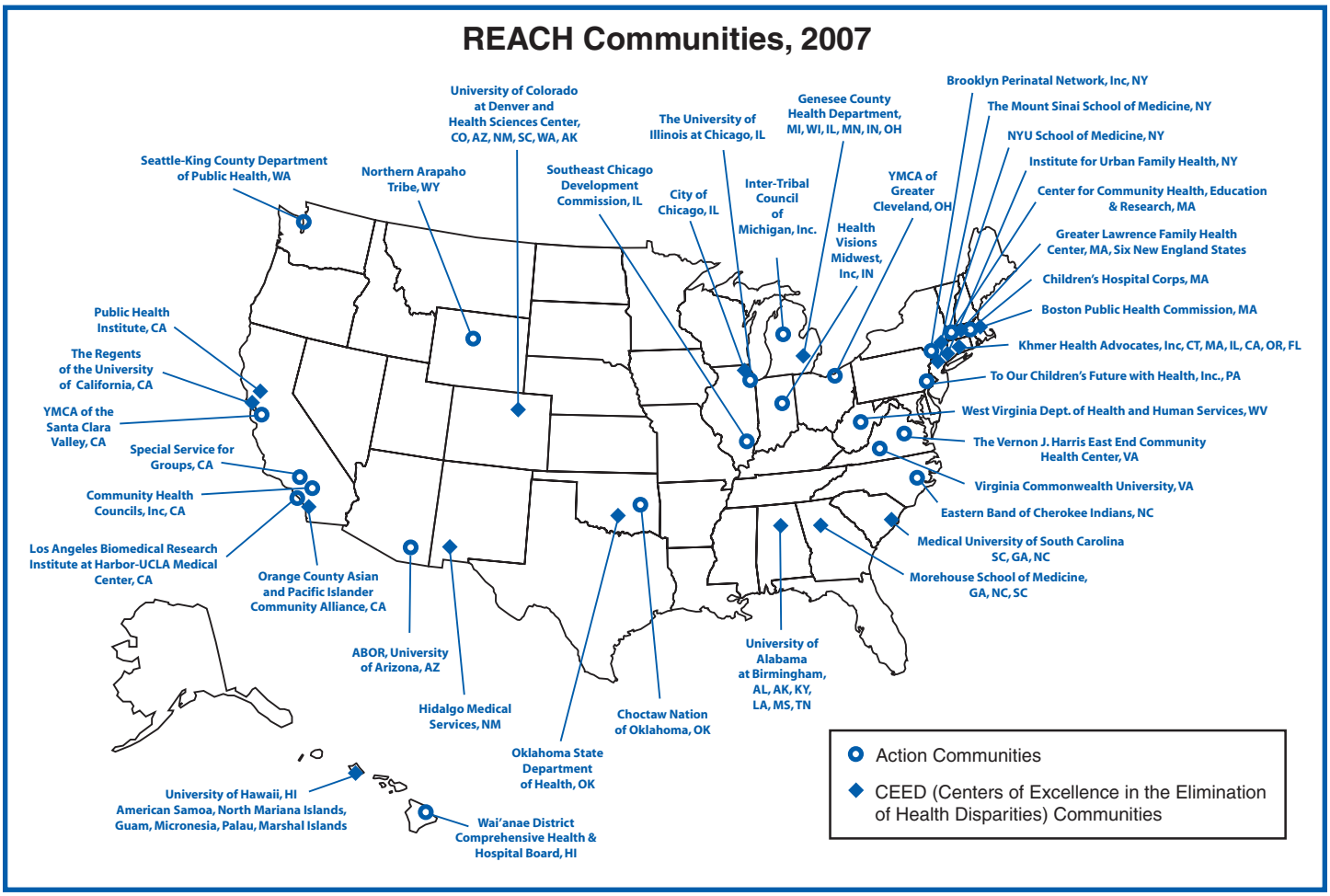
AT A GLANCE

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

Finding Solutions to Health Disparities 2008



"Eliminating racial and ethnic health disparities is a national imperative. By sharing the innovative strategies and interventions being built by the REACH communities, we can accelerate our progress in eliminating disparities and achieve the best possible health for all."

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Director, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
COORDINATING CENTER FOR HEALTH PROMOTION

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 African Americans represent only 12.7% of the U.S. population, they account for 26% of all asthma deaths. African Americans are nearly twice as likely to have diabetes as non-Hispanic whites. 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. 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.
- **American Indians and Alaska Natives.** The infant death rate for American Indians is almost double the rate for whites. Rates of sudden infant death syndrome are twice as high among American Indians/Alaska Natives as rates among the general U.S. population. Diabetes rates are 2.5 times higher among American Indians and more than twice as high among Alaska Natives compared with whites. American Indian women are nearly twice as likely to die of cervical cancer than white women. American Indian/Alaska Native adults are 60% more likely to have a stroke than whites.
- **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. As many as 1 in 10 Asian Americans has chronic hepatitis B. The rate of hepatitis B among Asian Americans is more than twice the rate among whites.
- **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. Hispanic women are more than twice as likely as non-Hispanic white women to have a diagnosis of cervical cancer.
- **Native Hawaiians/Pacific Islanders.** Pacific Islanders are more than twice as likely as whites to receive a diagnosis of diabetes. Infant mortality among Native Hawaiians is nearly 60% higher than rates among whites. Although hepatitis B is decreasing among Pacific Islanders, the rate is more than twice as high as the rate for whites. In 2000, the asthma rate for Native Hawaiians was nearly 140 in 1,000 persons.

Health Disparities Can Be Overcome

For years, public health officials, program managers, and policy makers have been frustrated by the seemingly intractable problem of health disparities and have been at a loss for solutions. In response, CDC created REACH, a program that continues to demonstrate that health disparities can be reduced and the health status of groups most affected by health inequities can be improved. REACH supports CDC's strategic goals by addressing health disparities throughout infancy, childhood, adolescence, adulthood, and older adulthood. This program has developed innovative approaches that focus on racial and ethnic groups, and these approaches are improving people's health in our communities, health care settings, schools, and work sites.

REACH U.S. Competition

In 2007, CDC held an open competition for the next funding phase of the REACH program, which will build on the successes of the initial phase. Forty REACH U.S. communities were funded: 18 Centers of Excellence in the Elimination of Health Disparities (CEEDs) and 22 Action Communities. CEEDs have expertise working with specific racial and ethnic groups, and they will be able to widely disseminate effective strategies and train new community partners. The Action Communities will implement and evaluate successful practice-based or evidence-based approaches and programs to impact population groups rather than individuals.

Effective strategies will be applied through innovative and nontraditional partnerships at the community level. CEEDs and Action Communities target one or more racial and ethnic groups, including African American, American Indian/Alaska Native, Asian American, Native Hawaiian/Pacific Islander, and Hispanic/Latino. Health focus areas include breast and cervical cancer, cardiovascular disease, diabetes, asthma, adult/older adult immunizations, infant mortality, hepatitis B, and tuberculosis.

CDC's Leadership Role

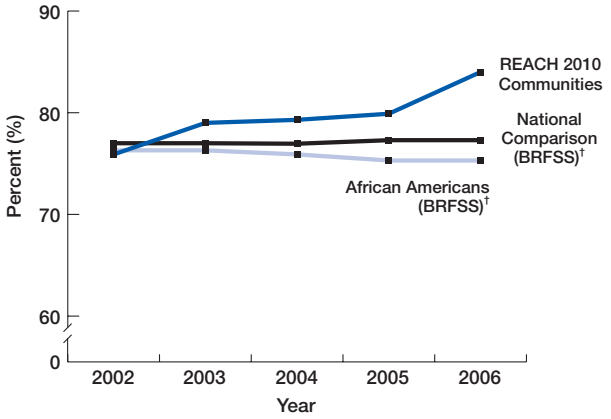
REACH U.S. supports community coalitions that design, implement, evaluate and disseminate community-driven strategies to eliminate health disparities in key health areas. In fiscal year 2008, Congress allocated $34 million to support the REACH program. CDC provides training, technical assistance, and support to REACH communities to help them understand social determinants of health and their relationship to health disparities. As a result, REACH communities empower community members to seek better health; serve as catalysts for change to local health care practices; and mobilize communities to implement evidence-based public health programs that address their unique social, historical, economic, and cultural circumstances.

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 2002, the proportion of African Americans in REACH communities who were screened for cholesterol was below the national average. By 2006, this percentage exceeded the national level (see figure).
- Since 2002, the cholesterol screening rate for Hispanics in REACH communities has surpassed the national rates for Hispanics.
- 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, surpassing the national rate for this population.
- The rate of cigarette smoking among Asian American men in REACH communities decreased from 42% in 2002 to 20% in 2006, dipping below the national average for the overall U.S. population.

African Americans Who Have Had Their Cholesterol Checked*



* 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.

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 on trust.
- **Empowerment.** Giving individuals and communities the knowledge and tools needed 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 on Causes.** Assessing and focusing on the underlying causes of poor community health and implementing solutions designed to stay embedded in the community 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 valued by community members, including groups with a primary mission unrelated to health.
- **Community Leaders.** Helping community leaders and key organizations to act as catalysts for change in the community, including forging unique partnerships.
- **Ownership.** Developing a collective outlook to promote shared interest in a healthy future through widespread community engagement and leadership.
- **Sustainability.** Making changes to organizations, community environments, and policies to help 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.

Alabama: Bridging the Gap in Breast and Cervical Cancer Screenings for African Americans

The Breast and Cervical Cancer Coalition at the University of Alabama at Birmingham works to increase breast and cervical cancer screening rates for African American women throughout the state. In Choctaw County, African American women were much less likely to get a mammography screening compared with white women. In 8 years, the proportion of African American women who received mammography screenings increased from 29% to 61%, surpassing the rate for white women by 13%. In Dallas County, a lower mammography screening rate for African American women (30%) compared with white women (50%) was virtually eliminated during the same time. According to data from the eight counties that the Alabama REACH program focuses on, the gap in mammography screening rates between African American and white women decreased by 76% over the same 8-year period.

South Carolina: Dramatic Improvements in Diabetes Outcomes for African Americans

The REACH 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 among African American men with diabetes who were hospitalized decreased by nearly 54% in 7 years. In Georgetown County, the rate decreased 54% in 3 years.

For profiles of 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 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. In the span of 3 years, blood sugar measures below 7.0 improved by 8.7%, systolic blood pressure below 130 mm Hg improved by 17.5%, and diastolic blood pressure below 80 mm Hg improved by 14.4%. In addition, the proportion of participants who were referred for eye exams improved 26.5%.

Future Directions

REACH communities are demonstrating that health disparities among racial and ethnic minority groups can be reduced. CDC and REACH communities know enough now to urge the spread of effective strategies nationwide, and CDC will increase its efforts in this area. For example, we will use the ongoing successes of proven strategies to influence health care practices and policies throughout the public health system. In addition, we will fund at least 36 "legacy communities" to spread effective strategies to more and more communities across the nation. Legacy communities will be funded as part of the CEEDs, and they will receive mentoring and support from the CEEDs.

By sharing effective strategies and lessons learned from 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 collaborate to analyze local data and evaluate program strategies.

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