

Refereed Article:

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The Institute for Community Health: a collaborative organization focused on community health improvement

Abstract:

The Institute for Community Health (ICH) is a collaboration of three Massachusetts health care systems; the Cambridge Health Alliance, the Mount Auburn Hospital of CareGroup, and the Massachusetts General Hospital of Partners HealthCare. It was developed to improve the health of Cambridge, Somerville, and surrounding cities and towns. The vision for ICH was to be a nationally recognized organization dedicated to health status improvement through facilitation and collaborative sponsorship of community-based participatory research (CBPR), assessment, dissemination, and educational activities.

In the early years, board members developed bylaws and hired an executive director. They also conducted several studies to understand the potential and provide direction for the organization. Most importantly, ICH cultivated existing relationships with community partners and developed new relationships with coalitions, community-based organizations, governmental institutions (like the school and health departments) and citizens depending on the issue at hand. Through its work, ICH has catalyzed action, supported and built capacity of community partners, and impacted health indicators. Over the last 7 years, the organization has grown substantially and has dealt with organizational development issues. There were numerous challenges including maintaining partnerships, growth, disseminating results and dealing with the ongoing funding needs. Today, ICH represents one innovative strategy for developing a local public health research institute that has successfully balanced the demands of academics and funders with community partnership. The lessons learned throughout the process and the insight gained can hopefully be helpful to others wishing to accomplish similar goals and sustain like-minded organizations.

Acknowledgement:

We would like to acknowledge all the Board members of ICH and the administrators at the three founding partner hospitals who have been so helpful and supportive throughout the development of the organization. We would also like to acknowledge our numerous community partners without whom this work would not be possible. Lastly, we would like to thank our staff that has worked tirelessly on collaborative processes and public health research.

Introduction

Over the past several decades, funding organizations, researchers and practitioners have paid increasing attention to the role of collaborative approaches in reaching public health goals.⁽¹⁾⁽²⁾⁽³⁾ Too often, research that takes place in academic settings is not relevant to the needs identified by communities.⁽⁴⁾ Recently community-based participatory research (CBPR) methods have been used to engage community members in researching the answers to community health issues. In CBPR “community” is involved in every aspect of the research process from hypothesis generation to analysis and dissemination of results.⁽⁵⁾ Nyden noted that “CBPR has...the goal of involving community members in the research process, improving a community’s own capacity to engage in research, and facilitating social change.”⁽⁶⁾ Although the value of a community-based participatory approach is gaining recognition, many researchers continue to struggle with implementation given the competing demands of their home institutions and local community partners.

This article describes one innovative strategy for developing a local public health research institute. The Institute for Community Health (ICH), a non-profit collaboration funded by three competing health care institutions in Massachusetts, has been able to balance the demands posed by academic institutions and funding organizations while simultaneously developing strong community-based partnerships to improve



community health. This article will discuss the history, the organizational structure, growth, and development of the Institute for Community Health.

Setting the Stage

ICH's philosophical underpinnings date to the mid 1980s. The Cambridge City Manager suggested that the hospitals nurture a community-based coalition to prioritize needs to address the AIDS epidemic. He argued that local institutions and funding agencies would value an organized community voice and likely respond to resource requests. Subsequently, Health of the City (HOC) was founded to expand the focus of the collaboration to general health, broadly defined. HOC received funding from The Pew Charitable Trusts and the Rockefeller Foundation and went on to charter the Healthy Children and Men of Color task forces to identify community health issues and seek solutions. The small staff supervised volunteer Harvard public health and medical students in an effort to address community concerns. Two among many accomplishments included: the funding of a community dental residency program, construction and staffing of a dental clinic; the change in local policy allowing the distribution of condoms and contraception at school clinics.

The shifting alignment of Boston health care organizations in the mid-1990's set the stage for ICH's next developmental phase. In an effort to compete in a changing landscape, hospitals were merging and acquiring physician practices. Two large Harvard Medical School affiliated health care systems were formed: the CareGroup Healthcare System (including The Beth Israel, New England Deaconess, and Mount Auburn Hospitals, among others) and Partners HealthCare (Massachusetts General and Brigham and Women's Hospitals).⁽⁷⁾ In the midst of these changes, the Cambridge Health Alliance (CHA), the only remaining public health care system in Massachusetts, felt a need to identify partners to ensure its survival. CHA chose a unique strategy, affiliating with both CareGroup and Partners rather than choosing a single partner.

In an unprecedented partnership between competitors, the three hospital systems, (later, Mount Auburn Hospital became the primary CareGroup representative), agreed to found the Institute for Community Health, based upon HOC. The goal of this partnership was to establish a public health research institute dedicated to improving the health of the communities they jointly served. As Harvard affiliates, the partners would also have the potential to leverage university resources. Throughout the following years, the three institutions found common ground at the Institute Board of Director's table and maintained their commitment through active participation and financial contributions.



The Institute for Community Health (ICH)

ICH development

The three founding members chose to establish ICH as a 501c3 organization led by an executive director who reported to a Governing Board. However, rather than maintaining complete independence, the collaborators agreed to nest the Institute in one of the hospital systems so that the infrastructure needs and cash flow would be assumed by a larger entity. Since the HOC and the Cambridge Public Health Department were both embedded in CHA, it made sense to house ICH there. Hence, ICH became a wholly owned subsidiary of CHA. This had the following implications:

- CHA was named the principal partner in the bylaws,
- All ICH staff were on the CHA payroll and received CHA benefits,
- ICH dollars rolled up under the CHA audit,
- Dollars contributed to ICH by the other partner organizations could be rolled forward if unspent,
- Should ICH fold, any remaining dollars would be spent on community benefits.

Early on, no member organization was willing to commit resources beyond 3 years. All hoped that external funds would eventually support the organizational infrastructure.

Governance

The ICH Bylaws clarified a number of issues relevant to the governance of the organization including board makeup, structure, and liability. A board of nine members was established, three from each member organization. The organizations would rotate chairmanship every two years. In the first year, several tasks were undertaken; development of an operating budget, a search for an executive director, 501c3 documentation and filing, and election of the first Board chair, the CEO of the Mount Auburn Hospital.

With Board membership limited to contributing institutions, ICH had neither the appearance nor the reality of community input into decision-making. A solution was found through existing community coalitions and boards. The HOC's Healthy Children Task Force and the Cambridge Health Alliance's Joint Public Health Board, which represented important stakeholders in both Cambridge and Somerville, were identified as groups that could provide community input. ICH leadership established regular meetings with both groups to obtain feedback on topics ranging from research policies to issue identification.

In 2001, the Board conducted a national search for an executive director (ED). The new ED's background in public health and community coalition building was an important asset for the growing organization. The ED began by leading a strategic planning process that utilized the "Think Big" report, community health status indicators, and other information about the external opportunities and threats. The resulting



Vision and Mission statements and 3-year plan helped frame the direction for ICH, its foci, growth and development.

Vision and Mission

During the first strategic planning process, the Board refined the mission and vision of the organization and identified critical issues. This work has been reaffirmed unanimously at each subsequent strategic planning process:

Vision: The Institute for Community Health will be a nationally recognized organization dedicated to health status improvement through facilitation and collaborative sponsorship of community-based research, assessment, dissemination, and educational activities.

Mission: ICH will stimulate the creation of innovative programs and health policies through a community-based approach that will promote long-term healthy lifestyles. In order to accomplish this, the ICH will:

- Collaborate with community health partnerships to identify health needs and concerns,
- Conduct community-based participatory health research that links academic institutions to community partners,
- Pursue research and assessment initiatives that link clinical care to public health,
- Provide community education and training by offering community-based learning opportunities for health professionals, students, and community members,
- Evaluate the efficacy of programs and policy to build sustainable models of community health,
- Assist community groups in using health information to effect change and develop action programs,
- Disseminate community-specific assessment and research results to community members and local/national audiences to guide program and policy development.

Core Values include a commitment to:

- Understanding and respecting diverse populations as well as the uniqueness of communities,
- Safeguarding privacy,
- Supporting and building lasting partnerships,
- Improving the health status of communities.

Academia's value in research and students' education often seemed to conflict with the public's interest in public/community health practice. While not strictly academic in nature and independent of a university, ICH staff and board members possessed research skills necessary to conduct projects. Simultaneously,



given the links to academic teaching hospitals and universities, (Harvard, Tufts, and Boston University), ICH was able to leverage partnerships with academics in a variety of content areas. Over the years, the educational component of ICH has attracted hundreds of students who have worked on various community projects and gained important practical experience. The strategic planning process identified additional critical issues: nurturing community relationships; securing continued funding; balancing research and evaluation projects, providing education and training; managing institutional growth and assuring integrity and quality in the conduct of ICH activities. These remain defining issues to this day.

In addition to focusing on process issues and obtaining input from community groups, ICH staff and board members conducted the “Think Big”⁽⁸⁾ survey. This survey sought to identify opportunities in the field of public health for an institution of this nature and get feedback on emerging public health priorities relevant to the communities served. Interviews were conducted with 12 local and national public health leaders. The resulting report supported the vision of ICH and provided excellent information for strategic planning. It also identified emerging issues such as childhood obesity and mental health, both of which also had been identified in meetings with community stakeholders.

The ICH Board also invested in a population based random digit dial survey - the Behavior Risk Factor Surveillance Survey⁽⁹⁾ - to determine health needs of Cambridge and Somerville. The BRFSS questions were drawn from Centers for Disease Control and Prevention (CDC) modules and questions pertinent to specific community issues were added. This survey provided a wealth of data to local non-profits and governmental agencies for future grant proposals and established a baseline of health data for future measurement of progress.

Community partnerships:

ICH was founded with the intent of primarily supporting the communities of Cambridge and Somerville Massachusetts. These target communities are urban, diverse and border Boston. In 2000, the combined population was approximately 170,000.⁽¹⁰⁾ Over 30% of the population were immigrants coming from countries such as Haiti, Brazil, Dominican Republic, India, Ethiopia and Pakistan. In addition, both communities were the homes of prominent universities and large student populations. The Board recognized that the organization’s future vitality would depend upon expanding existing community relationships and building new ones. While partnerships were strong in Cambridge, based on previous HOC efforts, those in Somerville were in their infancy.

Both Cambridge and Somerville have long histories of community activism. Cambridge in particular, has a legacy of progressive politics and an investment in human services. A variety of community coalitions existed in both communities, supported through categorical grants and focused on specific issues: child health, early education, substance abuse prevention, and violence. Two coalitions proved to be



particularly important in this developmental phase – in Cambridge, the Healthy Children Task Force (HCTF), and in Somerville, Somerville Cares About Prevention (SCAP). Both were closely aligned with health and school departments. ICH continued to facilitate and coordinate the HCTF and in Somerville, ICH joined the SCAP steering committee. In addition, ICH staff met with mayors, aldermen, councilors, superintendents, executive directors of community agencies, and health department directors.

Throughout this phase of development, ICH staff committed substantial time getting to know the communities and building trust by lending expertise, often without financial support. For example, in Somerville, ICH staff was very involved with efforts focused on youth substance abuse and suicide. In Cambridge, ICH worked with the schools on obesity prevention. ICH also developed strong relationships with both health departments. These partnerships developed slowly through concerted efforts to be visible at community meetings and events, to meet with opinion leaders, to provide in-kind technical assistance to community partners, and to respond to communications and requests. ICH provided community agencies with vital background information for grant writing, expertise in data collection and analysis, and program evaluation. Most importantly, ICH's community partners saw the Institute as building their capacity to identify and meet the complex needs of the communities they served.

Simultaneously, ICH built relationships with local schools of public health and medicine. Students were offered experiential learning practicums on various projects and supervised by ICH staff.

The first years of the organization were filled with grant writing. In the first year of the strategic plan, ICH along with its community partners brought in 5 grants. ICH as the lead on 2 of these grants, subcontracted over 40% of dollars directly to partners. Community and academic partners brought in 3 grants and subcontracted the evaluation and other components to ICH. An attempt was made to match opportunities identified with community priorities. The priorities identified initially included obesity prevention, child mental health, and substance abuse. Slowly ICH began to experience success. In some cases, the dollars were minimal (less than \$5000). ICH saw these contracts as opportunities to deepen relationships and staff often delivered much more than funds supported. These grants also provided pilot data for larger grants and research opportunities. On average, ICH writes over 20 grants a year in collaboration with community partners.

Participatory methodology

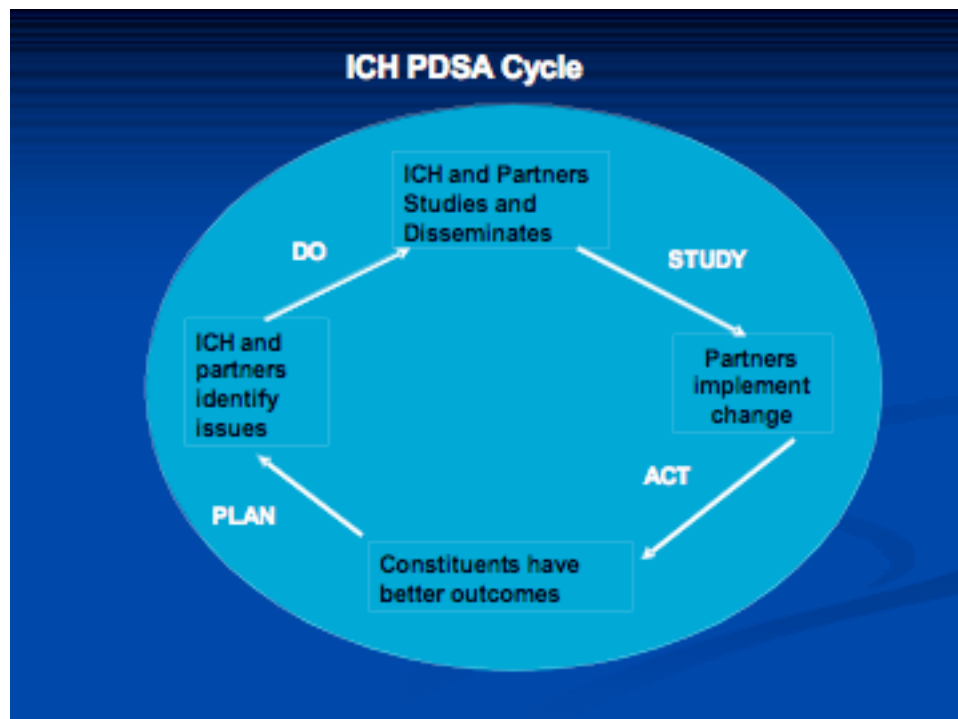
From its inception, ICH adopted the principals of community-based participatory research methodology (CBPR) as the foundation of work. The ICH adheres to these values:

- The community participates as an equal partner at every level of decision-making, including needs assessment, planning, implementation, evaluation and dissemination.



- Policies and programs are based upon mutual respect and justice for all people, free from discrimination or bias.
- Culturally competent approaches
- Research processes and outcomes should benefit the community.
- Productive partnerships between researchers and community members should last beyond the project

Research was not considered an end unto itself; rather, in line with the tenants of CBPR, it was considered a means to inform action. Implementing participatory methodology requires patience and trust. As projects were launched, it meant determining individual project leadership, joint management structures with community partners, and roles and responsibilities. As one community partner said “collaboration is time consuming but worthwhile.” ICH maintained its participatory methodology throughout projects and new staff was trained in CBPR methods, as were community partners. Project partners-school professionals, community organizations, coalition partners, were brought together within days of receiving grant notification. Roles and responsibilities were outlined, the participatory methods were clarified and as needed, memorandums of agreement were written. The manner in which ICH worked with communities was reminiscent of the “Plan Do Study Act (PDSA)” cycle, well known in quality improvement efforts, which analyzes processes and uses data to rapidly improve outcomes.⁽¹¹⁾⁽¹²⁾ ICH acted as a catalyst for the change process: working with partners to identify issues, study the problem, provide the data, and support partners as they implemented change for the betterment of the populations served.



Examples that illustrate this type of work are as follows:

The Cambridge Healthy Children Task Force identified health priorities that included obesity. The task force agreed to facilitate annual data collection to assess the scope and track the evolution of the obesity problem. ICH trained physical education teachers and school nurses to weigh and measure school children. The school department entrusted ICH with the data, now spanning 9 years, both to communicate to school personnel, city leaders and individual parents, and to leverage academic partnerships that have resulted in scholarly papers.⁽¹³⁾⁽¹⁴⁾ These data have prompted the city to focus on obesity prevention, promoting healthy food choices, physical activity, and discouraging TV watching. The Cambridge city council and Public Schools, have adopted a 5-2-1 strategy (at least 5 fruits and vegetables; no more than 2 hours of recreational screen time; and at least 1 hour of physical activity daily). ICH and its HCTF partners have secured almost \$2 million in grant funding to support these efforts. Additionally, ICH partnered with researchers at Children's Hospital Boston, Forsyth Dental Institute, Harvard School of Public Health, and Tufts School of Nutrition to bring scholarship to the cities' approaches, studying the relationship between access to open space and obesity; the effectiveness of providing parents with their children's Body Mass Index (BMI);⁽¹⁵⁾ the relationship of academic achievement and student fitness; report cards; and a randomized trial of substitutes for sugar sweetened beverages on BMI.⁽¹⁶⁾ During this period, the proportion of Cambridge overweight school children has declined significantly.

In Somerville MA, a series of youth suicides and overdoses occurred from 2001-2005. A community coalition, Somerville Cares About Prevention (SCAP), led the community response to the crisis in keeping with CDC recommendations on suicide contagion.⁽¹⁷⁾ ICH worked closely with the mayor's office and SCAP to monitor the data on suicides, suicide attempts and overdoses activity. This data was mapped using GIS⁽¹⁸⁾ software and presented to a workgroup. Analysis led the community to undertake new activities targeted at particular at-risk populations including: prevention strategies, media relationships, a trauma response network, and educational efforts. This critical data helped identify the contagion and those at highest risk. By 2005, the number of suicides and overdoses had decreased and the last death took place by the summer of 2005. To date, the community continues to be mobilized around suicide prevention and is now focused on continuing efforts with other at-risk populations. In addition, ICH collaborated with the Somerville Health Department and other agencies to bring in grant dollars for substance abuse prevention efforts.

Where we are today

Over the last 7 years, ICH has grown substantially. From 2002-2007, revenue has almost quadrupled from approximately \$600,000 to over \$1,600,000. Today there are 20 active projects going on. ICH in collaboration with community partners has been recognized with several awards: the 2007 US



Department of Health and Human service Innovations in Prevention award (obesity prevention) and The 2007 Massachusetts suicide prevention award.

A subsequent strategic planning process included a “360 degree” evaluation that obtained feedback from community partners on ICH performance. There are there are 5 senior staff coming from various disciplines including medicine, nutrition, epidemiology, anthropology, and public health. We have encouraged a multi-disciplinary approach to problem solving and a team approach to project management. The Board has been expanded to include 3 at-large members representing other stakeholders. There is a community coordinating committee of the Board representing local health departments, community members, and hospital community benefits. ICH is a vibrant organization of over 30 individuals committed to improving community health through CBPR, education and capacity building.

Lessons Learned

First, over the last seven years, the three original partner hospitals have all remained engaged as both contributors and Board members. Why? ICH has served as a neutral meeting place, a safe avenue for collaborative work between competitive entities. It has inspired our Board members to actively participate as ICH has grown financially and programmatically. In addition, ICH’s work, while research focused, clearly provides “community benefits.” The Hospital Community Benefits departments are able to claim this quid pro quo to justify their non-profit status.

Second, we cannot overstate the importance of nurturing relationships with community partners. This goes well beyond working on a specific project. ICH is itself a partnering community agency and therefore, responds when needed regardless of financial support. Members of ICH participate in coalitions and work with health departments to provide technical assistance and surveillance reports. Turnaround is quick and community partners see ICH as trustworthy and capable. Several themes emerged in the community’s “360 degree” evaluation of ICH. Partners appreciated ICH’s responsiveness to their requests, staff skills, and collaborative nature. They also noted ICH’s flexibility, and ability to “be there when needed”. This has translated into increased capacity for partner coalitions and organizations in the form of greater knowledge of data, new systems, more grants written and received, and ultimately changes in population health. It also provides the fuel to grow ICH. ICH is often included as the evaluator on numerous grants. Some organizations have contracted for training, data assistance, and surveys. ICH’s niche as a local research partner has been a competitive edge.

ICH also owes much of its success to its relationships with both the clinical environment and local public health. These partnerships have proven critical for linking prevention and intervention efforts. Board members, many of whom are chiefs of clinical departments, have been instrumental in making this



continuum a reality given their leadership roles in their respective institutions. Health Department directors have relied on ICH for basic public health assessment functions. ICH has provided doctorate level epidemiologic and analytic support in Cambridge and Somerville given that neither department was large enough to support this type of personnel.

Third, a growing start-up institution needs careful organizational development. ICH has 30 people and a budget of over 1.8 million. Over 60% of the support is from external funds. We have redesigned the management structure to maintain high community responsiveness and visibility while completing work. We have organized ourselves as a multidisciplinary team with a diversity of skills. This strategy has been helpful in providing technical assistance to community partners. Culture is also important. As an organization steeped in participatory methodology, our own work culture encourages broad participation but respects a leadership hierarchy for clarity. Finally, internal and external communication is key and only gets harder with growth. We have developed several strategies for addressing this and continue to refine them as we move forward.

ICH's focus on education for post-graduate students as well as baccalaureate students has helped build strong relationships with neighboring university faculty and administration. Students have not only learned about CBPR methods, evaluative methods, and community organizing, several have become ICH staff members. The importance of an active educational program cannot be underestimated for training the future workforce.

Finally, ICH has worked hard to assure the highest integrity in the conduct of its work. We are transparent about our principles of confidentiality, data ownership, institutional review and authorship. Fortunately, we have avoided the kinds of mishaps that could inflame a community and discredit a partnership for years to come.

Challenges

ICH is not without its challenges.

Relationships: The challenges in maintaining relationships cannot be underestimated. Both the Board and the community partners require vigilance. A subtle miscommunication can create a flurry of problems that need to be addressed. In addition, collaboration is dependent on sharing power and credit. Each time ICH has received a grant or award or any press coverage, community partners have been engaged. But there are always the potential to overlook participating parties. Putting together a press release for a project means working with all partners and bringing them to consensus in a short time frame. While ICH is improving in its ability to do this, it remains challenging. Most recently, ICH released a press release on improvements in obesity in Cambridge, which included at least six partners.



Managing organizational growth: In the last year, ICH almost doubled its size (staff and revenue) as new grants were received. ICH started small and intimate; communication between staff members was simple and ever present. As the organization has grown, it required new job descriptions, new relationship of senior staff to junior staff and junior staff to projects and community partners. ICH engaged an organizational consultant who was instrumental in improving the managerial capacity. One year later, senior staff has improved their own skills, and a new structure including a mid-level managerial group has been adopted. The experience of change was difficult and many of the original staff left the organization during this time.

Funding: ICH board members have continued to contribute unencumbered dollars to the organization. These dollars have supported much of the relationship building activities including staff time for collaborative work and technical assistance. Without these dollars, the mission of the organization would be at risk. Keeping these organizations at the table while simultaneously diversifying fund sources that is necessary for survival.

Dissemination: ICH, like all leaders in participatory research, has been challenged to translate results into general lessons. Due to the history of activism in each of the communities as well as the relatively short-term nature of most funding streams, it is difficult to quantify/measure our impact regarding community health improvement. Given that much of the ICH work is deeply embedded in community activities, there is rarely a comparison group for large system wide improvement. While positive changes have been observed in community health indicators (overweight, suicidal ideation); we are unable to directly link ICH's efforts to these outcomes.

We must also balance our commitment to be responsive to community needs with our desire to conduct research and disseminate findings in peer review journals to broader audiences. Current resource limitations require prioritizing the community.

The Future

ICH is entering a new period in its development as an organization. There is an abundance of research going on in our target communities and researchers from other institutions are now interested in CBPR. This raises questions of our partners' capacity to take on new projects. We are worried that the populace may become saturated. That said, in order to compete successfully for external funds, ICH may need to expand its target area. The Board is wrestling with this key question: How big should ICH become? What would be the impact of growth on community relationships? Should we expand outside the traditional catchment areas of any of the collaborating institutions?



Another question that the organization is grappling with is how to remain a multi-disciplinary team without falling into content silos- that is how do we maintain generalism versus specialization? We have currently developed a cross content project management strategy but we will be challenged to maintain this strategy, as we grow farther apart. Communication modes must be thoroughly considered to ensure the flow of information.

Scope of work: ICH has the potential to play a community engagement role for Harvard's clinical translational research effort. This opportunity could upset the current balance, while opening new opportunities for both community and academe. It is an exciting next phase for ICH and we will embark on a participatory planning process to determine our metrics for success.

Recommendations for Others

Academic-community partnerships have the potential to generate critical research that could generate practicable lessons. Organizations like the Institute for Community Health are in a unique position to fulfill this agenda. Although ICH structure and function reflects the particularities of its own environment, the factors that led to its creation and ongoing existence may prove helpful to others with similar goals. Perhaps the most important element of our experience is the local nature of our work. ICH has successfully enmeshed itself in the very fabric of the communities it serves. ICH is the result of collaboration at many levels: between hospital systems, academia, community agencies and ICH staff, and between and among ICH staff. These local experiences have allowed deep and broad partnerships to evolve, providing the fundamental elements necessary for future activities. While these relationships are robust, they continue to demand ongoing attention given their vulnerability to political shifts. Therefore, we encourage others interested in this type of investigation to recognize the pivotal nature of these partnerships.

We also urge others to think strategically vis-à-vis the role of a "research/evaluation" institute in community health change. We have found the benefits of these skills in health care improvement to be substantial. Several key themes have emerged from the Institute's story.

•The power of relationships

These must be built, maintained and enhanced, as they are the foundation for this type of work. Any organization planning to do this type of work must determine how to resource collaborative activities. Being present at the birth of ideas and identification of problems, through the decision making process, translates to engagement and partnership through the research phase.



•People

The ICH staff is multidisciplinary, responsive, and flexible. These traits make them resources within the community. They must be able to work outside of their comfort zones. Employing generalists who also have specific expertise has worked well.

•Board support

The ICH Board has been a critical support both financially and technically. Having a group that is vested in the organizations success and committed to leveraging intellectual resources and funds over years has made all the difference.

•Managing Growth

As ICH grows, we must be attentive to the risk of dilution. We must determine how best to continue to meet the needs of our primary communities while supporting the organization with new and potentially expanding work somewhat farther a field.

Why is this important?

The essence of CBPR is community engagement. This participatory approach to the health of the public should translate to sustainable programming, empowered populations, and positive change.⁽⁵⁾ If we are to push the boundaries of community engagement and garner the involvement of constituents in planning research or implementing evidence-based practices, all organizations that provide valuable expertise are welcome additions. The experience we have had to date with ICH has given us hope that academia and community can synergize in a manner that will lead to sustained health improvement.

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