REACH U.S.

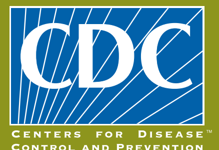
FINDING SOLUTIONS TO HEALTH DISPARITIES

AT A GLANCE

2010

NATIONAL CENTER FOR CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

IMPROVING HEALTH AND QUALITY OF LIFE FOR ALL PEOPLE



Racial and Ethnic Disparities in Health: The Facts

Despite great improvements in the overall health of the U.S. population, 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 a diagnosis of diabetes.

  Although African American children aged 19–35 months had comparable rates of immunization for hepatitis, flu, measles-mumps-rubella (MMR), 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 2006, non-Hispanic blacks were 70% more likely to die of viral hepatitis than whites.

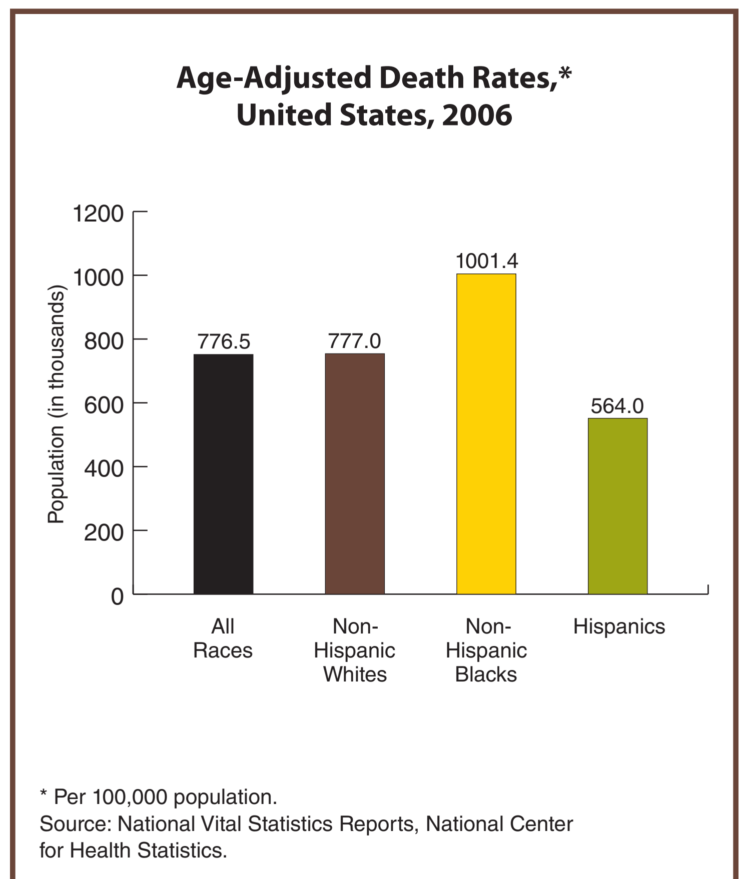
- **American Indians and Alaska Natives.** American Indian and Alaska Native adults are 2.3 times more likely than white adults to receive a diagnosis of diabetes. American Indian women are 1.7 times more likely to die of cervical cancer than white women.

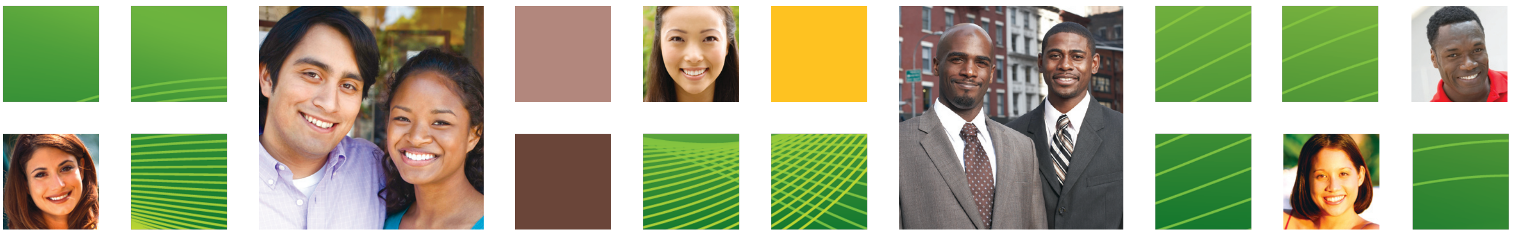
  American Indian/Alaska Native adults are 1.6 times as likely as white adults to be obese. In addition, infant mortality rates are 1.4 higher among American Indians/Alaska Natives than among non-Hispanic whites.

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

- **Hispanics/Latinos.** In 2005, Hispanics were 1.6 times more likely to die of diabetes than non-Hispanic whites. In addition, Hispanic women were twice as likely as non-Hispanic white women to have a diagnosis of cervical cancer. Although Hispanic children aged 19–35 months had comparable rates of immunization for hepatitis, flu, MMR, and polio, they were slightly less likely to be fully immunized when 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.





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 they have been at a loss for solutions. In response, CDC created Racial and Ethnic Approaches to Community Health Across the U.S. (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 U.S. 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.

CDC currently funds 40 communities to implement changes that address health disparities in key health areas (see map, page 4). In addition, about half of the 40 funded communities work with other selected communities to share lessons learned and to mentor these communities on how to effectively use best practices to reduce health disparities.

In fiscal year (FY) 2010, Congress allocated $39.6 million to support the REACH U.S. program. CDC provides training, technical assistance, and support to REACH communities to help them understand how social determinants of health—the economic and social conditions in the places where people live—can affect their health and longevity.

As a result, REACH communities empower residents to (1) seek better health; (2) help change 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.

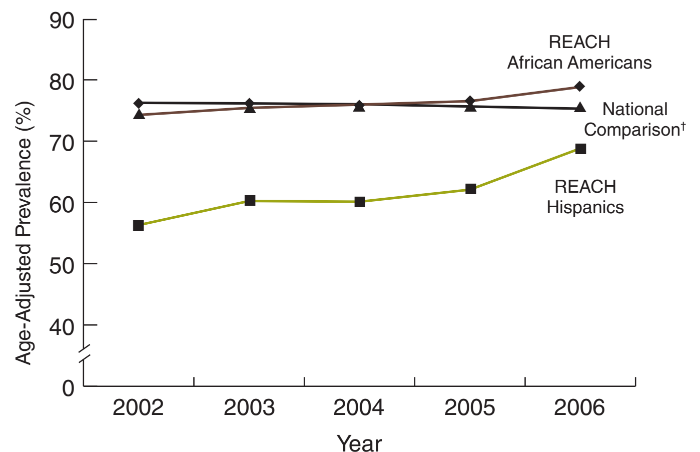
Data Show REACH U.S. Is Working

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, which focuses on breast and cervical cancer prevention, cardio-vascular health, and diabetes management, assesses how much people in REACH communities have changed their health behaviors and improved their health in these areas, which, in turn, reduces health disparities in REACH communities.

Survey results include the following:

- Over a 4-year period, the cholesterol screening rates for Hispanics living in REACH communities increased steadily, from 56.3% in 2002 to 68.6% in 2006 (see figure). In 2002, the cholesterol screening rate for African Americans living in REACH communities (74.2%) was below the national average (76.2%). By 2006, the rate had risen to 78.8%, which was above the national average of 75.2% for that year.
- In REACH communities that focused on breast and cervical cancer prevention, the percentage of women who reported having a pap smear in the previous year increased from 81% in 2002 to 86% in 2006.
- The rate of cigarette smoking among Asian American men in REACH communities decreased from 42% in 2002 to 20% in 2006.

African Americans and Hispanics Who Have Had Their Cholesterol Checked*



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

† National comparison data are from the Behavioral Risk Factor Surveillance System (BRFSS).

The Keys to Success

REACH U.S. 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 U.S. has used innovations in community engagement and environmental change to sharply reduce disparities among U.S. populations that are disproportionately affected by health inequities. CDC will continue to use the strategies proven to work in REACH communities to improve and change health care practices and polices across the public health system. In addition, CDC will continue to fund more communities to enhance their ability to make policy, systems, and environmental changes in order to reduce and eliminate health disparities. CDC and REACH communities also will continue to work together to analyze local data and evaluate program strategies.

REACH U.S. Communities Funded by CDC, Fiscal Year 2010*

* CDC currently funds 40 REACH communities.

For more information, please contact the Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion
4770 Buford Highway NE, Mail Stop K-45, Atlanta, GA 30341-3717
Telephone: 770-488-5269 • E-mail: cdcinfo@cdc.gov • Web: http://www.cdc.gov/reach

CS206284