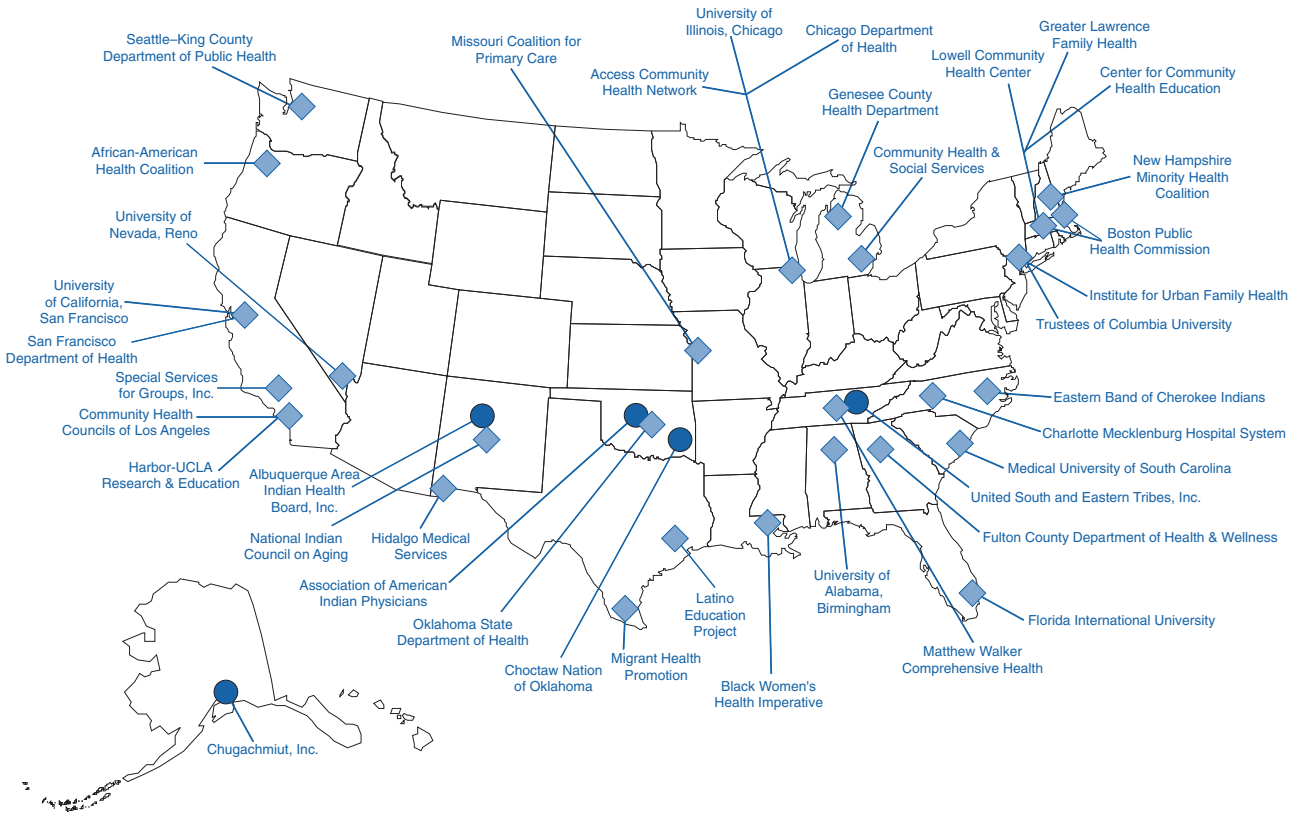
AT A GLANCE

Racial and Ethnic Approaches to Community Health (REACH) 2010:
Addressing Disparities in Health
2004

REACH 2010 Project Sites, Fiscal Year 2003



"CDC continues to support phenomenal community coalitions in their quest to eliminate racial and ethnic disparities in health. In turn, these communities are providing invaluable knowledge to CDC and the nation as we continue to promote better health for all Americans."

Julie Louise Gerberding, MD, MPH
Director, CDC, and Administrator, ATSDR

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
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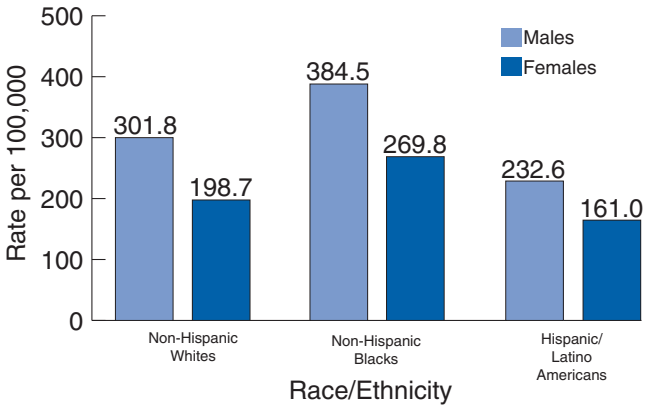
Racial and Ethnic Disparities in Health

Despite great improvements in the overall health of the nation, Americans who are members of racial and ethnic minority groups, including African Americans, Alaska Natives, American Indians, Asian Americans, Hispanic Americans, and Pacific Islanders, are more likely than whites to have poor health and to die prematurely, as the following examples illustrate:

- **Breast and cervical cancer:** Although death rates from breast cancer declined significantly during 1992–1998, they remain higher among black women than among white women. In addition, women of racial and ethnic minorities are less likely than white women to receive Pap tests, which can prevent invasive cervical cancer by detecting precancerous changes in the cervix.
- **Cardiovascular disease:** In 2001, rates of death from diseases of the heart were 30% higher among African Americans than among whites, and death rates from stroke were 41% higher.
- **Diabetes:** Compared with white adults, American Indians and Alaska Natives are 2.3 times, African Americans are 1.6 times, and Hispanics are 1.5 times more likely to have diagnosed diabetes.
- **HIV/AIDS:** Although African Americans and Hispanics represent only 26% of the U.S. population, they account for roughly 82% of pediatric AIDS cases and 69% of both AIDS cases and new HIV infections among U.S. adults. In 2002, they accounted for 62% of all people living with HIV or AIDS in the United States.
- **Immunizations:** Influenza vaccination coverage among adults age 65 years and older is 69% for whites, 50% for African Americans, and 49% for Hispanics. The gap for pneumococcal vaccination coverage among ethnic groups is even wider: 60% for whites, 37% for African Americans, and 27% for Hispanics.
- **Infant mortality:** Although the 2001 U.S. infant mortality rate of 6.8 deaths per 1,000 live births was the lowest ever recorded, African American, American Indian, and Puerto Rican infants continue to have higher mortality rates than white infants. In 2001, the black-to-white ratio in infant mortality was 2.3.

Because racial and ethnic minority groups are expected to comprise an increasingly larger proportion of the U.S. population in coming years, the number of people affected by disparities in health care will only increase without culturally appropriate, community-driven programs to eliminate these disparities. To be successful, these programs need to be based on sound prevention research and supported by new and innovative partnerships among governments, businesses, faith-based organizations, and communities.

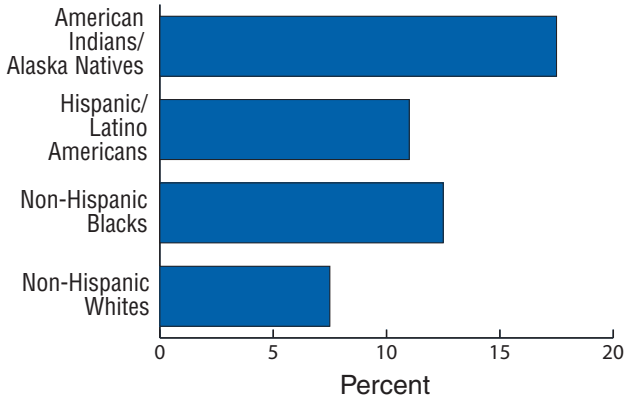
Death Rates* for Diseases of the Heart, by Race/Ethnicity, 2001



*Age adjusted rate per 100,000 population.

Source: National Health and Nutrition Examination Survey III, 1988–1994, National Center for Health Statistics, CDC.

Prevalence of Diabetes,* by Race/Ethnicity, 2002



*Age adjusted prevalence among U.S. adults age 20 or older.

Sources: 1999–2001 National Health Interview Survey and 1999–2000 National Health and Nutrition Examination Survey estimates, projected to 2002. Outpatient database of the Indian Health Service, 2002.

Healthy People 2010, which describes the nation's health objectives for the decade, has as one of its goals eliminating racial and ethnic disparities in health. The Centers for Disease Control and Prevention (CDC) has a major leadership role in carrying out the goals set forward in this initiative.

Launching REACH 2010

Racial and Ethnic Approaches to Community Health (REACH) 2010 is the cornerstone of CDC's efforts to eliminate racial and ethnic disparities in health. Launched in 1999, REACH 2010 is designed to eliminate disparities in the following six priority areas: cardiovascular disease, immunizations, breast and cervical cancer screening and management, diabetes, HIV/AIDS, and infant mortality. The racial and ethnic groups targeted by REACH 2010 are African Americans, American Indians, Alaska Natives, Asian Americans, Hispanic Americans, and Pacific Islanders.

REACH 2010 supports community coalitions in designing, implementing, and evaluating community-driven strategies to eliminate health disparities. Each coalition comprises a community-based organization and three other organizations, of which at least one is either a local or state health department or a university or research organization.

REACH 2010 grantees are using local data to implement interventions that address one or more of the six priority areas and target one or more racial and ethnic groups. The activities of these community coalitions include continuing education on disease prevention for health care providers, health education and health promotion programs that use lay health workers to reach community members, and health communications campaigns.

In fiscal year 2003, CDC funded 35 REACH 2010 projects and supported the new emphasis on projects in American Indian and Alaska Native communities. Five REACH 2010 core capacity-building projects in American Indian and Alaska Native communities in Albuquerque, NM; Oklahoma City and Talihina, OK; Anchorage, AK; and Nashville, TN, received continuation funding. Funding for REACH 2010 in 2004 will be $37.3 million.

Working With Partners

Several agencies and offices within the U.S. Department of Health and Human Services (HHS) have played critical roles in planning, coordinating, and supporting the REACH 2010 program. In an enormous show of support, the National Institutes of Health contributes $5 million annually to support REACH 2010 projects. Other partners within HHS include the Office of the Secretary, the Health Resources and Services Administration, the Administration on Aging, and the Agency for Healthcare Research and Quality.

REACH 2010 also receives support from public and private agencies. For example, the California Endowment supports the implementation and evaluation of two California coalitions addressing disparities.

Evaluating Communities in Action

The REACH 2010 evaluation model uses the following five stages to guide the collection of qualitative and quantitative data:

1. **Capacity Building**—Community coalition actions to reduce disparities.
2. **Targeted Actions**—Intervention activities believed to bring about a desired effect.
3. **Community/System Changes**—Changes to the community environment and to the knowledge, attitudes, beliefs, and behaviors of influential individuals or groups.
4. **Widespread Risk/Protective Behavior Changes**—Changes in rates of risk-reduction behaviors among a significant percentage of community members.
5. **Health Disparity Reduction**—Narrowing gaps in health status.

The REACH Information Network (REACH IN) is an Internet-based tool customized for REACH 2010 grantees to enter, store, and retrieve data for stages 1, 2, and 3 of the evaluation model and to generate graphs and reports on local activities. REACH IN also allows coalitions to share information.

Data from the REACH 2010 Risk Factor Survey provide important information on the health status of residents in REACH 2010 communities that have programs focused on breast and cervical cancer prevention, cardiovascular health, and diabetes. Communities will use this information to evaluate stages 4 and 5 of the model.

Positive behavior changes that have reduced health risks among REACH 2010 communities to date include increases in the percentages of community members receiving mammograms, Pap smears, and cholesterol and glycosolated hemoglobin screenings. These changes have helped to reduce disparities in cholesterol and blood sugar screenings.

A critical part of the REACH 2010 strategy is to test the effectiveness of programs in improving the health of racial and ethnic minority populations. The following are examples of REACH 2010 programs:

California – Targeting cervical cancer among Asian Americans

The Vietnamese Community Health Promotion Project (VCHPP), supported by the University of California, San Francisco, organized the Vietnamese REACH for Health Initiative Coalition to prevent cervical cancer among Vietnamese-American women in Santa Clara County. Through a media education campaign, outreach by lay health workers, and a low-cost Pap clinic staffed by a female Vietnamese physician, the VCHPP has improved Vietnamese women's knowledge of cervical cancer and its risk factors. Preliminary results show that 47% of Vietnamese-American women who had never had a Pap test before obtained one after meeting with lay health workers. Through VCHPP activities, the percentage of women receiving a Pap test in Santa Clara County increased by 15%.

Oregon – Targeting cardiovascular disease among African Americans

The African American Health Coalition, Inc., supported by Access Community Health Network in Portland, developed a program to address the root causes of the greater risk for dying of cardiovascular disease (CVD) among African Americans than whites. Among the interventions offered are

- "Lookin' Tight, Livin' Right," a community-based program that uses existing relationships between beauty/barbershop operators and their clients to assess readiness for change and to promote healthy behaviors.
- "HOLLA!," an intervention for young people that partners with local high schools to train students to educate their peers about CVD and its risk factors.
- Educational mailings to African Americans enrolled in Oregon's Medicaid program to increase their awareness of CVD risk and their use of preventive services.
- "Wellness within REACH," which offers free physical activity classes in an African American community. Three-quarters of participants report increasing their physical activity levels as a result of the program.

South Carolina – Targeting diabetes in African Americans

The Medical University of South Carolina/Charleston and Georgetown REACH Diabetes Coalition have formed an urban-rural coalition to improve the health of more than 12,000 African Americans with diagnosed diabetes in Charleston and Georgetown counties. After 24 months of program participation, African Americans have more physical activity in their lives, healthier foods at group activities, and better diabetes care and control. Between 1999 and 2002, the gap between African Americans and whites in annual A1c testing, which is used to measure blood sugar control, was virtually eliminated. The goal of the coalition is to eliminate all disparities in diabetes care and control in Charleston and Georgetown counties by 2007.

Massachusetts – Targeting diabetes in Hispanics

REACH 2010 Latino Health, supported by the Greater Lawrence Family Health Center project, has established interventions to address the high prevalence of diabetes among Puerto Rican and Dominican residents in Lawrence, Massachusetts. The types of interventions include intergenerational exercise programs, diabetes education for children and adolescents, nutrition education and modeling, and culturally appropriate empowerment groups. More than 3,260 residents have participated in these community-based interventions. Since the program began, the percentage of patients referred for eye exams has increased from 51% to 64% and the percentage of those screened for kidney disease has increased from 46% to 70%.

Future Directions

Working in partnership with local communities, CDC has made substantial strides in reducing racial and ethnic disparities in health. REACH 2010 will begin working with communities to plan and develop strategies for disseminating lessons learned. Applying these lessons learned will help future programs increase their effectiveness in eliminating health disparities nationwide. In addition, CDC and REACH 2010 will continue to assist communities in collecting local data that will help them evaluate community-specific strategies to reduce or eliminate health disparities.

For more information or additional copies of this document, please contact the Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Mail Stop K–45, 4770 Buford Highway NE, Atlanta, GA 30341-3717; (770) 488-5269.
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