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Community Engagement and its Impact on Child Health Disparities: Building Blocks, Examples, and Resources

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KEY WORDS

child health disparities, community engagement, child advocacy, community-based public health

ABBREVIATIONS

CDC—Centers for Disease Control and Prevention

AAP—American Academy of Pediatrics

CBO—community-based organization

AMHC—Arkansas Minority Health Commission

REACH—Racial and Ethnic Approaches to Community Health

The views presented in this article are those of the authors, not the organizations with which they are affiliated.

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abstract

National attention to racial and ethnic health disparities has increased over the last decades, but marked improvements in minority health, especially among children, have been slow to emerge. A life-course perspective with sustained community engagement takes into account root causes of poor health in minority and low-income communities. This perspective involves a variety of primary care, public health, and academic stakeholders. A life-course perspective holds great promise for having a positive impact on health inequities. In this article we provide background information on available tools and resources for engaging with communities. We also offer examples of community-primary care provider interventions that have had a positive impact on racial and ethnic health disparities. Common elements of these projects are described; additional local and national resources are listed; and future research needs, specifically in communities around issues that are relevant to children, are articulated. Examples throughout the history of pediatrics show the potential to eliminate racial and ethnic health disparities not only for children but also for all populations across the life course. *Pediatrics* 2009;124:S237–S245

Few topics in health, from individual health care to population health and from social determinants of health¹ to health policy, demand a more comprehensive examination than racial and ethnic health disparities. Health disparities are significant differences in health, health care, and developmental outcomes between populations, to modify a definition from the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD). National awareness of health disparities has progressed over the last 25 years from the Centers for Disease Control and Prevention² (CDC) and the US Department of Health and Human Services³ reports in the mid-1980s to the Institute of Medicine report in 2003,⁴ but the pace of progress in eliminating these disparities has been slow.⁵

In addition, the health-disparities literature tends to focus on mortality, morbidity, and health care interventions related to chronic diseases in adults. This does not mean that little is known about child health disparities, as shown by the annual editions of the Annie E. Casey Foundation's *Kids Count Data Book*,⁶ which review racial and ethnic disparities in child deaths, teen births, infant mortality, and low birth weight, among many other indicators. Furthermore, disparities by race and ethnicity are well documented for childhood asthma,⁷ obesity,^{8,9} immunizations,^{10,11} and health insurance coverage.¹² Health insurance disparities are particularly severe in Latino children.¹³

The concept of partnering with communities to improve health is not a new one, especially in the public health world, but it has recently gained momentum in more traditional medical settings as physicians come to realize that all nonbiomedical influences on individual health are not easily addressed in a clinic or hospital room.^{14,15} Recent reviews of the literature on

diabetes interventions¹⁶ and the role of cultural leverage in health care–disparities interventions¹⁷ point to the promise of community partnerships for bridging systems and populations. Pediatrics is particularly well suited to being the bridging force at the intersection of public health, advocacy, and community. In fact, “promoting community relationships and resources” is 1 of 10 health-promotion themes in the *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*,¹⁸ a publication of the American Academy of Pediatrics (AAP). Pediatricians and a host of child health providers build relationships every day with families, often across several generations. This experience with children and families makes community engagement less daunting for pediatricians and as rewarding as individual doctor-patient interactions.

In this article we describe the lessons that pediatricians can learn from the community-based public health movement about the building blocks of community partnerships. We also provide examples of what has been and what can be done through these partnerships to reduce child health disparities. Finally, we describe resources and models that can be adapted to local and regional communities.

SETTING THE STAGE FOR COMMUNITY ENGAGEMENT ON HEALTH DISPARITIES

The first foray of a physician or other health provider into a community-level issue often results from the realization that a particular problem identified while caring for a patient is large and requires a group effort to resolve. Examples in the literature of physicians who have engaged the community and the focus areas of this engagement include private practitioners addressing fragmentation of care,¹⁹ academic

faculty members meeting the needs of uninsured adolescents,²⁰ and a resident targeting the negative effects of juice consumption in young children.²¹ These examples involve advocacy projects with realizable goals focused on a particular issue and offer potential approaches to community advocacy and engagement.^{20,22} Projects such as these can form the basis for building lasting relationships with community members, community-based organizations (CBOs), state agencies, schools, and other community-based associations. These relationships require effort, nurturing, and true partnership. These relationships are essential for a multilevel approach toward performing research, sharing resources, implementing interventions, disseminating results, evaluating results, and, ultimately, reducing health disparities.^{14,23}

Developing provider-community relationships is time consuming at first. However, these relationships have the potential to last much longer than grant cycles and allow for creativity in developing networks, resources, sustainability, and buy-in. Fortunately, child health providers can learn more about community engagement from many sources. For example, McKnight's²⁴ succinct and rich exploration of the differences and interactions between communities and systems lays the groundwork for understanding social capital and asset-based community development, which Pan et al²⁵ nicely described. The Community-Based Public Health Initiative offers practice principles and model approaches,²⁶ research principles,²⁷ and examples of community impact.²⁸

With these tools, primary care providers can convene community members to discuss areas of common concern, preferably outside a major health care institution, and begin to build consensus and form strategies for addressing identified issues. The physician-community

alliance enhances the community's social capital, providing an opportunity to engage potential agents of systems change safely, and enables the physician to work cooperatively with people instead of serving as an ombudsman for a system. As the relationship matures, the pediatrician and community can identify other assets within or outside the community (including in the health care system) that can be used to execute a strategy. Furthermore, as pediatric and other primary care residents,²¹ academic departments, and children's hospitals join the broad effort, the community's access to resources improves, and the potential for building trusting relationships with large institutions increases.

While establishing consensus and identifying issues to address, colleagues in public health agencies and academic institutions can be valuable partners as new assets and resources are used to address areas of common concern. Goldhagen²⁹ has provided several examples of pediatric–public health partnerships and listed several potential assets for these partnerships. In the process of community engagement, pediatricians and their community partners might find that community- or neighborhood-level data on racial and ethnic minorities, particularly with regard to child health disparities, are unavailable. This is especially likely in emerging immigrant communities, geographically or linguistically isolated communities,³⁰ and small communities. In these cases, the partners might need to conduct assessments with involvement from the community to further define an issue.

The community-engagement process might also reveal the community's past negative experiences with physicians,³¹ researchers, or government agencies. The community must have a safe space to describe these experiences, which

might have occurred over generations, to avoid similar harms to the community from the partnership. All too often, researchers have had a “helicopter,”³² “hit-and-run,” or “parachute” relationship with communities, visiting the community only to obtain grant funding to sustain their research and not to help the community over the long-term. Again, child health care providers can turn to several sources to learn about conceptual frameworks for engaging in and evaluating community-based efforts,³³ proposed models for university- or agency-community collaborations,³⁴ and guidelines²¹ or strategies³⁴ for creating and maintaining community partnerships.

APPROACHES TO COMMUNITY ENGAGEMENT TO REDUCE HEALTH DISPARITIES

Pediatricians at all stages of training and practice have a rich history of community engagement to improve child health.³⁵ Several AAP programs, including Community Access to Child Health (CATCH)³⁶ and the Community Pediatrics Training Initiative (CPTI),³⁷ as well as an AAP policy statement on the pediatrician's role in community pediatrics,³⁸ have promoted community engagement.

Several projects funded by these programs are directed toward child health disparities. A search of AAP's community pediatrics grants database (www.aap.org/compeds/grantsdatabase/grantsdb.cfm) for the term “health disparities” returned 202 records for projects in 1993–2008.

However, no systematic review has been conducted of community-based child health interventions²⁰ and, by extension, of child health disparity–focused, community-based interventions. Most of the many health disparity–focused community-based interventions in the literature have focused on adults, few studies were large enough to show

whether these interventions eliminated health disparities,³⁹ and most did not follow participants for long enough to show a sustained effect.

A model might help pediatricians and other child health providers visualize the factors that influence the development of efforts to shape health policy. Richmond and Kotelchuck⁴⁰ have described a 3-factor approach (Fig 1) to developing and implementing public policy and, subsequently, health policy. This model shows how a knowledge base, political will, and social strategy interrelate and shape the development of public policy. Although initially postulated as a vehicle for examining the health care delivery system, this model is applicable to several public and community health issues, including advocacy and health inequalities.

In this model, a knowledge base that encompasses social, economic, and behavioral factors to help understand health issues is necessary for providing sufficient evidence on which to base health-improvement strategies. A public or professional constituency, fully engaged and ready to support change, can then influence the political will in favor of new program development. State agencies, CBOs, and other child health advocates (including physicians and other child health providers) would be appropriate constituents. Lastly, a social strategy can be developed by using information from the first 2 components; this strategy forms the base or infrastructure for health policy. Such a strategy could be disseminated through community-organizing approaches with CBOs and community-based associations.

Two examples from Arkansas illustrate this model in action. In the first example, the Coalition for a Healthy Arkansas Today (CHART) (which included >100 health-related organizations from around the state) advocated for spending all of Arkansas'

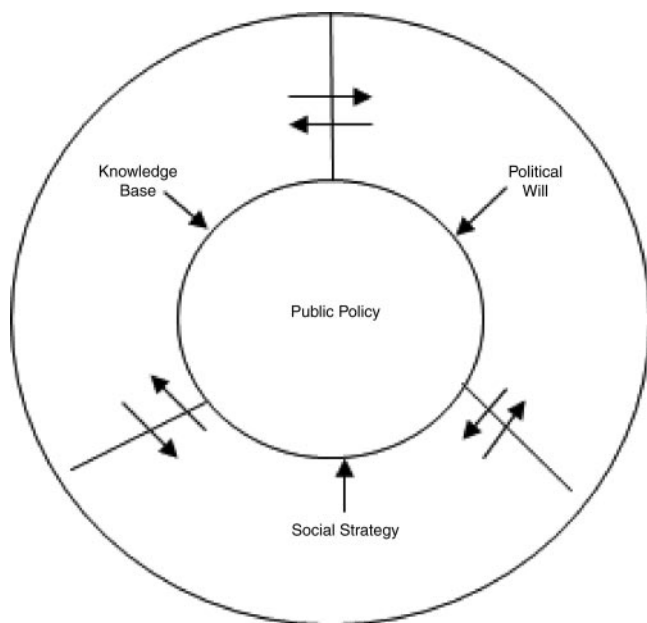


FIGURE 1

Three-factor approach to developing and implementing public policy. (Reproduced with permission from Richmond JB, Kotelchuck M. Political influences: rethinking health policy. In: McGuire CH, Foley RP, Gorr A, Richards RW. *The Handbook of Health Professions Education: Responding to New Realities in Medicine, Dentistry, Pharmacy, Nursing, Allied Health, and Public Health*. San Francisco, CA: Jossey-Bass; 1983:386–404.)

master tobacco settlement agreement funds on health improvement. The major focus areas of the CHART plan were tobacco-prevention and -cessation programs, expanded Medicaid services, public health and biomedical research projects, targeted state-needs programs, and a trust fund to provide secured program funding for the future. The details of this process have been described in the literature.⁴¹ In this example, funding went directly to address minority health concerns and support Medicaid, which disproportionately benefits minority individuals and communities.

In the second example, the Arkansas Minority Health Commission (AMHC) used some of its minority health initiative funds to conduct a descriptive study of racial and ethnic health disparities in the state.⁴² The researchers evaluated existing secondary data on social determinants of health, morbidity, behavioral risk factors, mortality, and hospital discharges (knowledge

base) and collected focus-group data⁴³ throughout the state (social strategy). This information served as the basis for several multilevel recommendations for addressing health disparities. The incorporation of community voices to contextualize the secondary data enabled the articulation of community experiences in the search for health care services.

The data collected allowed stakeholders outside the community to understand how past interactions with the health care system contributed to health disparities in minority and low-income communities. For example, in 1 community, black people recounted such negative experiences with the only community hospital over several generations that 1 participant disclosed complete avoidance of the facility, whereas white people in a different focus group in the same community described positive experiences with the hospital. In another county, when the same doctor saw a black participant's

children on the same day with the same symptoms as a white co-worker's children, the white children were diagnosed with the flu and given prescriptions, whereas the black children were diagnosed with "the crud" and sent home.⁴² After releasing its report, the AMHC initiated activities, such as exercise programs, hypertension school screenings, and further study of cardiovascular risk factors, in counties that had held focus groups to continue engaging with local communities.

Nationally, policy and programmatic efforts to eliminate racial and ethnic health disparities include *Healthy People 2010*, which articulated health outcome objectives, many with origins in childhood,¹⁴ and had the goal of eliminating disparities,⁴⁴ and the CDC's Racial and Ethnic Approaches to Community Health (REACH) 2010.⁴⁵ REACH 2010 promoted the creation of coalitions through a planning year that required CBOs to partner with other research, public health, health care, or academic organizations.⁴⁶ Each REACH 2010 site focused on 1 of 6 areas (immunizations, diabetes, cardiovascular disease, HIV/AIDS, infant mortality, and breast and cervical cancer screening and management) and targeted 1 or more racial or ethnic communities. The CDC originally funded 42 of these coalitions. By 2005, 40 of these projects remained and an evaluation logic model was used to report progress across sites.⁴⁵ In addition, aggregate evaluations were completed through the REACH 2010 risk-factor survey, which showed, for example, increased cholesterol-screening rates among Hispanic and black people in REACH 2010 communities and reduced disparities compared with national rates, as well as decreased smoking among Asian males.³⁹ By 2007, the program's name had changed to REACH US, and another round of funding had estab-

TABLE 1 Representative Community-Based Projects That Address Health Disparities

Name	Location	REACH Project	Goal(s)	Procedure(s)	Result(s)	Reference(s)
Northern Manhattan Start Right Coalition	New York, NY	✓	Improve immunization rates among minority children	Trained community health workers for outreach; partnered with academic center	Immunization rates were higher than national average rates after 2 y	49, 50
United South and Eastern Tribes	Nashville, TN	✓	Improve immunization rates among Native American children; analyze factors that contribute to infant death	Implemented disease-surveillance system	Ongoing	51
Vietnamese REACH for Health Initiative Coalition	Santa Clara County, CA	✓	Increase screening for cervical cancer in Vietnamese women	Developed action plan; partnered with academic center	Improved screening rates; created registry and reminder system; established Papanicolaou-smear clinic	52, 53
REACH Detroit Partnership	Detroit, MI	✓	Improve diabetes management		Reduced risk factors; improved glycemic control and diabetes self-management	54
Bronx Health REACH	New York, NY	✓	Improve diabetes and cardiovascular management	Community leaders participated, developed policy interventions	Ongoing	55–57
Harlem Children's Zone	New York, NY		Improve childhood asthma management	Provided community health worker training for in-home screening; partnered with academic center	Decreased hospitalizations, emergency department visits, and school absences; increased use of spacer devices; increased compliance with medication	58–61
SCHIP/Medicaid randomized, controlled trial	Boston, MA, area		Compare SCHIP and Medicaid to community-based advocacies in insuring Latino children	Conducted randomized, controlled trial	Increased insurance enrollment through community-based entities	62
Chicago-area consortium and American Lung Association of Metropolitan Chicago	Chicago, IL		Identify needs of children with asthma	Identified intervention plans	Changed legislation, increased education	63
Border Health Strategic Initiative	Yuma and Santa Cruz, AZ		Develop diabetes outreach education programs for Hispanics	Identified intervention plans	Identified community-based entities to provide medical care for the special population; increased education opportunities; identified agencies to assist patients with payment for clinical care and medication	64

SCHIP indicates State Children's Health Insurance Program.

lished 18 “centers of excellence in the elimination of health disparities” and 22 “action communities.”⁴⁷

The REACH 2010 and REACH US model of community engagement to address health disparities is an example of a “hybrid” model for health improve-

ment, or a combination of clinical, public health, policy, and community-oriented approaches to this national problem.⁴⁸ Table 1 lists examples of several hybrid projects from the literature, including some that are funded by REACH. All of these projects were

designed to reduce disparities, and some focused primarily on children.

These successful community-based interventions offer the following lessons:

- Community collaboration, from the earliest possible moment, is a key to

building sustainable partnerships, establishing trust, and ensuring appropriateness of interventions and strategies. The community must be involved in all facets of the partnership to increase buy-in and ensure that the project's interventions and strategies meet their needs.

- Partners must be diverse. The overall partnership and the community can benefit from the assets that each group brings to the effort.
- Lay health advisors (also known as community health workers) were valuable in eliminating health disparities from the inception of the REACH 2010 projects.⁴⁴ These advisors can serve as referral sources, advocates, recruiters, connectors, navigators, coaches, or data collectors. Other nonphysician health workers, such as public health nurses or case managers, have important roles in community outreach. A recent review identified several studies in which community health worker involvement in health-promotion or disease-prevention interventions in Latino communities produced statistically significant, positive community outcomes.⁶⁵

Another example from Arkansas included many of these elements. A child advocacy organization promoted health care coverage of children in families with incomes up to 200% of the federal poverty level through the state's Medicaid program. The state passed its legislation several months before the federal State Children's Health Insurance Program (SCHIP) was enacted and extensive coalition building with community-based outreach began. The organization's efforts reduced the percentage of uninsured children in Arkansas from >19% to 10% between 1996 and 2003. Partners in the effort included health care organizations, school nurses,

athletic coaches, CBOs, and Medicaid officials.⁶⁶

Several partners in this health insurance effort in Arkansas, as well as new ones, are now working on a statewide effort to improve child health. Over 2 years, the Natural Wonders Partnership Council gathered secondary data on child health indicators and social determinants; collected primary data through a telephone survey, community health provider roundtables, and community discussion groups; and issued 2 reports. The council includes health care provider groups and organizations, public health and human service agency representatives, representatives of state education agencies, nongovernment insurers, the AMHC, and academic pediatric and public health faculty members.

COMMUNITY-ENGAGEMENT RESOURCES

Several authors have described many resources that child health providers can use to engage communities,⁴⁸ develop projects of mutual interest,^{14,20} evaluate the projects,²⁰ and pose further research questions³⁵ to improve child health in a community. These resources include the following:

- *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* has many resources.¹⁸
- Many state AAP chapters have charitable foundations that issue grants to support projects that improve child health.
- Most states have a stand-alone minority health commission or a dedicated minority health office in a public health department or other state agency. These organizations can often provide access to federal funding for health-disparities programs or help providers locate state and local partnerships that address health disparities.

- The federal Office of Minority Health (www.omhrc.gov) has information on the recently formed National Partnership for Action to End Health Disparities.

- An environmental scan of the state or region can identify institutions that have received federal funds through such programs as the Clinical Translational Science Award from the National Institutes of Health, Prevention Research Centers or the Steps to a Healthier US program from the CDC, and Centers of Excellence awards from the National Center on Minority Health and Health Disparities. These programs frequently require community engagement and might present opportunities for involvement by primary care providers and communities.

- Community-Campus Partnerships for Health promotes health through collaborations between communities and higher education institutions. The collaborations conduct service learning, community-based participatory research, and coalition building to improve community health. The organization brings groups together, provides technical assistance, and offers a wealth of information on its Web site (www.ccpf.info).

- The AAP Community Pediatrics grants database (www.aap.org/commpegs) describes projects funded by the AAP. In addition, AAP fellows should consider joining the Council on Community Pediatrics.

RESEARCH PRIORITIES

As momentum builds to address health disparities in all populations, additional attention must be paid to child health-disparities research.

- Additional research is needed to examine the impact of community-based interventions on health disparities.

- Many of the projects reviewed for this article had short-term outcomes. Although many of these results were positive, researchers need to follow these outcomes over a longer period of time.
- Where disparity reductions are sustained, researchers and communities must disseminate results and try to apply successful interventions to larger populations.
- Researchers need to describe models in the literature for sustaining disparity reductions in diverse organizations and funding environments.
- Community-based interventions among Native American, Asian, and emerging immigrant communities should be enhanced and reported. Because these communities experience some of the largest health disparities, engaging them and addressing their disparities is particularly urgent.
- Research must approach each side of the equation in health system–community partnerships to understand markers of trust, success,

and change in ways that enrich community capacity while advancing population health.^{32,48}

CONCLUSIONS

Although the literature has described many community-based interventions that addressed health disparities, challenges remain in generalizing the findings, when available, of these interventions. Notably, most disparity-related interventions have focused on adults, few have measured the impact on disparities, and few have followed outcomes for enough time to show lasting change.

However, the examples we review in this article have shown that sustained community engagement can have an impact on child health disparities. The history of pediatrics has many examples of interdisciplinary collaborations and public health interventions for improving child health on a broad scale and has much to offer primary care providers, who are uniquely suited to cultivate relationships with families. To paraphrase Paulson,²² physicians who can take a thorough history (listen) and remember what their

mother taught them (be respectful) can learn to work in and with the community.

To have a meaningful impact on child health disparities, child health care providers must continue to make the transition from 1-on-1 clinical care and focused advocacy to community-based partnership building and long-term strategic initiatives. Pediatrics is a deeply relational profession, and these relationships give pediatricians an open door into communities. Walking through the door might not be easy, and what they find in the community might be overwhelming at first. However, the potential for having a lasting effect on health disparities, particularly child health disparities, makes the journey all the more essential.

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