

FACT SHEET

ELIMINATING RACIAL, ETHNIC AND RURAL HEALTH DISPARITIES

Invest in Evidence-Based Community Programs to Eliminate Health Disparities

Request: Support the highest level of funding possible [\$650 million] for CDC's National Center for Chronic Disease Prevention and Health Promotion by continuing to monitor the Prevention and Wellness provisions included in the American Recovery and Reinvestment Act of 2009 (ARRA).

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 2010 level of \$60 million.

REACH U.S. is part of CDC's Healthy Communities program. It has been essentially level-funded since 2003 and has been decreasing due to across the board rescissions [FY 09 funding (CR) - \$33.860 million].

REACH U.S. funding stimulates the local economy by creating jobs, helps keep people healthy enough for employment, and addresses a fundamental and ethical right to health for all.

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 morbidity 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.
- **CANCER:** African American women are more likely to die of breast cancer than are women of any other racial or ethnic group. Vietnamese American women have 5 times the cervical cancer rate of non-Hispanic white women.
- **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. – A Model Community-Based Program

- 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-driven solutions to address health disparities.
- REACH strategies are proven. Data show that persons in REACH communities significantly reduce their health risks and better manage their chronic conditions.
- REACH U.S. funding focuses 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.
- REACH U.S. funds a total of **40** grantee partners under one of two levels of funding
 - **Centers of Excellence In Eliminating Health Disparities (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 above. The CEEDs are resources 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 (ACs)** are community-based programs that implement 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. There are 22 REACH U.S. Action Communities; yet more are needed to keep pace with the growing demand for community-driven strategies.

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

REACH interventions have dramatically reduced health disparities in their communities. 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 >36%.
- The **REACH for Wellness program in Fulton County, Georgia's Atlanta Empowerment Zone** reports from 2002 to 2004, the percentage of adults regularly engaging in physical activity increased from 25% to 29%, checking their total blood cholesterol increased from 69% to 80%, and adults who smoked decreased from 26% to 21%.
- In **Alabama**, disparities in mammography screening between white and African American women in **Macon County** decreased from 15% to 8% from 1998 to 2003 and from 20% to 14% in **Dallas County**.
- In the **REACH Detroit Partnership** participants with diabetes who had uncontrolled blood sugar levels decreased by 17% (from 71% to 54% after 6 months) and the proportion of persons with high blood pressure decreased by nearly 12% (from 56% to 44%).
- **Data from the REACH Risk Factor Survey** show significant impact in 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 and Expertise:** 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. Assuring greater equity and accountability of the health system is important to a growing constituency base. To the extent that inequities in the health system result in lost productivity or use of services at a later stage of illness, there are health and social costs that affect us all.

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 Association of Health Education Centers; 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.
