RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH (REACH U.S.)

FINDING SOLUTIONS TO HEALTH DISPARITIES

AT A GLANCE

2009

NATIONAL CENTER FOR CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

IMPROVING HEALTH AND QUALITY OF LIFE FOR ALL PEOPLE

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CDC

CENTERS FOR DISEASE CONTROL AND PREVENTION

Racial and Ethnic Disparities in Health: The Facts

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 breast cancer is diagnosed 10% less frequently in African American women than in white women, African American women are 34% more likely to die of the disease. African American adults are 1.9 times more likely than non-Hispanic white adults to have been diagnosed with diabetes. Although African American children aged 19 to 35 months had comparable rates of immunization for hepatitis, influenza, MMR (mumps-measles-rubella), and polio, they were slightly less likely to be fully immunized compared with non-Hispanic white children. In 2004, African Americans had asthma-related emergency room visits 4.5 times more often than whites. In 2005, non-Hispanic blacks were almost twice as likely as non-Hispanic whites to die of viral hepatitis.

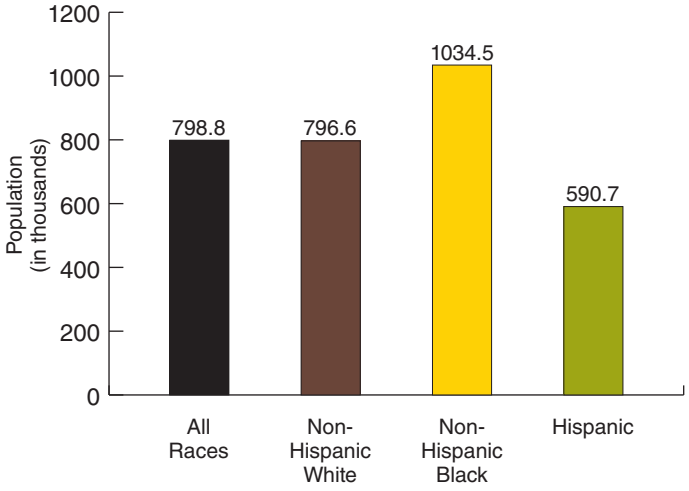
- **American Indians and Alaska Natives.** American Indian and Alaska Native adults are 2.3 times more likely than white adults to be diagnosed with diabetes. American Indian women are 1.7 times more likely to die of cervical cancer than white women. In 2005, American Indians/Alaska Natives aged 18 to 64 years were slightly more likely than non-Hispanic whites to have received the influenza (flu) shot in the past 12 months. In 2006, American Indian/Alaska Native adults were 60% more likely than non-Hispanic whites to be diagnosed with asthma. Infant mortality rates among American Indians/Alaska Natives are 1.4 higher than among non-Hispanic whites.

- **Asian Americans.** Rates of cervical cancer among Vietnamese American women are higher than rates among any other ethnic group in the United States—5 times higher than non-Hispanic white women. Although rates of asthma are generally lower among Asian Americans than among white Americans, in 2003, asthma-related deaths were 50% higher among Asian Americans.

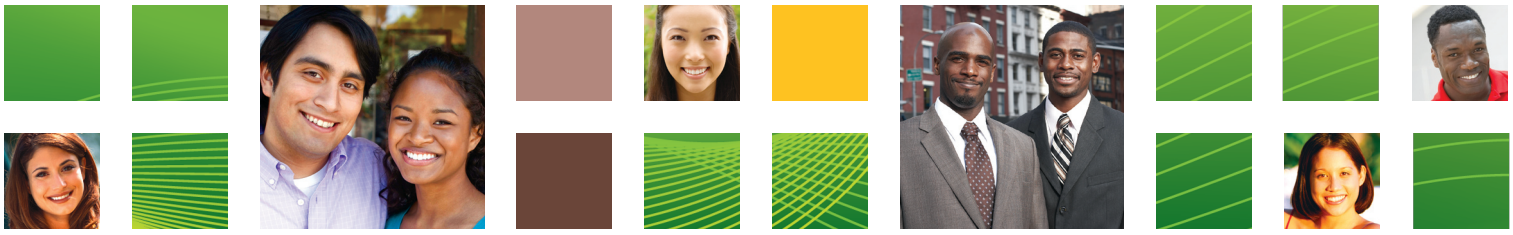
- **Hispanics/Latinos.** In 2004, Hispanic women were twice as likely as non-Hispanic white women to be diagnosed with cervical cancer. Although Hispanic children aged 19 to 35 months had comparable rates of immunization for hepatitis, influenza, MMR, and polio, they were slightly less likely to be fully immunized compared with non-Hispanic white children.

- **Native Hawaiians/Pacific Islanders.** In Hawaii, the rate of diabetes among Native Hawaiians is more than twice the rate among whites. Native Hawaiians are 5.7 times more likely to die of diabetes than whites living in Hawaii.

Age-Adjusted Death Rates*, United States, 2005



* Per 100,000 population.
Source: National Vital Statistics Reports, National Center for Health Statistics.



CDC's Leadership Role

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 Racial and Ethnic Approaches to Community Health (REACH U.S.), 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 is improving people's health in communities, health care settings, schools, and work sites.

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 almost $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—resources that contribute to the length and quality of life of individuals by their distribution across populations—and their relationship to health disparities. As a result, REACH communities empower community members to (1) seek better health; (2) serve as catalysts for change to local health care practices; and (3) mobilize communities to implement evidence-based public health programs that address their unique social, historical, economic, and cultural circumstances.

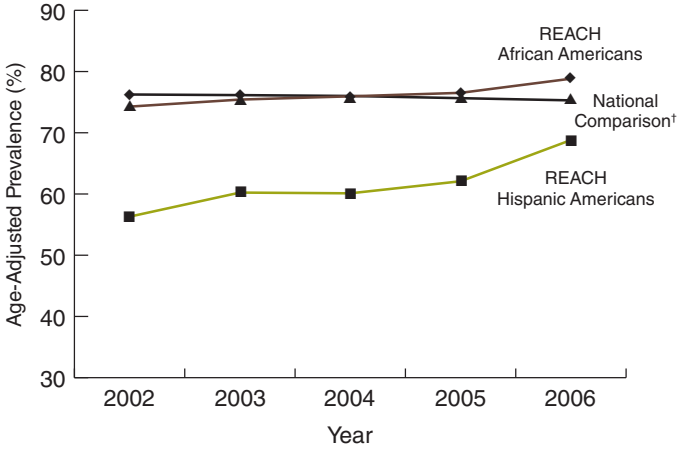
Data Show REACH is Working

Data from the REACH Risk Factor Survey show that the REACH 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 REACH communities, which focus on breast and cervical cancer prevention, cardiovascular health, and diabetes management. Survey results include the following:

- Over a 4-year period, the cholesterol screening rates for Hispanics of all educational levels in REACH communities have steadily increased. In fact, the cholesterol screening rate for Hispanics in REACH communities with a high school education, which was previously below the rate for the national Hispanic population, has surpassed the national rate for this population. Hispanics with less than a high school education in REACH communities now have rates that are approaching that of all Hispanics nationally.
- In 2002, the percentage of African Americans in REACH communities who were screened for cholesterol was below the national average. By 2006, this percentage exceeded the national average.
- Since 2002, the cholesterol screening rate for Hispanics in REACH communities has greatly improved, quickly catching up to the national average. The cholesterol screening rate for Hispanics from REACH communities increased by 18% during 2002–2006.

African Americans and Hispanic 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).

CDC's Leadership Role (continued)

The Keys to Success

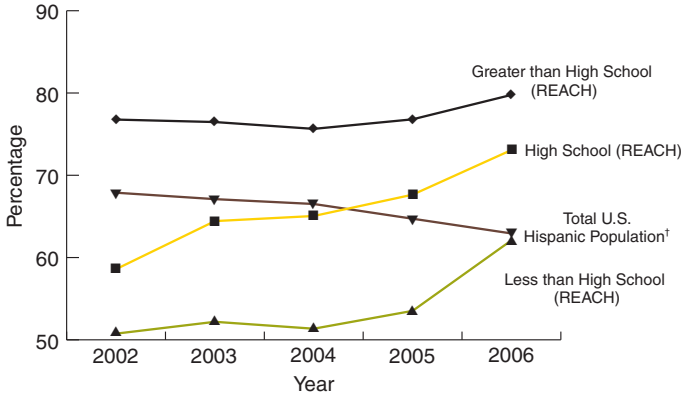
REACH has identified the following key principles and supporting activities for effective community-level work to reduce health disparities in racial and ethnic minority communities across the United States:

- **Trust.** Build a culture of collaboration with communities that is based on trust.
- **Empowerment.** Give 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.** Design health initiatives that are grounded in the unique historical and cultural context of racial and ethnic minority communities in the United States.
- **Focus on Causes.** Assess and focus on the underlying causes of poor community health and implement solutions that will stay embedded in the community infrastructure.
- **Community Investment and Expertise.** Recognize and invest in local community expertise and motivate communities to mobilize and organize existing resources.
- **Trusted Organizations.** Enlist organizations within the community that are valued by community members, including groups with a primary mission unrelated to health.
- **Community Leaders.** Help community leaders and key organizations forge unique partnerships and act as catalysts for change in the community.
- **Ownership.** Develop a collective outlook to promote shared interest in a healthy future through widespread community engagement and leadership.
- **Sustainability.** Make 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.** Foster optimism, pride, and a promising vision for a healthier future.

Future Directions

REACH communities are demonstrating that health disparities among racial and ethnic minority groups can be reduced and effective strategies can have their greatest impact in low-income communities. CDC will use the ongoing successes of proven strategies to influence health care practices and polices throughout the public health system. In addition, it will fund at least 36 legacy communities to spread effective strategies to communities across the nation. Legacy communities will be funded as part of the Centers of Excellence in the Elimination of Health Disparities (CEED), and they will receive mentoring and support from CEED. CDC and REACH communities also will continue to collaborate to analyze local data and evaluate program strategies.

Cholesterol Screening Rates Among Hispanics by Education Level*



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