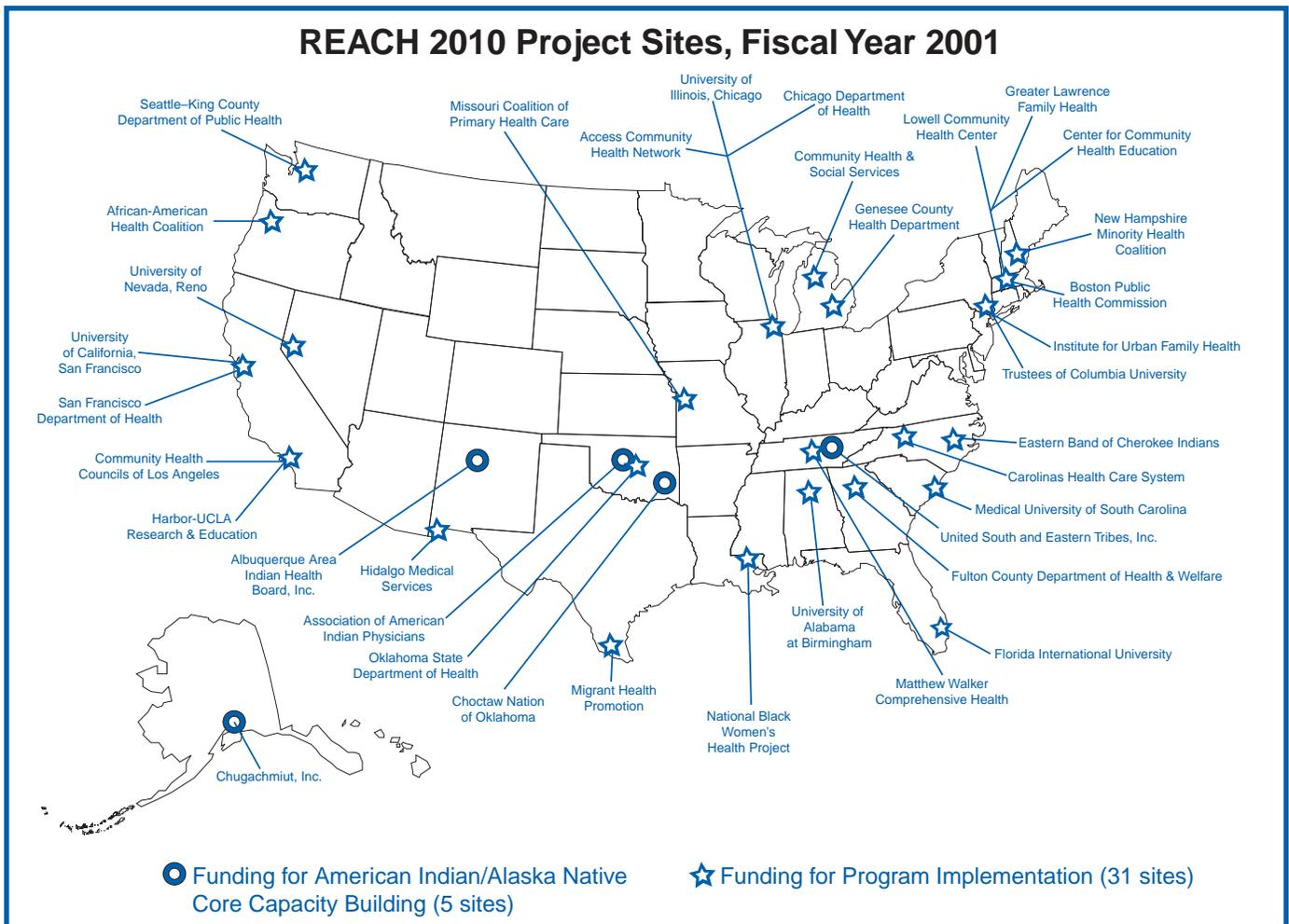


Racial and Ethnic Approaches to Community Health (REACH 2010): Addressing Disparities in Health 2002



“The REACH 2010 demonstration project is a tremendous catalyst in advancing effective community-driven strategies to eliminate racial and ethnic health disparities. Bringing together coalitions of community groups, academia, and local and state governments, these programs will serve as models to promote better health for all Americans.”

*David Satcher, MD, PhD
Surgeon General*

Racial and Ethnic Disparities in Health

Because racial and ethnic minority groups are expected to comprise an increasingly larger proportion of the U.S. population in coming years, the future health of America will be greatly influenced by our success in improving the health of these groups. 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:

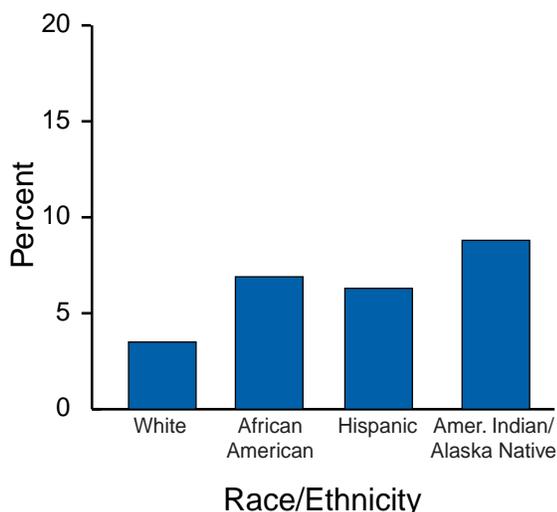
- **BREAST AND CERVICAL CANCER:** African American women are more likely to die of breast cancer than are women of any other racial or ethnic group. The incidence of cervical cancer—a largely preventable cancer—is more than five times greater among Vietnamese women in the United States than among white women.
- **CARDIOVASCULAR DISEASE:** Heart disease and stroke are the leading causes of death for all racial and ethnic groups in the United States. In 1999, rates of death from diseases of the heart were 29% higher among African American adults than among white adults, and death rates from stroke were 40% higher.
- **DIABETES:** Compared with whites, American Indians and Alaska Natives are 2.5 times more likely to have diagnosed diabetes, African

Americans are 2.0 times more likely, and Hispanics are 1.8 times more likely.

- **HIV/AIDS:** Although African Americans and Hispanics represented only 25% of the U.S. population in 1999, they accounted for roughly 55% of adult AIDS cases and 82% of pediatric AIDS cases reported through 1999.
- **IMMUNIZATIONS:** In 1999, Hispanics and African Americans aged 65 and older were less likely than whites to report having received influenza and pneumococcal vaccines.
- **INFANT MORTALITY:** African American, American Indian, and Puerto Rican infants have higher death rates than white infants. In 1999, the black-to-white ratio in infant mortality was 2.5 (up from 2.4 in 1998). This widening disparity between black and white infants is a trend that has persisted over the last two decades.

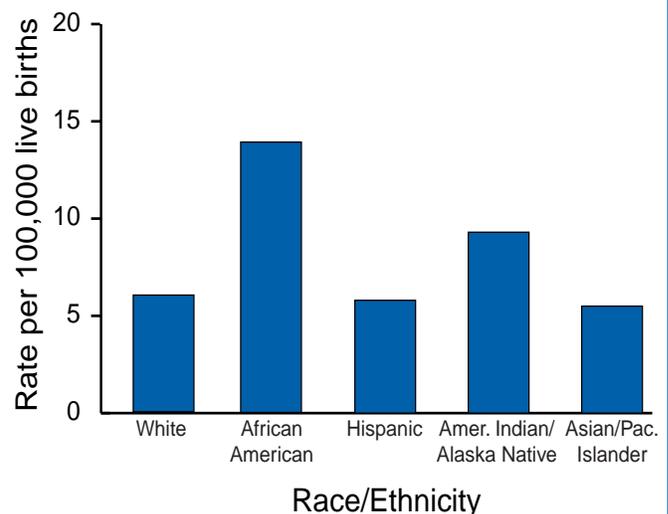
Culturally appropriate, community-driven programs are critical for eliminating racial and ethnic disparities in health. For these programs to be effective, prevention research is needed to identify the causes of health disparities and the best means of delivering preventive and clinical services. Establishing these programs will also require new and innovative partnerships among federal, state, local, and tribal governments and communities.

Age-Adjusted Prevalence of Diabetes, by Race/Ethnicity, 2000



Sources: National Center for Health Statistics, CDC; Indian Health Service

U.S. Infant Mortality Rates, by Race/Ethnicity of Mother, 1998



Source: National Center for Health Statistics, CDC

CDC's Leadership Role

Healthy People 2010, which describes the nation's health objectives for the 21st century, 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 infections/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 is a two-phase, 5-year demonstration project that 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.

During a 12-month planning phase, REACH 2010 grantees use local data to develop a community action plan that addresses one or more of the six priority areas and targets one or more of the racial and ethnic minority groups. During the 4-year implementation phase, community coalitions carry out activities outlined in their community action plans and evaluate program activities.

In fiscal year 2001, Congress appropriated \$37.8 million* to fund 31 REACH 2010 projects and add a new emphasis on projects in American Indian and Alaska Native communities. Five new REACH 2010 core capacity-building projects were funded in American Indian and Alaska Native communities in Albuquerque, NM; Oklahoma City and Tahlequah, OK; Anchorage, AK; and Nashville, TN. Funding for 2002 will remain the same as the 2001 levels.

Supporting REACH Interventions

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



Cambodian Community Health 2010, in Lowell, Massachusetts, is targeting

cardiovascular disease and diabetes among Cambodian refugees. During the planning phase, the project held Community Conversations in seven locations throughout the Cambodian community to involve all community members in developing the action plan. A Cambodian Elders' Council was also formed to give a voice to older Cambodian refugees, who are often homebound and isolated by the language barrier.



Reach Out is a Chicago-area collaboration that draws on leadership within African American and Hispanic/Latino churches to encourage low-income African American and Hispanic/Latina

women to be screened for breast and cervical cancer. Focus groups of women members of local African American and Hispanic/Latino churches were held during the planning phase. These sessions clearly established that these women wanted clinically sound and spiritually relevant information about how breast and cervical cancer could affect them. Using these results, the coalition initiated three pilot educational forums in churches to mobilize women to seek breast and cervical cancer screening.



The Nashville REACH 2010 Coalition conducted focus groups among African

American women in North Nashville to better understand why cardiovascular disease and diabetes death rates are 78%–134% higher among North Nashville's African American women than among Nashville's majority population. As a result of these discussions, REACH 2010 interventions are being designed to address the physical effects of stress, deliver culturally appropriate messages that balance self-acceptance and health promotion, increase the availability of healthy food choices, remove barriers to physical activity, provide model exercise programs, and involve community health care providers.

*The National Institutes of Health contributed \$5 million to the overall funding of these projects.

“The widely accepted truth that health is a right belies the reality of continuing health disparities in this nation. The REACH 2010 program has permitted local communities to take a creative, innovative look at solutions to health problems that in some instances have existed for centuries. REACH 2010 projects focus on empowering communities, building coalitions, and creating solutions that can be used throughout the nation to eliminate health disparities once and for all.”

*Adewale Troutman, MD, MPH, Principle Investigator,
REACH 2010 Project, Fulton County, Atlanta, GA, and
Director, Fulton County Department of Health and Wellness*

Working With Partners

Other agencies and offices within the Department of Health and Human Services (DHHS) have played critical roles in planning, coordinating, and supporting the REACH 2010 Program. In an enormous show of support, the National Institutes of Health contributed \$5 million to support five REACH 2010 programs in FY 2000 and has pledged to maintain that level of support over the next 3 years. Through an interagency agreement with the Administration on Aging, CDC is providing \$3 million over 3 years to establish four projects addressing health disparities in elderly populations. Other partners within DHHS include the Office of the Secretary, the Health Resources and Services Administration, and the Agency for Healthcare Research and Quality.

In addition, other public and private agencies are supporting REACH 2010, as the following examples illustrate:

- In fiscal year 2000, the California Endowment provided \$9.6 million through the CDC Foundation to implement and evaluate activities over the next 3 years in two California coalitions identified through CDC's REACH 2010 competitive process.
- RAND, with funding from the Robert Wood Johnson Foundation, conducted a literature review of best practices related to coalition efforts and created solutions to health concerns in racial and ethnic minority communities to support REACH 2010 projects.

Evaluating REACH 2010

The evaluation of the REACH 2010 program is of critical importance in determining the program's effectiveness in reducing health disparities. Working with its grantees and partners, CDC has developed an evaluation model to guide the collection of national data. This model evaluates programs on their effectiveness in the following areas: building community capacity, developing targeted actions, improving health systems and agents of change, decreasing risk behaviors and increasing protective behaviors, and reducing disparity-related illness and death.

In addition, CDC has selected the University of South Carolina to manage a special interest project to develop evaluation guidance for REACH 2010 and other projects aimed at eliminating health disparities.

Future Directions

REACH 2010 projects are empowering community members to transform their neighborhoods into places that encourage people to adopt and sustain healthy behaviors and to avoid risk behaviors. Through close collaboration with community members and creative partnerships with public and private organizations, CDC will continue to spearhead the country's efforts to eliminate health disparities by carrying out the lessons learned from the REACH 2010 projects in communities across the country.

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.
ccinfo@cdc.gov www.cdc.gov/reach2010