ♦ Support intervention grants designed to eliminate health disparities. ♦ Provide mid-career training grants on health disparities and disability.
Prison Populations C17	1. Support studies to clarify where in the criminal justice system health disparities are created or sustained. (e.g., screening and detection, in-prison health service provision, community reentry programs, community health service provision post-incarceration, etc). 2. Support studies to develop implement able-wellness, prevention, and health self-care and self-advocacy programs for prison populations, with special attention to aging-populations. 3. Support studies to develop strategies to improve continuity of health care for justice-involved individuals as they pass through various systems and programs in the justice system. 4. Work to eliminate the "silo-ing" of health information within separate systems of services in order to facilitate research. 5. Support more basic epidemiology work on the prevalence rates of disorders in the incarcerated populations in order to better able the detect health disparities. 6. Support the development of health care delivery strategies that involve peer-leaders or formerly incarcerated persons.

Health Disparity Target Populations	Priority Areas and Recommendations For Research
Rural Populations A18, C20	1. Give State and Federal attention to rural communities and health facilities with regard to access to care, distance to travel for care, the availability of healthcare professionals, Medicare reimbursement rates and the consequences of these factors on the quality of health care of individuals in rural America. 2. Provide clearer definitions of "rural" and "remote rural" areas to address the implications they have on access to and the quality of health services that people experience in these communities. 3. Explore the overlaps among culture, values based-health systems, and patient-centered care within the context of diverse populations that have the burdens of health disparities. Other recommendations 4. Go to the community and engage the community. 5. Develop policies that are needed to enhance coordination. 6. Build capacity in rural areas.. 7. Increase access to child health services
US Pacific Populations C16	1. Involve Pacific Islanders in the planning and development of programs. Stop funding universities who want to study PIs for their own gain with no tangible benefits for those who participate in these studies. 2. Invest in capacity-building. All projects and grant mechanisms should budget capacity-building (training and mentoring) of PIs. 3. Choose our partners. PIs must have a say in who gets funded to do work in the Pacific. RFAs should have clear criteria for how grantees are selected (e.g., track record of efforts to involve the community and a demonstration of willingness to share resources and money power).
Women A22, B21, C18	1. Develop qualitative and quantitative measures for the superwomen schema found among conditions in which women predominate. 2. Integrate science, clinical practice, and health care policy to reduce the stigma associated with mental illness and particularly depressive conditions. 3. Prioritize bio-medical and bio-behavioral investigations that lend themselves to interdisciplinary research. 4. Use the top 10 health status indicators in Healthy People 2010/2020 as an organizing principle and foundation from which to build an intra-agency federal program that coordinates and develops strategies to achieve outcomes from NIH, Dept. of Education., Agriculture, AHRRQ, etc. 5. To approach women's health and health disparities use coordinated federal inter-agency collaborative approaches to bench-to-bedside practices to disseminate information, educate the public, and answer broad lifespan questions on women's health (all along the research continuum, (from., research to practice). 6. Use principles from existing models of interdisciplinary research (such as BIRCWH, SCOR, etc.) to develop strategies and programs to address key issues in women's health and HD research. 7. Train allied health professionals to provide counseling in conjunction with primacy care (agree to include mental health services in primary care-screening and care provision). 8. Conduct effectiveness studies in women's health research interventions 9. Involve community members (advisory boards) in developing interventions.

TRACK 4 – BUILDING CAPACITY

Building Capacity	Priority Areas and Recommendations For Research
City and County Public Health Departments A24	1. Promote the Public Health Policy Agenda 2. Support and establish centers for health equity to address inequities and focus on the broader social determinants of health 3. Promote community-centered local public policy agenda. 4. Advocate for equal distribution of resources in communities. 5. Promote Internal Capacity-Building 6. Strengthen the social fabric of neighborhoods. 7. Promote organizational and structural change within public health to invest within communities working across all public and private partnerships. 8. Retrain the pubic health workforce to address social justice and the effect of social determinants on the health of the public. 9. Create new policies that can influence curriculum and training in public health including Health Impact Assessments.
Community Campus Partnerships A8, D21	1. Integrate a social justice content model into the health disparity curriculum. 2. Use mentoring for students and junior faculty. 3. Train academic (researchers) to do CBPR and they should be trained to review CBPR grants and contracts. 4. Encourage community leaders to serve as the voice of science and policy to increase visibility of HD research issues so that policies will have substantive advocates. 5. Increase focus on prevention, translational research, and best practice models of CBPR. 6. Publish secondary data-analysis of CBPR results.
Comprehensive Centers B23	1. NCMHD should develop RO1 and R21 Funding Opportunity Announcements (FOA) to continue funding for pilot studies currently funded through comprehensive centers of excellence such as P-20 and P-60 Centers. 2. NCMHD should support training of health disparities researchers, especially those from underrepresented racial/ethnic groups. 3. NCMHD should provide R24 FOA to support the next level of comprehensive center development. 4. NCMHD should look at Centers of Excellence models of VA and provide continuous support for those successful comprehensive centers of excellence as a way to rapidly bridge science, practice and policy.

Building Capacity	Priority Areas and Recommendations For Research
Graduate Education D23	1. Develop mentoring programs, and convey what it means to have a mentor working with people to become more prepared for graduate work, tutoring, research, and new curriculum. 2. Fund public health programs at Tribal colleges/universities and HBCUs. 3. Broaden the view and possibilities of younger students (K-12) to engage in research 4. Improve clinical training programs. 5. Model provisions of graduate education and completion to meet the students' needs. 6. Provide visibility to the success stories. (e.g., IMHOTEP at Morehouse College). Evaluate the usefulness of not using GRE scores as criteria for admission to graduate programs. 7. Fund CBPR research about social determinants, racism, culture, and SES.
K-12 Education B24	1. Advocate for science mentoring to begin before high school. Elementary and middle school are preferable. High school is too late. 2. Encourage parent and community involvement in elementary science education - is vital for success. 3. Emphasize the importance of outcomes tracking for levels K-12 and beyond.
Practice-Based Research Networks A23	1. Create funding methods that support longitudinal relationships between practices and researchers. 2. Find methods of integrating efforts across federal agencies (CDC, CMS, HRSA, and NCI). 3. Create an infrastructure (organization, agency, and grant) that can be a focus for practice-based research). 4. Provide incentives for provider practices that participate in research. 5. Provide more funding to practice-based research.
State Health Departments C21	1. Focus NIH research dollars on CBPR approaches and on translation to take things to scale (we— do not need more research to establish health disparities). 2. Search for methods for state health departments and universities to find shared goals and missions. 3. Explore strategies and blend goals of state departments (interagency and intersectoral) around issues of health (e.g. the fact that 'drop outs' have higher health problems would be an issue for education departments). 4. Use the fact that kids are "captured" at schools, as a way to optimize blending and addressing shared goals for improving lives of children, youth and communities.
Undergraduate Education C22	1. Establish programs that provide students opportunities to give back to their communities and to create a "health disparities movement". 2. Fund and promote underutilized, health disparities-related initiatives such as global health internships or health management programs. 3. Promote dialogue across institutions and disciplines, through a series of web casts (live and archived) for undergraduate students and undergraduate faculty focusing on mentoring, education, and research in the context of health disparities. This should be done by the NCMHD and the NIH at large.

Building Capacity	Priority Areas and Recommendations For Research
Young Investigators C23	1. Provide protected time for junior faculty, especially people who have clinical responsibilities. 2. Encourage NIH staff should visit institutions to talk about funding opportunities for junior faculty. 3. Develop bridge-plans for moving successful post doctoral researchers into junior faculty positions. 4. Develop a schema to help junior faculty choose mentors and institutions.

TRACK 5 – Partnerships, Collaborations, and Opportunities

Partnerships, Collaborations and Opportunities	Priority Areas and Recommendations For Research
Federal Partners A25, C24, C25, D24	1. Encourage federal departments to annually review and report their collaboration with each other related to the elimination of health disparities. 2. Compile partnerships best-practices examples by sub areas (e.g., science, practice and policy) and make available to the major departments. 3. Establish a sub-cabinet to coordinate and promote inter-departmental partnerships among federal agencies entities to eliminate health disparities. 4. Use the lessons-learned at Department of Veteran Affairs to expand and build a national electronic, medical records system for patient care.
Foundations, Health and Medical Partners B25, D25	1. Develop Collaborative Partnerships and Opportunities to support innovation. 2. Develop the pipeline of policy researchers and research scientists in the field of health disparities. 3. Increase workforce diversity. 4. Provide funding and capacity-building opportunities for professional organizations and foundations

VI. CONCLUSIONS AND FUTURE DIRECTIONS

Conclusions

Twenty-three years after the landmark Heckler Report, disparities in health and health care are still pervasive. Over the years, the landscape has expanded to encompass a variety of target-population categories including race, ethnicity, gender, age, sexual orientation, socio-economic status, and geography. Health disparities and their subsequent health outcomes have expanded from disease- orientation to a comprehensive integrated approach of population health perspectives. Now more than ever, the charge of eliminating health inequities has become be a social justice issue and a moral obligation.

Eliminating health disparities remains a daunting challenge that requires transdisciplinary scientific research, efficient health infrastructure, and visionary policies to create sustainable health outcomes for underserved, minority, and vulnerable populations. The NCMHD successfully convened the *Science of Eliminating Health Disparities Summit* at an opportune time of health reform and transformation of health care. The Summit shed light on the transitions of minority health and health disparities and focused on changing landscape of research to improve health within communities. Recommendations were provided based on current research on what has been identified and understood to be the underlying cause of health disparities. The NCMHD will move forward together with its partner institutes and research community to explore novel and transdisciplinary research and prioritize programs and interventions that serve as best-practice models for addressing health disparities.

As NCMHD continues in its bold steps to support innovative translational and transformational health disparities research, it will build on the recommendations provided at this Summit and reach out beyond the traditional partnerships in health disparities research towards partnerships that transcend and intersect the disciplines of science, practice and policy. We are now aware that addressing health disparities requires a framework of a complex interplay of determinants, which includes not only healthcare access, but biological, behavioral, social, environmental, economical, cultural and political factors. We are equally mindful that more than ever, health disparities research must be innovative, translational and be able to transcend disciplines. Closing the disparities gaps now requires careful data-collection considerations and inclusivity, greater analysis and careful interpretation of research, translation of beneficial research, as well as the dissemination of results into practice and community settings.

VII. APPENDICES

Appendix A

Plenary Session and Presentation Topics

Plenary Session 1

Health Disparities and the Intersection of Science and Policy	Reducing Health Disparities in Our Society: Reshaping Opportunities through Science Pursuing a National Policy for Preventing Hepatitis B-induced Liver Cancer: Implications for Eliminating Health Disparities The Good Red Road: Science, Policy and Health Disparities in American Indians and Alaska Natives Health Inequality: Science, Policy, and Politics
Charting a New Course for Health Disparities	

Plenary Session 2

Perspectives on Health Care Reform: Eliminating Health Disparities	Health Disparities: The Intersection of Science and Practice Health Disparities and the Intersection of Science and Practice – Community-Based Participatory Research (CBPR): What Predicts Outcomes?" Research to Practice: Moving from Disparities Research to Health Equity Health Disparity Research with Latino Populations: Advances & Future Directions
Health Disparities and the Intersection of Science and Practice	

Plenary Session 2a

Health Disparities and the Intersection of Science, Practice and Policy	Moving Upstream: How Interventions that Address the Social Determinants of Health can Improve Health and Reduce Disparities Linking science, practice and policy through community-based participatory research to study and address health disparities A Patient Activation and Empowerment Intervention Creating, Maintaining and Blurring Boundaries: The Intersections of Science, Policy and Practice
Policy Implications for Eliminating Health Disparities	

Plenary Session 3

The Role of Media and Policy in Eliminating Health Disparities
Special Plenary Town Hall Meeting

Appendix B

Table of Breakout Session Tracks and Topics

Table 1 Science, Practice and Policy Tracks

Track I Translating Science to Practice and Policy	Track II Health Disparity Diseases and Conditions	Track III Health Disparity Target Populations
Clinical Trials – Diversity in Community participation in Research and Clinical Trials	Breast Cancer	African-Americans
Community Health Centers	Cardiovascular Disease and Stroke	American Indian and Alaska Natives
Community Health Workers	Cancer	Asian-Americans
Cultural Competency	Cervical and Ovarian Cancer	Children and Adolescent Health
Discrimination, Racism and Stress	Colon Cancer	Elderly Populations
Data-Collection methods – Racial and Ethnic, Gender and SES Categorization	Diabetes and Obesity	Hispanic/Latino
Faith-Based Initiatives	Hepatitis	Immigrant Populations
Gene-Environment Interactions	HIV/AIDS	Lesbian, Gay, Bisexual and Transgendered Populations
Global Health	Infant Mortality	Low Socio-economic Status Populations
Health Literacy	Immunization and Vaccination Rates	Men
Media and Policy	Mental Health	Native Hawaiian and Pacific Islanders
Patient Provider Communication	Oral Health	Persons with Disabilities
Quality Improvement	Pregnancy Outcomes	Prison Populations
Social Determinants of Health – WHO Commission Knowledge Networks	Prostate Cancer	Rural Populations
Social Marketing	Respiratory	US Pacific Populations
Social Networks	Substance Abuse	Women
	Tobacco	

Table 2. Capacity-Building, Partnerships and Collaborations Tracks

Track IV Building Capacity (Comprehensive Centers, Pipeline of Researchers and Public Health Infrastructure)	Track V Partnerships, Collaborations and Opportunities
City and County Public Health Departments	Federal partnerships and collaborations
Community Campus Partnerships	Foundations
Comprehensive Centers	Health Organizations
Graduate Education	Medical Associations
K-12 Education	
Practice-Based Research Networks	
State Health Departments	
Undergraduate Education	
Young Investigators	

Appendix C

Plenary Session Moderators and Speakers

Margarita Alegria, PhD
Professor
Harvard Medical School
Director, Center for Multicultural Research,
Cambridge Health

Dr. Maya Angelou
Poet and Reynolds Professor of
American Studies at Wake
Forest University

Claudia R. Baquet, MD, MPH
Professor and Associate Dean for
Policy/Planning
University of Maryland
School of Medicine

Moon S. Chen, Jr., PhD, MPH
Professor, Division of Hematology
and Oncology, Department of
Internal Medicine at the University
of California, Davis School of Medicine

Giselle Corbie-Smith, MD, MS
Associate Professor of Social
Medicine and Medicine
University of North Carolina at Chapel Hill

The Honorable Elijah E. Cummings
Member of Congress, D-MD

Governor Howard Dean, MD
Chairman, Democratic National Committee

Mario De La Rosa, PhD
Professor, College of Social Work
and Public Health
Director, Center for Research on
U.S. Latino HIV/AIDS and Drug Abuse
Florida International University

Susan Dentzer
Editor-in-Chief
Health Affairs

Nancy Giles
Commentator
CBS News Sunday Morning

Jeffrey Henderson, MD, MPH
President/CEO
Black Hills Center for
American Indian Health

Hilton Hudson, MD
Chairman, Health Literacy Foundation,
Hilton Publishing Company,
Cardiovascular Surgeon

Elmer Huerta, MD, MPH
Director, Cancer Preventorium
Washington Cancer Institute
Washington Hospital Center

G. Timothy Johnson, MD, MPH
Medical Editor
ABC News

Raynard S. Kington, MD Ph.D., PhD
Acting Director
National Institutes of Health

Howard K. Koh, MD, MPH, FACP
Harvey V. Fineberg Professor of the
Practice of Public Health
Associate Dean for Public Health Practice
Harvard School of Public Health

Evelyn L. Lewis, MD, MA, FAAFP
Director Medical Policy, World Wide Public
Affairs and Policy,
Pfizer, Inc.

Meredith Minkler, DrPH, MPH
Professor, Health and Social Behavior, School
of Public Health,
University of California, Berkeley

Kenneth P. Moritsugu, MD, MPH, FACPM
Vice President, Global Strategic Affairs
LifeScan,
A Johnson & Johnson Company

John Ruffin, Ph.D.
Director
National Center on Minority Health and Health
Disparities

David Satcher, MD Ph.D., PhD
Director, Satcher Health Leadership Institute
16th Surgeon General of the United States

Raj Shah
Chairman & CEO
Capital Technology Information Services
(CTIS) Inc.

Brian Smedley, PhD
Vice President and Director
Health Policy Institute of the Joint
Center for Political and Economic Studies

David Takeuchi, Ph.D
Professor
Department of Sociology and
School of Social Work
University of Washington

Robert Otto Valdez, Ph.D.
Executive Director, RWJF Center
for Health Policy
Professor
Family & Community Medicine and
Economics, University of New Mexico

Nina Wallerstein, DrPH
Professor
Masters in Public Health Program,
Department of Family and Community
Medicine
Director, Center for Participatory Research
University of New Mexico,
School of Medicine

David R. Williams, Ph.D.
Florence and Laura Norman Professor of Public
Health
Professor of African and African-American
Studies and Sociology
Harvard University

Mary Woolley
President/CEO
Research!America

Appendix D

Breakout Session Moderators and Speakers

Moderators and speakers of the 100 Summit breakout sessions are listed below. All session topics included "Understanding and Eliminating Health Disparities" in the title. Titles of session topics and names of organizations listed below were abbreviated to fit within the table.

Session Number	Session Topic	Track	Moderators/Speakers	Organizations
A1	Cultural Competency	1	Mod: Sabra Woolley Denice Cora-Bramble Cathy Meade Charles Martinez Tawara Goode	NCI Children's National Medical Center Moffitt Cancer Center Oregon Social Learning Center Georgetown Univ. Medical Center
A2	Data-Collection Methods: Racial, Ethnic Gender and SES	1	Mod: Vence Bonham Vicky Mays Edna Paisano Rashida Dorsey Cara James	NHGRI UCLA Indian Health Service Office of the Assistant Secretary for Planning and Evaluation, DDHHS Kaiser Family Foundation
A3	Health Literacy Research Agenda	1	Mod/Sp: Rose Marie Martinez Romana Hasnain-Wynia Ruth Parker Marin Allen	Institute of Medicine Northwestern University Emory University NIH, Office of the Director
A4	Media	1	Mod: George Strait Larry Adelman Makani Themba Nixon Donna Vallone	NCMHD CA Newsreel The Praxis Project American Legacy Foundation
A5	Gene-Environment Interactions	1	Mod: Ebony Bookman Katrina Armstrong Lynn Jorde Alexandra Shields Peggy Sheppard	NIEHS University of Pennsylvania University of Utah Harvard University WE ACT for Environmental Justice
A6	Global Health	1	Mod: Michelle Williams Maureen Sanderson Sixto Sanchez Sam Mbulaiteye	University of Washington Meharry Medical College Instituto Nacional de Salud NCI, NIH

Session Number	Session Topic	Track	Moderators/Speakers	Organizations
A7	Community-Based Participatory Research	1	Mod: Francisco Sy Amy Schulz Elizabeth Baker Kathleen O'Connor	NCMHD University of Michigan St. Louis University University of Texas
A8	Community Campus Partnerships	1	Mod: Robert Kaman Emily Morrison Frank Dillon Carol Bender Sandra Daley	University of North Texas HSC George Washington University Florida International University University of Arizona University of CA
A9	Mental Health	2	Mod: Cheryl Boyce Steven Lopez Nolan Zane Debra Furr-Holden Laurie Bauman	NIMH University of Southern CA University of CA Davis Johns Hopkins SPH Albert Einstein College of Medicine
A10	Colon Cancer	2	Mod: Vickie Shavers Elena Martinez Thomas Weber Mira Katz Richard Wender	NCI University of Arizona Albert Einstein College of Medicine Ohio State University Thomas Jefferson University
A11	HIV/AIDS	2	Mod: Debra Meres Marguerita Lightfoot Scott Rhodes Antonia Villarruel	NIAID University of CA San Francisco Wake Forest University University of Michigan
A12	Hepatitis	2	Mod: Arunsri C. Brown Tony Marion Roshan Bastani Wu Tsu-Yin David Gretch	NIAID University of Tennessee University of CA, Los Angeles University of Michigan Harborview Medical Center
A13	Diabetes & Obesity	2	Mod: Wendy Johnson Askew Sherman James Joseph Kaholokula Beti Thompson	NIH, DNRC Duke University University of Hawaii at Manoa Fred Hutchinson Cancer Ctr.
A14	Cancer	2	Mod: Sheri Sheinfeld Gorin Margo Michaels David Lounsbury Kimlin Ashing-Giwa Robin Matsuyama	Columbia University ENACT, MD. Memorial Sloan-Kettering. City of Hope Virginia Commonwealth University

Session Number	Session Topic	Track	Moderators/Speakers	Organizations
A15	Breast Cancer	2	Mod: Doris Browne Cheryl Clark Nashira Baril Daisy de Leon Sarah Hawley Kipling Gallion Amelie Ramirez	NCI Brigham & Women's Hospital Brigham & Women's Hospital Linda Loma University University of Michigan Univ of Texas Health Science Ctr. Univ of Texas Health Science Ctr.
A16	African-American	3	Mod: Sharon H. Jackson William Darity Vanessa Northington Gamble Adaora Adimora William Robinson	NIAID Duke University George Washington University University of North Carolina NAAPTN
A17	Native Hawaiian/ Pacific Islander	3	Mod/Sp: Reginald Ho Jo Ann Umilani Tsark Marjorie Mau Deborah Goebert	University of Hawaii Papa Ola Lokahi University of Hawaii University of Hawaii
A18	Rural Populations	3	Mod: Faye Gary Gilbert Friedell Spero Manson Gerald Mohatt Frederick Avis	Case Western Reserve Univ. University of Kentucky University of Colorado University of Alaska Benefis Health Systems.
A19	Persons with Disabilities	3	Mod: Connie Pledger Thomas LaVeist Gloria Krahn	U.S. Dept of Education Johns Hopkins University CDC
A20	Hispanic/Latino Populations	3	Mod: Judith Arroyo Guillermo Prado Lina Jandorf Melanie Domenech Rodriguez	NIAAA University of Miami Mount Sinai School of Medicine Utah State University
A21	Asian-American	3	Mod/Sp: Nadia Islam Summin Lee Peter Wong Hui Song	Center for Asian Amer. Studies University of Maryland Asian Pacific Islanders with Disabilities Association of Asian Pacific CHO.
A22	Women	3	Mod: Tamara Lewis Johnson Jeanette South-Paul Rosina Cianelli Cheryl Woods-Giscombe	NIAID University of Pittsburgh University of Miami University of North Carolina
A23	Practice-Based Research Networks	4	Mod: Steve Taplin George Rust Rowena Dolor David Baker Lyndee Knox	NCI Morehouse School of Medicine Duke University Medical Center Northwestern University University of South Carolina

Session Number	Session Topic	Track	Moderators/Speakers	Organizations
A24	City & County Public Health Departments	4	Mod: Irene Dankwa-Mullan Adewale Troutman Anthony Iton Joshua Sharfstein Linda Ray Murray	NCMHD Louisville Health Department Alameda County Public Health Baltimore City Health Dept. Cook County Health Dept.
A25	Federal Partners	5	Mod: Prabha Atreya Beverly Watts Davis Tanya Pagan Raggio-Ashley Carolyn Cochran Anna Pilato Laura Hoard Anne Bergan	NCMHD SAMHSA HRSA/DHHS HRSA/DHHS CFBCI, DHHS Admin for Children & Families Admin for Children & Families
B1	Discrimination, Racism And Stress	1	Mod: Nancy Breen Richard Hofrichter Gilbert Gee Makani Themba Nixon Paula Braveman	NCI NACCHO University of CA, Los Angeles The Praxis Project University of CA, San Francisco
B2	Community Health Workers	1	Mod: Tarsha McCrae America Bracho Joseph Grzywacz Aida Giachello Sherry Hirota	NIAID Latino Health Access Wake Forest University University of Illinois Asian Health Services
B3	Faith-Based Initiatives	1	Mod: Rueben Warren Marci Campbell Neil Calman Charmaine Ruddock Nancy Schoenberg Ben O'Dell	Interdenominational Theol. Ctr. University of North Carolina Institute for Urban Family Hlth. Inst for Urban Family Health University of Kentucky Faith-based & Comm In/DHHS
B4	Health Literary	1	Mod: Nathan Stinson Michael Paasche-Orlow David Baker Dean Schillinger	NCMD Boston Univ. Sch. of Medicine Feinberg Sch. of Med/NW Univ. University of CA, San Francisco
B5	Global Health Workforce	1	Mod: Ileana Herrell Nilda Peragallo Michael Johnson Edward Zuroweste	NCMHD University of Miami Fogarty International Ctr. Migrant Clinicians Network
B6	Substance Abuse	2	Mod: Dionne J. Jones Kamilla Venner Roland Moore Gerald Mohatt Luis Velez	NIDA University of New Mexico Pacific Inst for Research & Eval. University of Alaska University of Texas

Session Number	Session Topic	Track	Moderators/Speakers	Organizations
B7	Cardiovascular Disease And Stroke	2	Mod: Jane Scott Amie Hsia Keith Norris Marcia Wilson	NHLBI Georgetown University Charles R. Drew Univ. of Med & Sc. George Washington University
B8	Respiratory Diseases	2	Mod: Floyd Malveaux Diane Gold Herman Mitchell Andrea Apter	Merck Childhood Asthma Network Harvard University Rho Incorporated University of Pennsylvania
B9	Prostate Cancer	2	Mod: Gary Ellison John Carpten Paul Godley Myron Williams Roshan Bastani	NCI Translatl. Genomics Research Inst. University of North Carolina Clark Atlanta University University of CA, Los Angeles
B10	Immunization Rates	2	Mod: Pierce Gardner Roderick Go Danielle Ompad Katherine O'Brien	Stony Brook University Stony Brook University New York Academy of Medicine JH Bloomberg Sch. of Pub.Hlth.
B11	Cancer	2	Mod/Sp: Kenneth Chu Debra Holden Pamela Williams Nora Katurakes Donna Costa Maureen Johnson	NCI, NIH RTI International Spartanburg Regl. Hlth. Care Sys. CCHS, H.F. Graham Cancer Ctr. Cancer Inst. of St Joseph Med. Ctr. NCI, NIH
B12	Cardiovascular Disease And Physical Activity	2	Mod: Drew Carlson Corey Wiggins Jennifer Carroll Roland Thorpe Francisco Villarreal	NHLBI My Brothers Keeper University of Rochester JH Bloomberg Sch. of Pub.Hlth. University of CA, San Diego
B13	Diabetes	2	Mod/Sp: Joanne Gallivan Sabita Persaud Chandra Osborn Mary Shaw Ranjita Misra	NIDDK, NIH Bowie State University Vanderbilt University Texas A&M University Texas A&M University
B14	HIV/AIDS	2	Mod: Lois Takahashi Enbal Shacham Amy Fasula Jury Candelario Ronald Sy	University of CA, Los Angeles Washington University CDC Asian Pacific AIDS Intervention Team AIDS Services in Asian Communities

Session Number	Session Topic	Track	Moderators/Speakers	Organizations
B15	Mental Health	2	Mod: Courtney Ferrell Tara Earl Charlotte Brown Deborah Dobransky-Fasiska Scott Nolen	NIMH Boston College University of Pittsburgh University of Pittsburgh NY St Psyc. Inst./Columbia Univ.
B16	Substance Abuse	2	Mod: Donna Vallone Pamela Jones Olivia Carter-Pokras Alex Prokhorov	American Legacy Foundation Univ. of Nebraska Medical Center University of Maryland U of TX/MD Anderson Cancer Ctr.
B17	Low Socioeconomic Status Populations	3	Mod/Sp: Pebbles Fagan Paul Ong Leonard Syme Carlos Mendes de Leon	NCI University of CA, Los Angeles University of CA, Berkeley Rush University Medical Center
B18	Asian-American	3	Mod/Sp: Moon Chen Ninez Ponce Grace Ma Tung Nguyen	University of CA, Davis University of CA, Davis Temple University University of CA, San Francisco
B19	Lesbian/Gay/ Bisexual /Transgender Populations	3	Mod: Scott Rhodes Tania Israel Deborah Bowen Jesus Ramirez-Valles	Wake Forest University University of CA, Santa Barbara Boston University University of Illinois at Chicago
B20	Elderly	3	Mod: Michele K. Evans Anita Stewart Carol Mangione Peggy Dilworth-Anderson Keith Whitfield	NIA University of CA, San Francisco University of CA, Los Angeles University of North Carolina Duke University
B21	Women	3	Mod/Sp: Michele Kiely Kathy Katz Nabil El-Khorazaty Marie Gantz Ayman El-Mohandes	NICHD, NIH Georgetown University RTI International Children's National Med. Center George Washington University
B22	Child & Adolescent	3	Mod: Yvonne Bronner Deena Chisolm Michelle Eakin Sylvie Naar-King Maria Trent	Morgan State University Ohio St. Univ. College of Medicine Johns Hopkins University Wayne State University JH Univ School of Medicine
B23	Comprehensive Centers	4	Mod: Sheila McClure Angela Ford Mario de La Rosa Michael Fine Debra Wallace	NCRR University of Pittsburgh Florida International University VA Pitt HC Sys & Phil VA Med. Ctr U of NC at Greensboro

Session Number	Session Topic	Track	Moderators/Speakers	Organizations
B24	K-12 Education	4	Mod: Dorkina Myrick Sandra Daley Lovell Jones J. Michael Wyss	NCI University of CA, San Diego University of Texas University of Alabama
B25	Foundations	5	Mod: Faith Mitchell Debra Perez Marion Standish Marsha Lillie-Blanton Marc Nivet	Grantmakers in Health Robert Wood Johnson Foundation The California Endowment Kaiser Family Foundation Josiah Macy Foundation
C1	Discrimination, Racism And Stress	1	Mod: Peter Kaufmann Brian Smedley Camara Jones Joseph Gilbert	NHLBI Joint Center for Pol. & Econ. Stud. CDC Assembly of First Nations
C2	Social Networks	1	Mod: J. Taylor Harden Sean Joe Ana Navarro Marino Bruce	NIA University of Michigan University of CA, San Diego Meharry. Medical College
C3	Community Health Centers	1	Mod: Mitchell Wong Margaret Hargreaves William Blot Michelle Proser	University of CA, Los Angeles Meharry Medical College Vanderbilt University Natl. Assn. of Comm. Health Centers
C4	WHO Commission on Social Determinants of Health	1	Mod: Paula Braveman Vilma Santana Heidi Bart Johnston Arjumand Siddiqi Jennie Popay	University of CA, San Francisco Federal University of Bahia Intl. Ctr. for Diarrhoeal Dis. Rsch. University of NC at Chapel Hill University of Lancaster
C5	Gene-Environment Interactions	1	Mod: Sheila Caldwell Sandra Lee Maureen Lichtveld Edith Parker Charles Rotimi	NCCAM Stanford University Tulane University University of Michigan Natl. Hum. Genome Rsch. Inst./NIH
C6	Health Literacy	1	Mod: Cindy Brach Rebecca Sudore Debra Roter Michael Wolf Angelo Volandes Drenna Waldrop	AHRQ University of CA, San Francisco JH Bloomberg Sch. of Pub. Hlth. Northwestern University Massachusetts General Hospital Univ of Miami Sch. of Medicine

Session Number	Session Topic	Track	Moderators/Speakers	Organizations
C7	Population & Individual Level Data	1	Mod: Emmanuel Taylor Richard Warnecke Katherine Tucker Sarah Gehlert Timothy Rebbeck	NCI University of Illinois at Chicago Tufts University University of Chicago University of Pennsylvania
C8	Oral Health	2	Mod: Ruth Nowjack-Raymer R. Gary Rozier Amid Ismail Jane Weintraub Adeola Olufolake Jaiyeola	NIDCR University of NC at Chapel Hill University of Michigan University of CA, San Francisco N Plains Tribal Epidemiology Ctr
C9	Infant Mortality	2	Mod: Jennifer Pohlhaus Michael Lu Diane Rowley James Collins Paul Wise	OD, ORWH University of CA, Los Angeles University of NC at Chapel Hill Northwestern University Stanford University
C10	Cardiovascular Disease And Stroke	2	Mod/Sp: John Flack Gary Gibbons Amy Schulz Sheryl Weir Gbenga Ogedegbe	Wayne State University M. Sch of Med Cardio Rsch Inst University of Michigan Michigan Dept. of Comm. Hlth. Columbia University
C11	Cervical & Ovarian CA	2	Mod: Phil Castle Claudia Baquet Edward Partridge Dineo Khabele Tung Nguyen	NCI University of Maryland University of AL at Birmingham Vanderbilt Univ Medical Ctr. University of CA, San Francisco
C12	HIV/AIDS	2	Mod: Victoria Cargill Beny Primm Carmen Zorrilla Vickie Mays Donna Mildvan Marya Viorst Gwadz	OD, NIH Addiction Research & Trmnt. Corp. University of Puerto Rico University of CA, Los Angeles Albert Einstein Coll. of Medicine Inst for AIDS Research, NDRI
C13	Substance Abuse	2	Mod: Alan Trachtenberg Dennis Donovan Jean Bonhomme Marguerita Lightfoot Anita Fernander	Indian Health Service University of Washington Morehouse School of Medicine University of CA, San Francisco University of Kentucky
C14	Diabetes & Obesity	2	Mod: Sanford Garfield Siobhan Maty Daheia Barr-Anderson Mary Murimi Kapuoala Gellert Fahina Pasi	NIDDK Portland State University University of Minnesota Louisiana Technical University Kaunakakai, HI National Tongan American Society

Session Number	Session Topic	Track	Moderators/Speakers	Organizations
C15	Hispanic/Latino	3	Mod: Maria Canto Lourdes Baezconde-Garbanati Charles Martinez Margarita Alegria Isabel Scarinci	NCI University of Southern California Oregon Social Learning Center Harvard Medical School University of Alabama
C16	US Pacific Populations	3	Mod/Sp: Nia Aitaoto Stevenson Kuartei Patrick Luces Father Ryan Jimenez	Papa Ola Lokahi Bureau of Public Health Guam Dept of Health Commwlth of Nthrn Mariana Isls
C17	Prison Populations	3	Mod: Denise Juliano-Bolt Susan Loeb Newton Kendig James Thomas Ingrid Binswanger	NIMH Pennsylvania State University Federal Bureau of Prisons University of North Carolina University of Colorado
C18	Women	3	Mod: Janine Austin Clayton Stacie Geller Michelle Berlin Martha Medrano	ORWH/OD University of Illinois at Chicago OR Health & Science University Univ of TX Hlth Sc Ctr at SA
C19	Asian-American	3	Mod: Belinda Seto Suhaila Khan Jae Hyun (Julia) Lee Furjen Deng Michael Byun	NIBIB Asian & Pac. Islr. Am. Hlth. Forum Ctr for Pan Asian Comm Services Sam Houston State University Ohio Asian Amer. Hlth Coalition
C20	Rural Populations	3	Mod: Thomas Brady Margaret Miles Caryl Waggett Mark Dignan Sohini Sengupta	NIDA University of NC at Chapel Hill Alleghany University University of Kentucky University of NC at Chapel Hill
C21	State Health Departments	4	Mod: Aleta Meyer Lauren A. Smith Mike Royster Carlessia Hussein	NIDA St of MA Dept of Public Health Virginia Dept. of Health MD Dept of Health & Mental Hyg.
C22	Undergraduate Education	4	Mod: Ed Ramos Isaiah Warner Timothy Turner Gary King Richard Lichtenstein	NHGRI Louisiana State University Tuskegee University Pennsylvania State University University of Michigan
C23	Young Investigators	4	Mod/Sp: James Hebert Rosemary Gibbons John Luque Janet Frank	Medical Univ of South Carolina University of Washington Moffitt Cancer Center University of CA, Los Angeles

Session Number	Session Topic	Track	Moderators/Speakers	Organizations
C24	Federal Partners	5	Mod: Lorrita Watson Cecilia Rivera Casale Benedict Truman Garth Graham Phillip Smith	NCMHD AHCRQ/DHHS CDC Office of Minority Health/DHHS Indian Health Service/DHHS
C25	Federal Partners	5	Mod: Idalia Sanchez Devon Payne-Surges Mark Grider Leonard Haynes Kellina Craig-Henderson	NCMHD EPA U.S. Department of Justice U.S. Department of Education National Science Foundation
D1	Patient-Provider Communication	1	Mod: Paul Cotton Lisa Cooper Somnath Saha Quyen Ngo-Metzger	NINR Johns Hopkins University Oregon Health & Science University University of CA, Irvine
D2	Quality Improvement	1	Mod/Sp: Dennis Andrulis Thomas LaVeist Rhonda Moore Johnson Winston F. Wong Ernest Moy	Drexel University Johns Hopkins University Intgr. Clinical Svcs. Highmark, Inc. Kaiser Permanente AHRQ
D3	Social Marketing	1	Mod: Lenora Johnson Gwendolyn Quinn K. “Vish” Viswanath Penny Lo Elmer Huerta	NCI Moffitt Cancer Ctr. & Rsch. Inst. Harvard School of Public Health Hmong Women’s Heritage Assn. Washington Hospital Center
D4	Clinical & Community Research Trials	1	Mod: Carmen L. Rosa Claudia Baquet Mona Fouad Armin Weinberg	NIDA University of Maryland University of Alabama Baylor College of Medicine
D5	Global Health	1	Mod: Gary King Manuel Carballo Jessie Mbwambo Isabella Annesi-Maesano	Pennsylvania State University Intl Centre for Migration & Health Muhimbili Univ. Coll. of Hlth. Sciences INSERM & Universite Pierre et Marie Curie
D6	Health Literacy	1	Mod: Lynn Haverkos Stacy Bailey Andrea Apter Timothy Bickmore Susmita Pati	NICHD Northwestern University University of PA, Philadelphia Northeastern University Children’s Hospital of PA

Session Number	Session Topic	Track	Moderators/Speakers	Organizations
D7	Discrimination, Racism & Stress	1	Mod/Sp: Salma Shariff-Marco Kristen Bibbins-Domingo Jae Eun Lee Akiko Hosler Derek Griffith	NCI University of CA, San Francisco Jackson State University University of Albany University of Michigan
D8	Community & Faith-Based Organizations	1	Mod: Marian Johnson-Thompson Neil Calman Giselle Corbie-Smith Marvella Ford Cheryl Holt	NIEHS Institute for Family Health University of NC at Chapel Hill Medical University of SC University of Maryland
D9	Health Literacy	1	Mod: Nadine Rogers Miyong Kim Nancy Morris Zarya Rubin Suzanne Christopher	NIDA Johns Hopkins University University of Vermont Transcendent International LLC Montana State University
D10	Breast Cancer	2	Mod: Erica Breslau Lovell Jones Ronda Henry-Tillman Linda Burhansstipanov Suzanne Conzen	NCI University of Texas Univ of Arkansas for Med. Svcs. Native American Cancer Initiatives University of Chicago
D11	Diabetes & Obesity	2	Mod: Lawrence Agodoa Yvette Roubideaux Barbara Howard Arleen Brown	NIDDK University of Arizona MedStar Research Institute University of CA, Los Angeles
D12	Mental Health	2	Mod: Carmen Moten Guillermo Bernal David Takeuchi James Jackson Deborah Dobransky-Fasiska	NIMH University of Puerto Rico University of Washington University of Michigan University of Pittsburgh
D13	Immunization & Vaccination	2	Mod: Diana S. Berard Amy Groom Thomas Hennessy Anne Schuchat	NIAID Indian Health Service, CDC Arctic Investigations Prgm., CDC NCIRD, CDC
D14	Cardiovascular Disease and Stroke	2	Mod: Patrice DesVigne Nickens George Howard Herman Taylor Larissa Aviles-Santa	NHLBI Univ of Alabama at Birmingham Univ of Mississippi Medical Center NHLBINatl.
D15	Substance Abuse	2	Mod: Lula Beatty Maite Mena Carmen Masson Mesfin Mulatu	NIDA University of Miami University of CA, San Francisco The MayaTech Corporation

Session Number	Session Topic	Track	Moderators/Speakers	Organizations
D16	American Indian/ Alaska Native	3	Mod: Jane Daye Spero Manson Jeffrey Henderson Brenda Seals	NCI University of Colorado Black Hills Ctr. for Am. Indian Hlth. Native American Cancer Research
D17	Immigrants	3	Mod: Terry Huang Rafael Lantigua Francesca Gany Steven Wallace	NICHD Columbia University NY University Sch of Medicine University of CA, Los Angeles
D18	Child & Adolescent Health	3	Mod: Regina Smith James Tina Cheng Renee Jenkins Marianna Hillemeier John Thorp	NICHD Johns Hopkins University Howard University Pennsylvania State University University of North Carolina
D19	Men	3	Mod: Carl Hill David Williams Marian Gornick Amos Smith Jean Bonhomme	NICHD Harvard University CMS/DHHS (retired) Comm Action Agcy of New Haven Morehouse School of Medicine
D20	African-American Populations	4	Mod: Hazel Dean Dorothy Coverson Carol Ferrans Von Nebbitt Jamie Zoellner	CDC Emory University University of Illinois at Chicago Howard University University of Southern Mississippi
D21	Community Campus Partnerships	4	Mod: Yvonne Maddox Barbara Israel Laurie Bauman Joseph Keawe'aimoku Kaholokula	NICHD University of Michigan Albert Einstein College of Medicine University of Hawaii at Manoa
D22	Loan Repayment Program	4	Mod: Robert Nettey Nadia Islam Alfiee Breland-Noble Eleanor Gil-Kashwabara Brian Rivers Randall Sell	NCMHD New York University Duke University Portland State University Univ South FL Moffitt Cancer Ctr. Drexel University
D23	Graduate Education	4	Mod: Diane Adger-Johnson Marjorie Mau Gayle Slaughter Bill Jenkins Robert Valdez	NIAID University of Hawaii Baylor College of Medicine Morehouse School of Medicine University of New Mexico

Session Number	Session Topic	Track	Moderators/Speakers	Organizations
D24	Federal Partnership	5	Mod: DeLoris Hunter Joel Kupersmith Robert Post Jon Gant	NCMHD Department of Veterans Affairs U.S. Dept of Agriculture U.S. Dept of Housing & Urban Dev
D25	Health/Med Partners	5	Mod: Derrick Tabor Sandra Gadson Adolph Falcon Ted Mala Ho Tran	NCMHD National Medical Association Natl. Alliance for Hispanic Health Southcentral Foundation Asian & Pac Isldr Amer Hlth Forum

Appendix E

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Dr. Sanya Springfield

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Appendix G

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