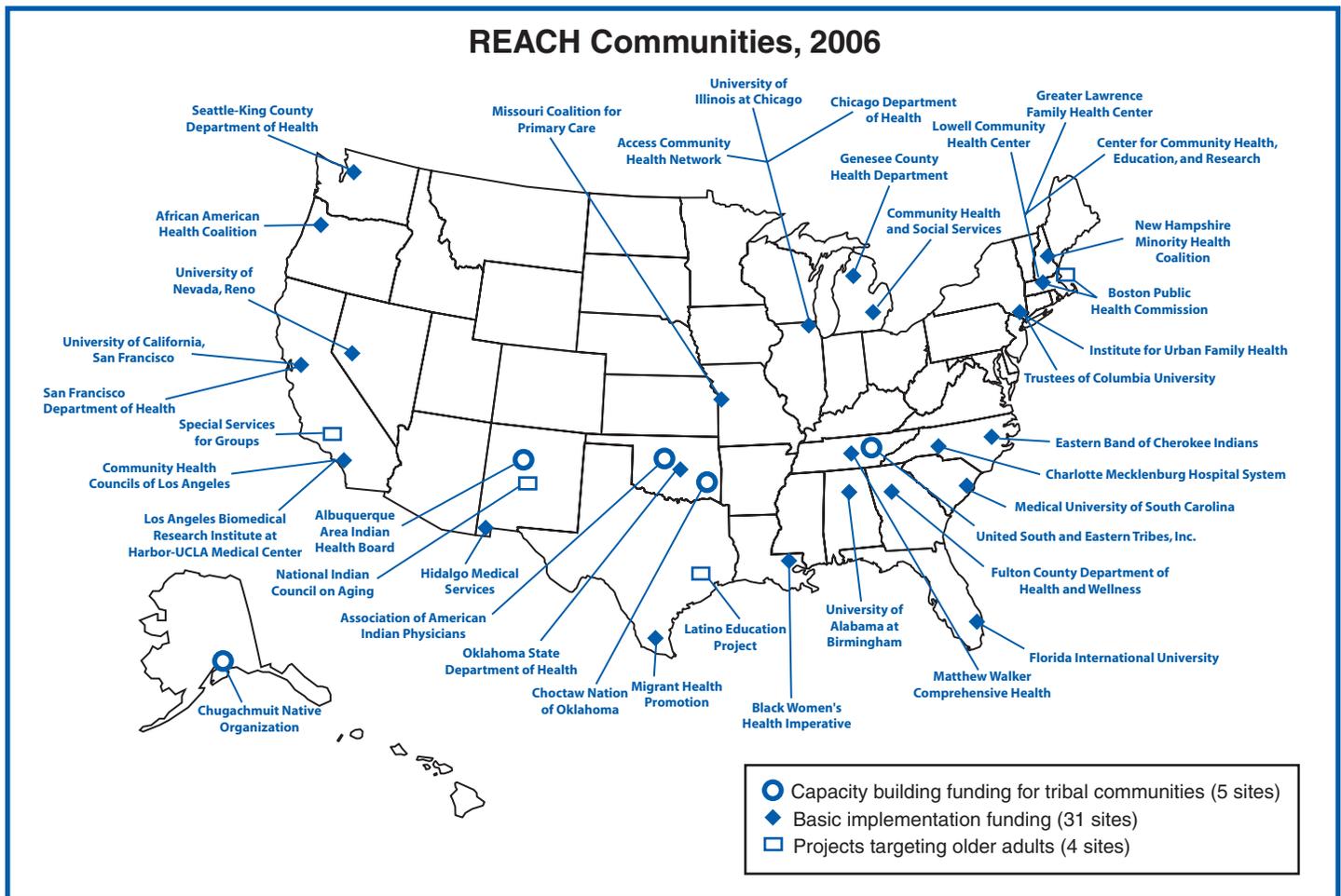


Racial and Ethnic Approaches to Community Health (REACH) U.S.

Finding Solutions to Health Disparities

2007



“The greatness about REACH is that we have trained and empowered everyday people in the community. These are folks who are going to sustain it long after we leave, and these are the true champions of REACH.”

*Larry Johnson, MPH
Program Manager, REACH for Wellness, Fulton County, Georgia*

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The Facts on Racial and Ethnic Disparities in Health

Despite great improvements in the overall health of the nation, health disparities remain widespread among members of racial and ethnic minority populations. Members of these groups are more likely than whites to have poor health and to die prematurely, as the following examples illustrate.

- **African Americans.** Although the nation's infant death rate has decreased, the rate for African Americans is almost double the national rate. Heart disease death rates are 30% higher for African Americans than for whites, and stroke death rates are 41% higher. Black women have a higher death rate from breast cancer than white women, despite having nearly identical mammography screening rates. Diabetes remains nearly twice as high among non-Hispanic blacks compared with whites. Although pneumonia and annual flu vaccinations are covered by Medicare, only 39% of non-Hispanic black adults aged 65 years or older are likely to receive either shot, compared with 63% of whites; only 40% receive the pneumonia shot, compared with 61% of whites. African Americans have the highest HIV/AIDS diagnosis rate of all racial and ethnic groups and account for 50% of all HIV/AIDS cases.
- **American Indians and Alaska Natives.** The infant death rate for American Indians is almost double the rate for whites. Diabetes rates are 2.5 times higher among American

Indians and more than twice as high among Alaska Natives compared with whites. American Indians and Alaska Natives also have the third highest rate of HIV/AIDS diagnoses.

- **Asian Americans.** Vietnamese American women have a higher cervical cancer incidence rate than any ethnic group in the United States—five times that of non-Hispanic white women. Asians in California are 1.5 times more likely than whites to receive a diagnosis of type 2 diabetes.
- **Hispanics/Latinos.** Only 18% of Hispanics with high blood pressure have this condition under control, compared with 30% of whites. Type 2 diabetes is being diagnosed more often in Hispanic children and adolescents than in the past. Only 42% of Hispanics aged 65 years or older receive a pneumonia or annual flu shot, compared with 63% of whites. Only 28% receive the pneumonia shot, compared with 61% of whites. Hispanics have the second highest rate of HIV/AIDS diagnoses and account for 18% of all HIV/AIDS cases.
- **Pacific Islanders.** Pacific Islanders are more than twice as likely as whites to receive a diagnosis of diabetes. Although the estimated HIV/AIDS rate among Pacific Islanders is the lowest in the United States compared with all other racial and ethnic groups, the rate increased an average of 9% each year during 2001–2004.

Health Disparities Can Be Overcome

For years, public health officials, program managers, and policy makers in the United States have been frustrated by the seemingly intractable problem of health disparities. Officials at all levels have been at a loss for solutions. In response, CDC created REACH U.S. (formerly REACH 2010), a program that is demonstrating that health disparities can be reduced and the health status of groups traditionally most affected by health inequities can be improved. REACH U.S. supports CDC's strategic goals by addressing health disparities in the critical life stages of infancy, childhood, adolescence, adulthood, and old age. The program also has developed innovative approaches to dealing with racial and ethnic groups, and these approaches are improving people's health in our communities, health care settings, schools, and work sites.

CDC's Leadership Role

REACH U.S. supports community coalitions that design, implement, and evaluate community-driven strategies to eliminate health disparities in key health areas, such as heart disease, diabetes, breast and cervical cancer, immunizations, infant mortality, and HIV/AIDS. In fiscal year 2007, Congress allocated \$34.1 million to support the REACH program.

CDC provides training, technical assistance, and support to REACH communities to help them understand social determinants of health and their relationship to health disparities. CDC also helps communities develop, implement, and sustain effective interventions; evaluate their programs; and disseminate strategies that work.

As a result, REACH communities are

- Empowering community members to seek better health.
- Bridging gaps between the health care system and the community by encouraging residents to seek appropriate care and by changing local health care practices.
- Changing local social and physical environments to overcome barriers to good health.
- Mobilizing to implement evidence-based public health programs that fit their unique social, political, economic, and cultural circumstances.
- Moving beyond interventions that address individual behavior to the systematic study of community and systems change.

Data Show REACH is Working

Data from the REACH Risk Factor Survey show that the REACH U.S. program is helping people to significantly reduce their health risks and manage their chronic diseases. This survey assesses improvements in health-related behaviors and reductions in health disparities within the 27 REACH communities that focus on breast and cervical cancer prevention, cardiovascular health, and diabetes management. Survey results include the following:

- In 2001, the proportion of African Americans in REACH communities who were screened for cholesterol was below the national average. By 2004, this percentage exceeded the national level (see figure).
- Since 2001, the sizable gap in cholesterol screening rates between Hispanics in REACH communities and the national average has been shrinking.
- The proportion of American Indians in REACH communities who are taking medication for high blood pressure increased from 67% in 2001 to 74% in 2004 (see figure).
- The rate of cigarette smoking among Asian American men in REACH communities decreased from 35% in 2001 to 24% in 2004.

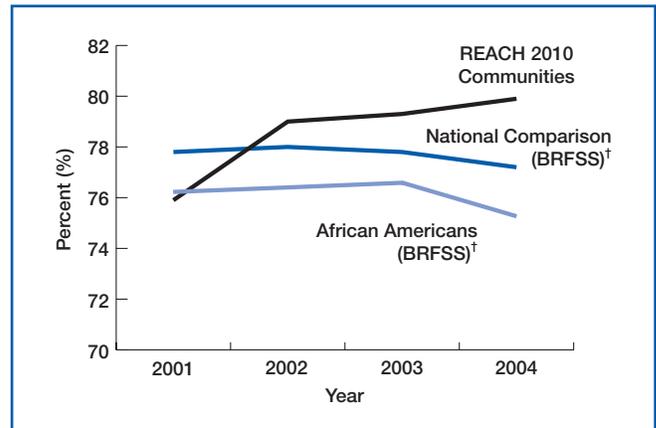
The Keys to Success

REACH U.S. has identified the following key principles and supporting activities that can be used to “unlock” the unique causes of health disparities in racial and ethnic minority communities across the United States.

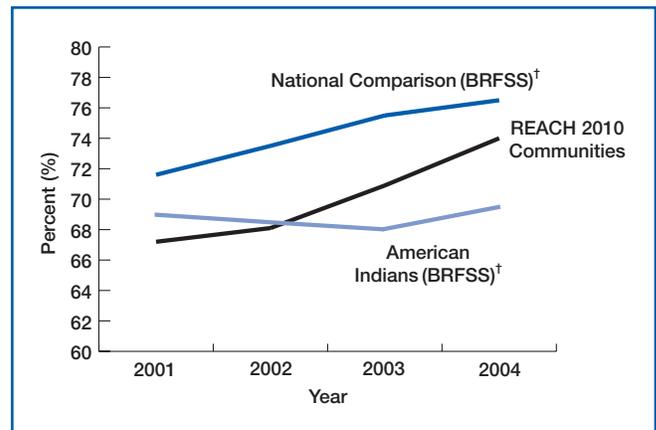
- **Trust.** Building a culture of collaboration with communities that is based in trust.
- **Empowerment.** Giving individuals and communities the knowledge and tools they need to create change by seeking and demanding better health and building on local resources.
- **Culture and History.** Designing health initiatives that acknowledge and are based in the unique historical and cultural context of racial and ethnic minority communities in the United States.
- **Focus.** Assessing and focusing on the underlying causes of poor community health and implementing solutions that are designed to remain embedded in the community’s infrastructure.
- **Community Investment and Expertise.** Recognizing and investing in local community expertise and working to motivate communities to mobilize and organize existing resources.
- **Trusted Organizations.** Embracing and enlisting organizations within the community that are valued by community members, including groups whose primary mission is not related to health.

REACH Risk Factor Survey*

African Americans Who Have Had Their Cholesterol Checked



American Indians on Medication for High Blood Pressure



* Data are from REACH communities with cardiovascular disease and diabetes projects.

† National comparison data from the Behavioral Risk Factor Surveillance System (BRFSS) include all racial and ethnic groups.

- **Community Leaders.** Helping community leaders and key organizations be catalysts for change in their communities.
- **Ownership.** Developing a collective outlook that promotes shared interest in a healthy future through widespread community engagement and leadership.
- **Sustainability.** Making changes to organizations, community environments, and policies that will help to ensure that health improvements are long-lasting and community activities and programs are self-sustaining.
- **Hope.** Fostering optimism, pride, and a promising vision for a healthier future.

REACH Communities in Action

South Carolina: Dramatic Improvements in Diabetes Outcomes for African Americans

The REACH 2010: Charleston and Georgetown Diabetes Coalition focuses on diabetes care and control for more than 12,000 African Americans with diabetes. As a result of the coalition's work, a 21% gap in annual blood sugar testing between African Americans and whites has been virtually eliminated. In addition, more African Americans in the target area are getting the recommended annual tests to monitor their cholesterol levels and kidney function and being referred for eye exams and blood pressure checkups. Lower-extremity amputations among African Americans with diabetes also have decreased sharply. For example, in Charleston County, the percentage of amputations decreased by almost 36%, from 31% in 1999 to less than 20% in 2002. In Georgetown County, the percentage decreased from 44% in 1999 to 24% in 2002.

California: REACHing out to Vietnamese American Women to Promote Cervical Cancer Screening

The Vietnamese REACH for Health Initiative Coalition works to prevent cervical cancer among Vietnamese American women in Santa Clara County, California. Numerous activities have been implemented to improve screening rates among Vietnamese American women in this community, including a lay health worker outreach program, continuing medical education for physicians, and a media education campaign. The coalition also set up a low-cost clinic for Pap test screening that employs a female Vietnamese American physician and staff who speak Vietnamese. As a result of this program, 47.7% of Vietnamese American women in Santa Clara County who had never had a Pap test received one after meeting with a lay health worker. The overall percentage who received Pap tests increased by 15% during 2000–2004.

New York: The Start Right Coalition Works to Improve Immunization Rates

The Northern Manhattan Start Right Coalition is a community program that works to increase childhood immunization rates for children younger than age 5 years in the Harlem and Washington Heights areas of New York City. Children aged 19–35 months who were enrolled in the program had immunization rates 10% below the national average in 2002. In 2003, the same age group surpassed the national average for all racial and ethnic groups by 13% and was nearly 10% above the New York City average.

For profiles of all REACH communities, visit the REACH U.S. Web site at www.cdc.gov/reach

Massachusetts: Empowering Latinos Makes a Difference in Diabetes Care and Control

The REACH 2010 Latino Health Project developed culturally tailored interventions to reduce the diabetes burden in the Latino community. As a result, participants showed dramatic improvements in control of high blood sugar and high blood pressure, which are risk factors for diabetes-related complications. During 2001–2003, blood sugar measures below 7.0 improved by 8.7% (from 20.7% to 22.5%), systolic blood pressure below 130 mm Hg improved by 17.5% (from 53.6% to 63%), and diastolic blood pressure below 80 mm Hg improved by 14.4% (from 69.6% to 79.6%). In addition, the proportion of participants who were referred for eye exams improved 26.5%, from 51% in 2001 to 64% in 2003.

Future Directions

REACH communities are demonstrating every day that health disparities among racial and ethnic minority groups can be reduced. In addition, the success of the REACH U.S. program has been featured in numerous publications, including special issues of the following journals: *Preventing Chronic Disease* (2006;3[3]), *The Journal of Health Care for the Poor and Underserved* (2006;17[2]), *Health Promotion Practice* (2006;7[suppl 1]), and *Ethnicity and Disease* (2004;14[3] [suppl 1]).

CDC and REACH communities know enough now to urge the spread of effective strategies nationwide, and CDC will increase its efforts in this area. By sharing these strategies and the lessons learned in REACH communities, CDC will give more communities and public health programs across the country the tools they need to eliminate health disparities among minority populations.

CDC and REACH communities also will continue to work together to analyze local data and evaluate program strategies. In 2007, the REACH U.S. program will begin a new 5-year cycle of community funding, with an increased emphasis on disseminating effective strategies.

**For more information, please contact the Centers for Disease Control and Prevention
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