

# FACT SHEET

## ELIMINATING RACIAL, ETHNIC AND RURAL HEALTH DISPARITIES

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### *Invest in Evidence-Based Community Programs to Eliminate Health Disparities*

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**FY 09 Request:** Fund CDC's National Center for Chronic Disease Prevention and Health Promotion's Racial and Ethnic Approaches to Community Health Across The U.S. (REACH U.S.) Program at an FY 09 level of \$50 million. This program has been essentially level funded since 2003 and has been decreasing due to across the board recessions (FY 08 funding - \$33.860 million).

**Request:** Support legislation to disseminate lessons from REACH programs to additional communities.

### **Basic Facts about Health Disparities**

Health disparities remain widespread among members of racial and ethnic minority groups, and for some conditions, disparities continue to widen. As the U.S. population becomes increasingly diverse, the nation's health status will be heavily influenced by the health of racial and ethnic minority communities.

African Americans, Alaskan Natives, American Indians, Asian Americans, Hispanic Americans, and Pacific Islanders are more likely than whites to have poor health and to die prematurely:

- **CARDIOVASCULAR DISEASE:** Heart disease and stroke are the leading causes of death for all racial and ethnic groups in the United States. Rates of death from diseases of the heart were 30% higher among African American adults than among white adults, and death rates from stroke were 41% higher.
- **DIABETES:** Compared to whites of similar age, prevalence of diabetes is more than twice that in American Indians/Alaskan Natives; 1.6 times higher among African Americans and 1.5 times higher among Hispanics.
- **BREAST CANCER:** African American women are more likely to die of breast cancer than are women of any other racial or ethnic group.
- **IMMUNIZATIONS and INFANT MORTALITY:** Rates of immunizations are lowest among minorities. African American, American Indian, and Puerto Rican infants have higher death rates than white infants.

### **CDC's REACH U.S. Program – A Model Program for States and Communities**

- Launched in 2007, REACH U.S. is the next evolution of REACH 2010 which was developed by HHS and CDC to find “out of the box” community-based solutions to address health disparities.
- By establishing a national infrastructure to promote evidence- and practice-based public health programs, community-based participatory approaches, and the integration of systemic influences, REACH U.S. supports and disseminates programmatic activities that are successful in the elimination of racial and ethnic health disparities.
- REACH U.S. funds a total of **40** grantee partners that were selected to operate under one of two levels of funding—Centers of Excellence In Eliminating Health Disparities (CEEDS) or Action Communities (ACs).
  - CEEDS serve as national and regional expert centers by providing experience and expertise working with one or more racial and ethnic groups as well as having a high level of expertise in addressing one or more of the priority health problems listed below. The CEEDs were established to be a resource for mentoring communities in processes of community mobilization, community-based participatory research, and program development and evaluation. CEEDs also provide pilot funding, support, local training, and guidance to Legacy Projects to encourage them to initiate or enhance work towards the elimination of health disparities. There are **18** REACH U.S. CEEDs.
  - Action Communities are community-based programs implementing evidence-based programs and approaches to eliminate disparities in a selected health problem. ACs are particularly attentive to cultural and environmental influences on health status and behaviors. ACs play a central role in the translation of evidence-based public health strategies in their local communities. There are 22 REACH U.S. ACs.

Both levels of funding focus on at least one of the following racial and ethnic groups: African American/Black, American Indian/Alaska Native, Asian, Native Hawaiian/Other Pacific Islander, and Hispanic/Latino as well as at least one of the following health priority area(s): breast and cervical cancer; cardiovascular disease; diabetes mellitus; adult/older adult immunization, hepatitis B, and/or tuberculosis; asthma; and infant mortality.

## **#1 Lesson Learned: *Health Disparities are NOT Inevitable, and CAN be Overcome.***

REACH interventions have demonstrated dramatic increases in reducing the health disparities gap. For example:

- In **South Carolina, the REACH Charleston and Georgetown Diabetes Coalition** reports that a 21% gap in blood sugar testing between African Americans and whites has been virtually eliminated, and amputations among African-American males with diabetes have been reduced by >33%.
- The **REACH for Wellness program in Fulton County, Georgia's Atlanta Empowerment Zone** reports from 2002 to 2004, the percentage of adults who regularly participated in moderate to vigorous physical activity increased from 25.4% to 28.7%; the percentage who reported checking their total blood cholesterol increased from 69.1% to 79.7%, and the percentage of adults who smoked decreased from 25.8% to 20.8%.
- In **Macon County, Alabama**, disparities in mammography screening between white and African American women decreased from 15% to 2% from 1998 to 2003.
- **Data from the REACH Risk Factor Survey** show that the REACH program is having a significant impact in key areas of risk reduction and disease management:
  - From 2001 to 2004, **African Americans** transitioned from being less likely to more likely than whites to have their cholesterol checked.
  - The gap in cholesterol screening between **Hispanics** from REACH communities and the national average, which was previously sizable, is closing in REACH communities.
  - The proportion of **American Indians** from REACH communities who began to take medication to reduce their high blood pressure increased from 67% in 2001 to 74% in 2004.
  - Cigarette smoking among **Asian men** from REACH communities decreased from 35% in 2001 to 24% in 2004.

## **#2 Lesson Learned: REACH Communities Are Discovering Keys to Success:**

- **Trust:** Build a culture of collaboration between communities and organizations.
- **Empowerment:** Equip individuals and communities with the knowledge and tools necessary to seek and demand better health, and enhance the resources and capacities that are already available.
- **Culture and History:** Design health initiatives that acknowledge and integrate the unique historical and cultural context of racial and ethnic minority communities in the United States.
- **Focus:** Identify the community's specific health needs and challenges, and implement strategies that will remain embedded in the community's health infrastructure.
- **Community Investment:** Motivate communities to mobilize and organize their resources in support of effective and sustainable programs that can eliminate health disparities among racial and ethnic minorities.
- **Trusted Organizations:** Embrace and enlist organizations within the community, even those whose primary mission is other than health, that are valued by community members.
- **Community Leaders:** Activate leaders and key organizations that are catalysts for change within their communities.
- **Ownership:** Develop a collective outlook that promotes shared interest in a healthy future through widespread community engagement and leadership.
- **Sustainability:** Integrate effective practices into the community to ensure the continuation of healthy improvements and the adoption of supportive infrastructures.
- **Hope:** Foster optimism, pride, and a promising vision for a healthier future.

The general public supports an investment in eliminating health disparities. In a 2006 poll by Research!America in 2004, 91% of the public said it was important to conduct health and medical research to address health disparities.

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*Advocating for healthier people through health education on behalf of the 35,000 members of the American Academy of Health Behavior; American Association for Health Education; American College Health Association; American Public Health Association/Public Health Education & Health Promotion Section; Coalition of National Health Education Organizations; Council of Accredited MPH Programs; Directors of Health Promotion and Education; Eta Sigma Gamma; National REACH Coalition for the Elimination of Racial & Ethnic Health Disparities; Society for Public Health Education; and Society of State Directors of Health, Physical Education and Recreation.*

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