Moving the Dial to Advance Population Health Equity in New York City Asian American Populations

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The shift toward a health equity framework for eliminating the health disparities burden of racial/ethnic minority populations has moved away from a disease-focused model to a social determinants framework that aims to achieve the highest attainment of health for all. The New York University Center for the Study of Asian American Health (CSAAH) has identified core themes and strategies for advancing population health equity for Asian American populations in New York City that are rooted in the following: social determinants of health; multisectoral, community-engaged approaches; leveraging community assets; improved disaggregated data collection and access to care; and building sustainability through community leadership and infrastructure-building activities. We describe the strategies CSAAH employed to move the dial on population health equity. (*Am J Public Health.* 2015;105:e16–e25. doi:10.2105/AJPH.2015.302626)

In recent years, there has been a shift in public health toward advancing health equity. A health equity framework acknowledges the structural and social determinants of health, while advancing the health of all populations by eliminating the burden of health disparities on racial/ethnic minorities.[1] Groups engaged in health disparities research are currently faced with the challenge of balancing how best to apply a health equity framework to their ongoing work and cultivate the necessary infrastructure to foster a coherent vision toward this goal. Our purpose is to describe our experience at the Center for the Study of Asian American Health (CSAAH) at the New York University (NYU) School of Medicine in evolving our research mission and agenda to reflect a paradigm shift from a focus on disparities to a community action-oriented model of advancing health equity. We further describe the direct and relevant benefits and measureable impacts to the communities we serve.

Transitioning toward a health equity model can be both ambiguous and counter to biomedical perspectives, which often apply a disease-focused paradigm for basic, clinical, and behavioral research. A health disparity generally refers to a disproportionate disease burden in health status or access to care that is experienced by one group compared with another, which stems from an array of factors that include behavioral, environmental, and social determinants.[2] A health inequity refers to systematic health differentials across population groups that are a result of unjust burdens placed on individuals and communities.[3] Concepts related to structural determinants, such as social hierarchies and environmental racism, are often woven into the discussion of health inequities.[4] Drivers of health inequities are predominantly social determinant in nature, and inherently, they are perceived as unjust. By contrast, health disparities do not always imply a moral connotation or sense of injustice.

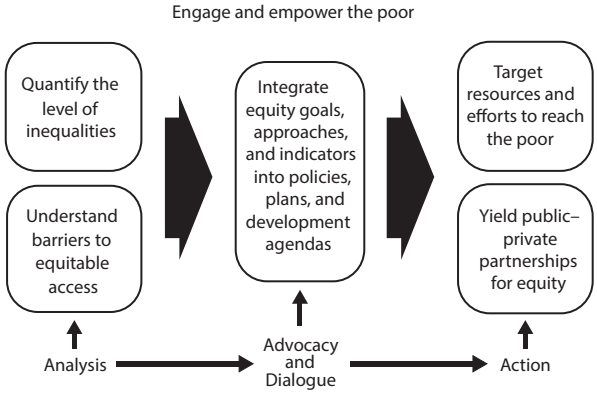
This discourse is related to the recent shift from a health inequities agenda to a health equity agenda, which shifts attention to the highest attainment of health for all.[5,6] A health equity framework calls for alignments in analysis, advocacy, and action—moving beyond the simple identification of health disparities to translating them through meaningful stakeholder engagement in an iterative "policy-to-action process."[7] The US Agency for International Development (USAID) Equity Framework illustrates the trajectory from disparities to inequities to equity (Figure 1)[7] and reflects CSAAH's evolution toward an equity agenda for population health.

NEW YORK UNIVERSITY CENTER FOR THE STUDY OF ASIAN AMERICAN HEALTH

Formerly established in 2003 as a National Institutes of Health (NIH), National Institute on Minority Health & Health Disparities Project Excellence in Partnership Outreach Reach and Training (EXPORT) Center, the primary mission of CSAAH is to address, alleviate, and eliminate Asian American health disparities through a transdisciplinary and community-based participatory research (CBPR) approach. The Project EXPORT funding mechanism formalized a long-standing relationship between the NYU School of Medicine and its community and clinical partners serving the New York City (NYC) Asian American population. Since 2007, with 2 successful renewals as a Comprehensive Center of Excellence,[8] CSAAH has greatly expanded its regional and national community, and academic partner base to include leading national organizations serving the Asian American and the Native Hawaiian and Pacific Islander communities (NHPI) in the United States.

To accomplish our mission and create a formal health disparities research infrastructure, CSAAH began its work by applying a CBPR approach to its overarching strategic and action plans. CBPR is defined as "A collaborative approach to research that equitably involves all partners in the research process and recognizes the unique strengths that each brings."[9] Table 1 describes the key CBPR principles delineated by Israel et al.[10] and the example strategies for each principle. Based on consensus-building discussions with community and academic partners, CSAAH's strategic plan is guided by the following principles:

1. systemic change through the use of multiple strategies and working with diverse stakeholders;
2. equitable "partnerships" in research, training, and outreach;



Source. US Agency for International Development.[7]

FIGURE 1—United States Agency for International Development "EQUITY Framework for Health."

3. action-oriented research;
4. strengthening the research capacity of both community and academic partners to fully engage in the research process; and
5. conducting multicultural evaluation as a means to foster ownership, sustainability, and impact.

These guiding principles are integrated into CSAAH's community engagement, education, dissemination, research, and research training activities. The process is further described elsewhere.[11]

A major challenge for CSAAH, in its role as an academic medical center, was to balance the needs of multiple institutional stakeholders, such as the NIH and the Centers for Disease Control and Prevention (CDC), with those of the community and public health stakeholders, and to ensure sustained community ownership of CSAAH research priorities. It also became clear that CSAAH needed to align its programmatic activities with that of national stakeholders, including grassroots policy and advocacy organizations, who were working to develop a coordinated agenda to advance health equity for all, including Asian American and NHPI populations. In leveraging these ongoing efforts, we formed a partnership with the Asian & Pacific Islander American Health Forum (APIAHF), a leading national grassroots policy and advocacy organization, and with their support, we developed CSAAH's National Advisory Committee for Health Disparities Research, which includes national and local community stakeholders CSAAH, APIAHF, and the National Advisory Committee. These organizations collaborated to develop a series of agenda-setting conferences and activities that actively engaged multiple perspectives to establish a strategic plan for action-oriented research and policy development that represented a multisectoral approach and agenda.

In parallel to national mobilization efforts, local grassroots organizations were also seeking equity in resource allocations to meet the social, and consequently, the health needs of Asian Americans in NYC. In aligning our work with a health equity framework, CSAAH has been an active collaborator in such grassroots efforts. For example, CSAAH is a partner of Project Coalition for Health Access to Reach Greater Equity (CHARGE), which is a health collaborative founded in 2007 by the Coalition for Asian American Children and Families. Project CHARGE is composed of 16 community partners that work together to address

TABLE 1—Community-Based Participatory Research (CBPR) Principles and Strategies, Advancing Health Equities in Asian Americans in New York City

CBPR Principle	Strategy
Collaborative, equitable partnership in all phases of research	Engagement that spans identifying priorities from design to intervention development and implementation to evaluation to dissemination.
Community is the unit of identity	Research is focused on the community.
CBPR builds on strengths and resources of community	Research builds on community assets and moves away from a deficit model.
CBPR fosters co-learning and capacity building	Efforts are incorporated to build the capacity of all partners to engage in research through orientation and training about research methods for community partners, and also training that orients academic researchers to be better partners/listeners to the local knowledge and expertise of community partners in the research endeavor.
Balance between knowledge generation and benefit for community partners	There is a genuine process for identifying at the outset the expectations/goals of the research to be conducted and eliciting the practical benefits for community partners in engaging in this research.
CBPR focuses on problems of local relevance	Communities are engaged in determining the priorities.
CBPR disseminates results to all partners and involves them in wider dissemination of results	Results are disseminated in multiple vehicles and strategies, peer-reviewed articles, newspaper articles, policy briefs, monographs, and community forums.
CBPR involves a long-term process and commitment to sustainability	Sustainability is defined as an ongoing goal to strive toward in the development of research activities.

health access for the 15% and growing population of Asian American and NHPI New Yorkers.[12] Through participation in Project CHARGE initiatives, CSAAH has been able to disseminate our research findings to educate city and state elected officials on the needs of Asian American communities, including data disaggregation, language access, health care access, and targeted health outreach and education. Such education has taken the form of invited testimonies on research findings to the NYC Council, disseminating reports on research findings to policymakers through policy briefs and recommendations, and sharing stories of the impact of community health workers (CHWs) and other community-based initiatives on the lives of Asian American communities. Other efforts have included coordinated strategies to facilitate enrollment into health insurance plans for under- and uninsured Asian Americans and support for policy initiatives that integrate the use of peer facilitators or CHWs to improve the access to care for hard-to-reach populations with or without health insurance. These national and local partnerships and community directed research has expanded the infrastructure of CSAAH and fostered the dissemination of policies that aim to improve health equity for all, including Asian American and NHPI populations. The next section expands on the strategies and themes used by CSAAH in establishing its population health equity agenda.

KEY THEMES AND STRATEGIES FOR A POPULATION HEALTH EQUITY AGENDA

CSAAH has focused on several core themes and identified relevant strategies for establishing a population health equity agenda (Table 2). Table 3 broadly outlines the evolution of our work from a disparities focus to an equity framework.

Apply a Social Determinants of Health Framework

A critical theme for advancing a population health equity agenda is the social determinants of health,[4] a concept that generally focuses on a range of factors or conditions that reflect where we live, work, and play.[14] Social determinants include socioeconomic status, such as income and education, race/ethnicity, as well as factors such as racism, discrimination, social structure, social position, housing, transportation, political environment, cultural beliefs, and norms. The effect of social determinants on health has been estimated to range from 40% to 50%.[14–18] Therefore, health equity agendas recognize the contextual factors that affect risk and protective factors, from individual, family, neighborhood, community, systems, and environmental or institutional levels.

In considering the role of social determinants, a life course perspective has been recommended to better understand how health inequities emerge and persist in communities, by incorporating intergenerational approaches to reach out to communities across the life span and to account for family context. Life course interventions are those that recognize the dynamic context in which risk and cumulative exposures affect health across the life span.[19] For Asian American communities that are predominantly first- and second-generation immigrants, a transnational approach that integrates life course frameworks allows for greater elucidation of the roles of migration, immigration, and acculturative experiences on health and how they differ across generations.[19,20] For example, CSAAH has supported pilot studies to understand the impact of early childhood intervention programs in Chinese and Bangladeshi communities,[21] and has initiated mixed-methods needs assessment initiatives in both youth and older adult populations to better understand contextual factors that affect the health of these communities.

Use a Multisectoral, Health in All Policies, Approach

Health in all policies is defined as a collaborative approach to improving the health of all people by incorporating health considerations into decision-making across health and nonhealth sectors and policy areas.[15]

This strategy implies that a multisectoral stakeholder group is convened that includes representation from the following: local and state health departments, other nonhealth government agencies (e.g., education, criminal justice, housing, transportation), community organizations, faith-based networks, community leaders, and other community-based resources. The health in all policies focus on health in multiple arenas addresses the need to identify shared goals and strategies as well as common measures to assess progress and impact on improving health. For example, through the CDC-funded Racial and Ethnic Approaches to Community Health for Asian Americans initiative, CSAAH has convened a multisectoral coalition to implement evidence-based strategies to promote healthy eating and cardiovascular disease prevention and management in settings such as ethnic businesses, including grocery stores and restaurants, and faith-based organizations.

Incorporate Community Engagement

A CBPR approach that includes bidirectional learning and fosters equitable partnerships is recognized as critical to the development of relevant and sustainable strategies aimed at understanding and addressing health disparities. This approach is a requisite of the National Institute on Minority Health & Health Disparities funded research centers, including EXPORT and Centers of Excellence. CBPR principles are particularly salient in the case of health equities and are congruent with social determinants of health frameworks. CBPR focuses on developing tailored and targeted interventions at the unit of identity (e.g., Korean American immigrants), understanding and integrating community needs and priorities, leveraging community assets in the design and implementation of health interventions, building community capacity and leadership to participate as equal partners in the research process, and yielding research that has practical benefit and relevance to local communities.

Moreover, community-based strategies are key components for fostering sustainable outcomes necessary to achieve health equity. For example, in partnership with the APIAHF, CSAAH developed the innovative CDC-funded Strategies to Reach and Implement the Vision of Health Equity (STRIVE) program. This program distributed $3 million in grant awards, and provided training and technical assistance to 15 community-based organizations (CBOs) that serve Asian Americans and NHPIs. Each STRIVE grantee led the development and implementation of culturally relevant and sustainable, high-impact policy, systems, and environmental-level strategies to improve

TABLE 2—NYU Center for the Study of Asian American Health Strategies for Developing and Implementing a Population Health Equity Agenda Advancing Health Equities in Asian Americans in New York City

Key Themes	CSAAH Strategies and Examples
Social determinants of health	CSAAH's research is based on CBPR principles and the role of social determinants and acculturation that affect the health of Asian American communities, who are primarily first- and second-generation immigrants.
Perform ongoing descriptive/longitudinal research to monitor changes in social factors and population health outcomes[13]	In 2004–2007, CSAAH conducts a first round of CHRNAs in the Cambodian, Chinese, Filipino, Korean, South Asian, and Vietnamese communities in NYC. Currently, a second round of assessments is being implemented in major and emerging subgroups.
A multisectoral (Health in All Policies) approach	CSAAH conducts research, which is guided by multisectoral coalitions grounded in addressing social and health equity to ensure actionable, and policy-oriented outcomes.
Recognize the role of social determinants on social and health equity and incorporates health considerations into decision-making across sectors and policy areas to improve the health of all people[14,15]	CSAAH is committed to advancing the health of Asian American communities beyond the conduction of research and includes activities to raise awareness, to engage in outreach, and advocate for the implementation of strategies and policies.
Community engagement	In 2007, CSAAH recruits and forms an NAC, comprising 20 national partners/experts representing multiple sectors serving Asian American constituencies, to inform and develop research priorities.
Develop community-based ethnic coalitions and pan-ethnic advisory groups by identifying/recruiting health and nonhealth organizations and stakeholders	In 2011–2013, in partnership with the APIAHF, CSAAH co-leads the Strategies to Reach and Implement the Vision of Health Equity (STRIVE) program fostering community-driven initiatives.
Disaggregated data collection	In 2007–2012, CSAAH's National Center of Excellence in the Elimination of Hepatitis B Disparities (B Free CEED) program site is 1 of 28 Racial and Ethnic Approaches to Community Health across the US (REACH US) sites that worked with the CDC to survey an oversample of Asian Americans in NYC between the years 2009–2012.
Bridge information gaps by promoting equitable collection and reporting of data, such as through community health needs assessments to identify underserved population needs and to inform areas of health equity research[16]	In 2013, CSAAH and its community partners work with CDC and Westat to conduct targeted outreach for oversampling of Asian Americans in NYC for National Health and Nutrition Examination Survey data collection. CSAAH continues ongoing partnerships with APIAHF, Project Coalition for Health Access to Reach Greater Equity and other local and national coalitions with activities related to promoting equitable policy efforts informed by culturally competent data.
Asset-based approaches and building human and social capital	CSAAH CHWs help inform and tailor intervention programs to meet specific social, linguistic, and cultural needs and address health inequities among Asian American immigrant communities in NYC.
Integrate CHWs in program design and implementation and develop strategies that build on community assets and resources	In 2003–2013, participants in hypertension management program led by CHWs in Filipino American community demonstrate significant decreases in systolic and diastolic blood pressure, and improvement of hypertension management, heart disease knowledge, exercise, and dietary behaviors (e.g., sodium and fat intake). Implements health promotion and disease prevention strategies in partnership with trusted social service and faith-based organizations to reach underserved communities.
Linkages to access to care	In 2014, Agency for Healthcare Research and Quality designates Project Asian American Partnerships in Research and Empowerment (AsPIRE) Health Innovations Model for CHW research in bridging access to care for vulnerable populations.
Partner with and disseminate information through community-based organizations and social service agencies	In 2013–2014, in partnership with the Coalition for Asian American Children and Families, CSAAH receives a subcontract to train In-Person Assistors/Navigators for the NY State of Health Insurance marketplace, facilitating targeted enrollment—fielded 1000 calls; holds 170 in-person appointments; and enrolls more than 102 consumers in qualified health insurance programs.
Build sustainable shifts through internal structures	Founded in 1973, CSAAH community partner, Korean Community Services of Metropolitan New York, Inc. establishes a Public Health and Research Center to promote access and community education in areas ranging from health advocacy, diabetes prevention, hepatitis B, tobacco control, and women's health.
Strengthen community-based infrastructures through capacity-building activities and support efforts to inform health policy	Founded in 2004, CSAAH leadership serve on board of directors and work closely with the Kalusugan Coalition, Inc., a multidisciplinary collaboration dedicated to improving the health of the Filipino American community in NY/NJ area through network/resource development, educational activities, research, community advocacy. Since 2011, CSAAH leadership has served on various workgroups for the New York State Medicaid Redesign Team to identify community–clinical linkage strategies aimed to reduce health disparities and integrate social determinants of health perspective in improving quality and access to care. Such strategies include Medicaid reimbursement and financing models to support CHWs and peer facilitators employed in community settings and engaged in health promotion and disease prevention activities.

Note. APIAHF = Asian and Pacific Islander American Health Forum; CBPR = community-based participatory research; CDC = Centers for Disease Control and Prevention; CHRNAs = Community Health Resource and Needs Assessments; CHW = community health worker; CSAAH = Center for the Study of Asian American Health; NAC = National Advisory Committee; NYC = New York City; NYU = New York University.

TABLE 3—Evolvement of Research Portfolio at the NYU Center for the Study of Asian American Health From a Health Disparities to a Health Equity Framework: Advancing Health Equities in Asian Americans in New York City, 2003–2017

Years	Research Project	Summary of Implementation Strategies and Outcomes
2005–2013	Asian American Partnerships in Research and Empowerment (AsPIRE) Project	CHW intervention using a CBPR approach in partnership with the Kalusugan Coalition focused on reducing hypertension disparities in Filipino American populations in NYC Agency for Healthcare Research and Quality designated "Health Innovations Model" for CHW research in bridging access to care for vulnerable populations Worked in partnership with the Kalusugan Coalition and the National Heart, Lung, and Blood Institute to refine their CHW curriculum for cardiovascular disease prevention and received a subcontract to train, implement, and evaluate their CHW curriculum in 4 Filipino communities across the country
2007–2017	Diabetes Research Education and Action in Minority Populations (DREAM) Program	CHW intervention using a CBPR approach in partnership with the DREAM Coalition focused on improving diabetes management in the Bangladeshi American community; collaboration of the DREAM Coalition, Bellevue Hospital, Queens Hospital, Morris Heights Community Health Center, Long Island City Health Center and local community providers serving the Bangladeshi American community Obesity and Stress in South Asians (OASIS) Project—A CBPR study in partnership with the DREAM Coalition and its CHWs engage South Asian communities on the relationship between obesity and stress, working in partnership with faith-based and other community organizations
2009–2014	NYU Prevention Research Center (NYU PRC)	Campus-community partnership focused on building community capacity and leadership to address health disparities with a particular focus on evidence-based CHW models to address health disparities in undeserved, multiethnic populations In 2013 awarded the "Best Practice Award for Community-based Participatory Research" from the Centers for Disease Control and Prevention National Community Committee
2009–2014	Reaching Immigrants through Community Empowerment (RICE) Project	RICE Coalition comprising local community organizations serving Asian American immigrant communities in NYC and interested in achieving health equity Target communities include Korean and South Asian populations in NYC, CHWs based at community partner sites (UNITED SIKHS, and Korean Community Services) to improve diabetes and cardiovascular disease prevention using a CBPR approach April 2014—CHWs recognized by the White House Initiative on Asian Americans and Pacific Islanders as "Champions of Change"
2010–2014	Comparative Effectiveness Research (CER) Program	CHW intervention using a community engagement approach focused on reducing hypertension and colorectal cancer disparities in Black men in NYC Working with network of faith-based organizations and barbershops, compared 3 research arms: (1) patient navigator intervention, (2) motivational interviewing, and (3) combined patient navigator with motivational interviewing
2013–2014	Strategies to Reach and Implement the Vision of Health Equity (STRIVE) Project	Funded 15 local Asian American and Native Hawaiian and Pacific Islander (NHPI) community-based organizations (CBOs) across the US and the Pacific to implement tailored evidenced-based and policy, systems, and environmental change strategies on nutrition and physical activity to reach approximately 75% of their local community All 15 CBOs created a multisectoral coalition, conducted a community health needs assessment and policy scan, and developed a community action plan to inform their evidence-based strategy implementation In 13 mo, CBOs reached more than 1.4 million Asian Americans and NHPIs

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access to healthy food and increase physical activity within their local communities; they reached an estimated 1 472 373 people across the United States. Some examples of STRIVE's work in Asian American and NHPI communities include increasing access to farmers markets and culturally relevant, traditional fresh produce, as well as introducing organizational-level policies to increase procurement and provision of healthy foods during communal meals at faith-based organizations.[22]

TABLE 3—*Continued*

2013–2014	Project Asian American eXchange and Information System (AXIS)	Needs assessment led by a community advisory group of 7 leaders to better understand the informational needs of gatekeepers serving Asian American communities with the ultimate goal of improving health literacy, information, and reducing health disparities among Asian American populations Findings analyzed to develop recommendations for the National Library of Medicine's Web portal, to address information gaps and inform opportunities to identify, warehouse, and disseminate health information for Asian American communities
2014–2019	NYU School of Medicine–City University of New York School of Public Health Prevention Research Center (NYU-CUNY PRC)	Public-private partnership focused on integrating evidence-based interventions into community-clinical approaches to reduce cardiovascular disease disparities in NYC, with particular emphasis on ethnically diverse and immigrant communities Project Implementing Million Hearts for Provider and Community Transformation (IMPACT)—tests the influence of integrating CHWs with physician-level intervention models using electronic health record-based tools to improve hypertension among South Asians in NYC East Harlem CHW Initiative, CHW-led placed-based initiative designed to improve hypertension, diabetes, and asthma management among public housing residents in East Harlem
2014–2017	Project Racial and Ethnic Approaches to Community Health for Asian Americans (REACH FAR)	REACH FAR coalition comprising 4 CBOs or community coalitions to implement several key policy, systems, and environmental strategies to address hypertension prevention and management in Asian American communities (Bangladeshi, Filipino, Asian Indian, and Korean) in the NYC/NJ metropolitan area All 4 partners implementing strategies in faith-based organizations to improve nutrition of its members by serving healthier foods during communal meals All 4 partners working with restaurants and grocery stores serving Asian American communities to promote and offer healthy food and menu options to customers The coalition collaborating with the NYC Department of Health to offer health coaching efforts in faith-based organizations to improve high blood pressure management among its Asian American congregants

Note. CBPR = community-based participatory research; CDC = Centers for Disease Control and Prevention; CHW = community health worker; CSAAH = Center for the Study of Asian American Health; NYC = New York City; NYU = New York University.

Invest in Asset-Based Approaches That Build Human and Social Capital

Asset-based approaches build on existing community resources and strengthen community capacity in health promotion and disease prevention. The concepts of community capacity building and sustainability are often interconnected, and as neighborhoods evolve over time, shared goals and health outcomes follow in these transitions through the transfer of knowledge and community assets.[23] Building human and social capital are instrumental strategies for achieving health equity both at the local community, institutional and systems level. At the local level, recognizing the role of CHWs is vital in building both human and social capital, and in creating a culture of health that resonates with socially disadvantaged and underserved communities. CHWs are frontline public health professionals who have a unique understanding of and are trusted members of the community served. CHWs are effective liaisons between underserved communities and health care systems, and have been found to improve access to services and positive health promotion and disease prevention behaviors.[24,25] Other important roles that CHWs play are as community organizers and agents of social change, empowering community members toward efforts aimed at improving overall community wellness and health equity.[26,27]

Several of CSAAH's research studies, supported by the NIH and CDC, have demonstrated the efficacy and effectiveness of a CHW model to improve access to health care, and cardiovascular disease and diabetes-related outcomes for Filipino,[28–30] Bangladeshi,[31–33] Asian Indian,[22] and Korean[34] populations. In addition, studies have elucidated the cultural and social mechanisms through which CHWs affect health outcomes. For instance, in their study of a CHW intervention on diabetes management among Bangladeshi individuals in NYC, Islam et al. found statistically significant increases in reported self-efficacy in accessing health care among study participants. Quantitative results were further supported by qualitative findings that demonstrated specific mechanisms through which CHWs were able to enhance self-efficacy, such as assisting female participants with learning to access public transportation systems so that they were able to attend regular doctor visits without relying on family or friends.[31]

Institutional- and system-level issues include the support and promotion of health care and biomedical research workforce diversity to reflect population diversity.[35] By recognizing the need for greater diversity in the research

leadership and workforce, NIH is making rapid changes to improve the success rate of investigator-initiated, health-related grant submissions among individuals from underrepresented communities. In December 2012, NIH Director Francis Collins announced several major workforce training and mentorship initiatives to accelerate efforts that foster diversity in the biomedical research workforce.[36] These recently launched initiatives have the great potential to transform the diversity of the workforce to reflect population trends in the next decade that will ultimately advance health equity.

In CSAAH's work, we have made concerted efforts to promote the diversity of the health and biomedical research workforce by providing applied research and health promotion internship opportunities to high school, undergraduate, and graduate students. These opportunities include community organizing, advocacy, and social change activities that improve access to care and other social resources that affect health. CSAAH has developed robust training efforts geared toward both students and young professionals,[37] as well as CBOs to advance CBPR efforts in academic, government, and community settings.[38] Furthermore, CSAAH's home base at an academic medical center has strategically aligned investigators and faculty members to inform and build an institutional infrastructure for the dissemination and training of community-engaged approaches in health service delivery and graduate education.

Advocate for Disaggregated Data Collection

Community health needs assessments are tools used to identify underserved population needs and to better inform areas of health equity research and policies for capacity building.[16] The Patient Protection and Affordable Care Act (ACA) presents opportunities and new mandates for hospital organizations, governmental public health agencies, and other stakeholders to accelerate community health progress by conducting community health needs assessments.[16] Hospitals and academic medical centers, in particular, are now being tasked to align population health strategies that exemplify community benefits outside the boundaries of their delivery systems and yield measurable improved health impact on local communities. These community health needs assessments are based in part on existing secondary data collection efforts and input from community organizations and residents. These assessments serve as tools for both dissemination of information to communities and for advocacy.[39]

From 2004 to 2007, in collaboration with CBOs and advocates, CSAAH developed and implemented an exploratory series of Community Health Resource & Needs Assessments (CHRNA) in the Cambodian, Chinese, Filipino, Korean, Asian Indian, Pakistani, Bangladeshi, and Vietnamese communities in NYC. The primary purposes of the assessments were to (1) foster ownership in data collection activities by ensuring that community members were involved at the onset and throughout the project, (2) determine differences and similarities in the experience of health issues and resources across different Asian American ethnic groups, (3) identify asset-based approaches to addressing community priorities, and (4) guide CSAAH's research, community outreach, health education, and training activities.

CSAAH investigators and staff are active in dissemination efforts that highlight the need for granular data collection, reporting, and analysis across Asian subgroups,[40–45] and they have supported national and local partners in related efforts. Building on existing center resources, we worked closely with the CDC to specifically oversample Asian American communities in NYC to gather population-based data. CSAAH's National Center of Excellence in the Elimination of Hepatitis B Disparities program site[46,47] was 1 of the 28 Racial and Ethnic Approaches to Community Health across the US (REACH US) sites that worked with the CDC to survey an oversample of Asian Americans in NYC between 2009 and 2012. REACH US findings were compared with CHRNA data to ensure a comprehensive approach for understanding community priorities in relation to population-based health data. Ultimately, REACH US and CHRNA data provided an important mechanism to support disaggregated data collection and refutation of the model minority myth,[48,49] which are 2 challenges that have historically hindered Asian American health disparities research efforts.

Improve Linkages to Access to Care

Eliminating health disparities has been a major goal for Healthy People 2010 and has continued on with Healthy People 2020 goals. Although access to health care, including insurance access, often falls within clinical domains, it is often considered a social determinant of health.[50] National and statewide policies influence the question of who has basic access to health care, and system-level policies affect both utilization and quality of care, including the nature of patient–provider relationships.

Based on the 2007 California Health Interview Survey, Paek and Lim[51] observed that Asian Americans were less likely to utilize health care services than their White counterparts. In addition, Asian Americans had significantly poorer general health perception than Whites. A similar study using California Health Interview Survey data showed that English proficiency and immigration status had significant effects on access to care.[52] Similarly, other studies have also observed worse access to care outcomes for foreign-born Asian Americans compared with their US-born counterparts.[53]

Improving access to health care for disadvantaged and underserved populations often requires strategies that blur the boundaries between clinical practice and community health promotion. Recent legislative changes around the issues of health care reform, in particular the ACA, have further provided new opportunities for fostering unique community–clinical linkages. With the launch of the New York State of Health insurance marketplace in 2013, CSAAH and 8 additional CBOs partners from Project CHARGE received funding from New York State to serve as in-person assistor or navigator sites.[54] Because of CSAAH's investment in and training of a large cadre of CHWs, we were uniquely positioned to train CHWs as in-person assistors or navigators to provide culturally competent, linguistically appropriate, in-person enrollment assistance to individuals, families, small businesses, and their employees who were applying for health insurance through the marketplace. In turn, CHWs were able to leverage their cultural knowledge and connections to the community to implement health insurance ACA enrollment mandates in culturally and linguistically meaningful ways.

To date, CSAAH in-person assistors or navigators have facilitated targeted enrollment by fielding approximately 1000 calls, holding 200 in-person appointments, and enrolling more than 120 consumers in qualified health insurance programs. In total, during the first year of enrollment in the ACA, through the coalition partnership's 46 navigators who speak 19 Asian Pacific languages overall, the Coalition for Asian American Children and Families and its member organizations have enrolled almost 8000 individuals and families.

Build Sustainability Through Internal Structures

Implementing a health equity research framework requires engaging external stakeholders in addressing and building the sustainability of health interventions beyond the life of a grant. Two key elements are relevant to this process: first is applying a participatory approach to foster ownership of shared goals among community and academic partners; and second is sustainable partnerships and programs that work to co-develop community partners' research capacity and infrastructure.[23] For instance, through a subcontract with UNITED SIKHS, a major community partner serving both the South Asian communities in NYC and nationally, CSAAH investigators invested approximately $198 000 over the course of 5 years to support the implementation and development of a CHW initiative housed within the organization. By enhancing the capacity of the organization to engage in health programming and evaluation efforts, and supporting CHWs who were part of the organization's staff, UNITED SIKHS was subsequently successful in initiating new efforts to address oral health, policy, systems, and environmental strategies to improve access to healthy foods, and access to care in the South Asian community. UNITED SIKHS acquired approximately $1 169 743 in additional funding as either a lead or subcontracted agency. Similarly, of the 15 funded CBO partners of the STRIVE program, 6 have gone on to successfully receive a CDC grant as the lead agency to implement strategies to enhance and strengthen existing policy, systems, and environmental-level strategies to address chronic disease–related risk factors that affect Asian American and NHPI local communities.[55]

In the course of our work to advance health equity, CSAAH has encountered several challenges and lessons learned. Applying a social determinants of health approach requires the need to measure complex cultural phenomenon, including migration history and experience, integrating a life course approach, and measuring concepts, such as acculturation and culture, for which there exists a lack a consensus on scales and measures.[56,57] These measures and indicators are necessary to give context to the unique historical, political, and migration-related narratives experienced within Asian subgroups. CSAAH has worked to address these data gaps and limitations by promoting the use of mixed-methods research approaches. Collecting quantitative and qualitative data has allowed us to triangulate data to capture differences across Asian subgroups, as well as the nuances and depth on some of these complex sociocultural concepts.

The default approach to reporting Asian American health data are to present the data in the aggregate, thus masking any differences across the Asian subgroups and presenting Asian Americans as a monolithic group. In the aggregate, Asian Americans present as the "model minority" that Asian Americans are much healthier in general than any other racial/ethnic minority group.[48,58] Debunking this persistent model minority myth has required continuous attention and monitoring in our work to advance health equity.

Health promotion and prevention research has focused increasingly on sustainable, population-wide, evidence-based approaches. This has been a challenge because of the lack of evidence-based models and approaches for racial/ethnic minority populations, including Asian Americans.[59] We have worked to incorporate community engagement in our research by advocating for a twin approach that integrates both a population-based approach coupled with a targeted approach focused on Asian subpopulations. A twin approach ensures that communities and subpopulations are not being left behind by population-wide efforts that, in some cases, have improved the health of mainstream populations and widened the inequalities gap for those already confronted with a high burden of disease.[60–62]

Finally, operationalizing the health equity framework requires a commitment to capacity-building, education, advocacy, and policy efforts. Thus, we have had to learn to balance the time and effort related to the research and with time-intensive activities of participating in community coalitions and advocacy and agenda-setting work groups.

Conclusions

There have been major milestones and progress made in the framing of the health agenda for Asian Americans and racial and ethnic minorities during the last several decades. Implementing a paradigm shift takes time, and CSAAH's investment in community engagement, advocacy, and integrating health in all policies and social determinants of health approaches created the necessary foundation to support this sustainable change. The strategies and themes identified through our experience may be translatable to other communities and organizations in efforts to advance a population health equity framework across diverse populations. ■

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Contributors

C. Trinh-Shevrin conceptualized and supervised the program and led the writing, identifying the strategies for shifting toward a health equity framework. S. C. Kwon contributed to the conceptual development and writing, and led the program's evolution to a health equity framework. R. Park contributed to the writing, development of tables, and the article's framework. S. K. Nadkarni contributed to the writing. N. S. Islam contributed to the conceptual development and writing, and was substantially involved in the program development.

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Human Participant Protection

Institutional review board approval was not needed, as the study did not present research involving human participants.

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