REACH

RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH

REACHing ACROSS THE DIVIDE
FINDING SOLUTIONS TO HEALTH DISPARITIES

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

Acknowledgments

Special thanks are extended to the many people in the REACH program at CDC and in the program's communities who, through their innovative efforts to prevent and reduce the burden of disease and promote health equity in our racial and ethnic minority populations, contributed the success stories found in this book. We also thank the many collaborators from CDC who reviewed this document and contributed to its development, including the following individuals: Eveliz Metellus, MPH, for contributing to the written content of the document and coordinating its development; Amy Holmes-Chavez, MPH, Leandris Liburd, PhD, MPH, and Aisha Penson, MEd, CHES, who contributed portions of the written content and provided helpful feedback; Youlian Liao, MD, and Barbara Bowman, PhD, for sharing their scientific expertise; Rick Hull, PhD, Nancy Saltmarsh, and Elaine Garber, MFA, for offering their editorial guidance; and Maureen Berg, Joan Barbour, and Katherine Mollenkamp for providing graphic support.

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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From the Director

Eliminating racial and ethnic disparities in health has become a focal point in the prevention of unnecessary illness, disability, premature death, and the promotion of quality years of life for all persons.

The Centers for Disease Control and Prevention (CDC) has responded to disparities in health among racial and ethnic minority populations by launching Racial and Ethnic Approaches to Community Health (REACH). The REACH program is a cornerstone of CDC's efforts to identify, reduce, and ultimately eliminate health disparities. CDC funds REACH communities to address key health areas in which minority groups traditionally experience serious inequities in health outcomes. REACH communities form coalitions that plan, implement, and evaluate strategies to focus on the needs of one or more groups that include African Americans, Alaska Natives, American Indians, Asian Americans, Hispanics/Latinos, and Pacific Islanders.

Through *REACHing Across the Divide: Finding Solutions to Health Disparities,* we are pleased to share with you the successes and lessons learned in eliminating health disparities through the REACH program. The accomplishments highlighted in this book make a powerful case for the importance of working with communities to improve the health and well-being of their members. We now know that we can eliminate health disparities by engaging local leaders, building community partnerships, recognizing cultural influences, creating sustainable programs, leveraging resources, and empowering individuals and communities.

The case studies in this book represent only a fraction of the many ways that REACH communities are overcoming barriers to good health. It is inspiring to imagine the possibilities if communities across the country were to put these strategies into practice. Our intent in sharing these innovative strategies and interventions is to assist others in their efforts to successfully close health gaps among racial and ethnic minority groups around the nation. It is a public health imperative that we help people, especially those experiencing the greatest disparities in health, obtain and maintain the highest level of health possible.

Janet L. Collins, PhD
Director, National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention

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"In this course, I have learned more than I thought…I could handle. I was a little upset when we watched movies in class about racism. Part of me didn't want to believe there was racism going on around me. I wanted to turn a blind eye to it, and as long as it wasn't happening to me, it was OK."

—Student participant, Cultural Competence in Health Care course, Genesee County REACH initiative

Alarming Facts, Unacceptable Conditions

Have some communities been left behind?

Even as we celebrate significant advances in medical technology and public health innovations, all Americans do not benefit equally from these improvements. Today, health disparities remain widespread among members of racial and ethnic minority groups. The health status of these groups still lags far behind that of whites, and for some conditions, disparities continue to widen.

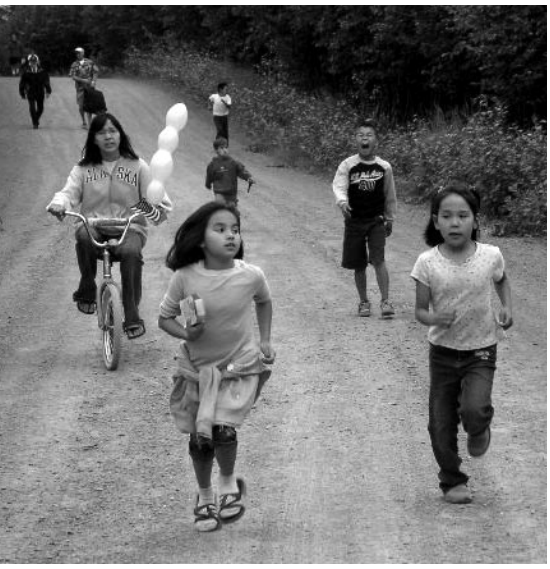
African Americans*

- Although the nation's infant death rate decreased, the rate for African Americans was almost double the national rate during 2000–2002.[1]
- In 2002, heart disease death rates were 30% higher for African Americans than for whites, and stroke death rates were 41% higher.[2]
- In 2003, the death rates from breast cancer for black women were higher than those for white women, although the incidence rate was higher for white women.[3] Both the incidence and death rates for cervical cancer were higher for black women when compared to those for white women.[3]
- In 2005, prevalence of diabetes remained nearly 2 times higher among non-Hispanic blacks than among whites.[4]
- Although influenza (flu) vaccines are covered by Medicare,[10] only 48% of non-Hispanic blacks aged 65 years or older, compared with 69% of non-Hispanic whites in the same age group, were likely to receive a flu vaccine in 2003.[5]
- In 2001–2004, African Americans had the highest rate of all racial and ethnic groups for diagnosis of human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS).[6] African Americans, approximately 12% of the U.S. population in 2004, accounted for 50% of all HIV/AIDS cases diagnosed in that year.[7]

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.

American Indians and Alaska Natives*

- In 2000–2002, the infant death rate for American Indians was almost double that for whites.[1]
- Prevalence of diabetes remained 2.5 times higher among American Indians and more than 2 times higher among Alaska Natives than among whites.[2]
- During 2001–2004, American Indians and Alaska Natives had the third highest rate of HIV/AIDS diagnoses.[3]



Asian Americans*

- Vietnamese American women have a higher incidence rate of cervical cancer than any ethnic group in the United States—5 times that of non-Hispanic white women.[8]
- In 2004, Asians in California were 1.5 times more likely than non-Hispanic white women to have a diagnosis of type 2 diabetes.[2]
- The estimated rate of HIV/AIDS cases among Asians and Pacific Islanders, although the lowest rate for any group, increased an average of 9% per year in 2001–2004.[6,7]

Hispanics and Latinos*

- In 2002, high blood pressure was controlled in only 18% of Hispanics compared with 30% of whites who had the condition.[9]
- In 2005, type 2 diabetes was diagnosed more frequently in Hispanic American children and adolescents when compared to whites.[4]
- In 2003, only 45% of Hispanics aged 65 years or older, compared with 69% of whites in the same age group, received a flu vaccine,[5] even though the vaccine is covered by Medicare.[10]
- During 2001–2004, Hispanics had the second highest rate of AIDS diagnoses,[6] and Hispanics accounted for 18% of all new HIV/AIDS cases diagnosed in 2004.[7]

Pacific Islanders*

- Pacific Islanders are more than 2 times more likely than whites to have a diagnosis of diabetes.[6]
- The estimated rate of HIV/AIDS cases among Asians and Pacific Islanders, although the lowest rate for any group, increased an average of 9% per year in 2001–2004.[6,7]

*NOTE: Because these statistics come from various studies, definitions of race/ethnicity may vary. Racial/ethnic terms are taken as used in the references. For example, the term "African American" may include persons of Hispanic descent. The term "Hispanic" may include people of any race.

"When REACH came into the picture, that was a blessing for me because it was just like my vision had come to fruition. Through REACH, I was able to take free aerobics classes. I later trained to become a fitness instructor. And now I teach aerobics classes at my church. REACH is phenomenal!"

—Aerobics class participant who is now a certified instructor

Racial and Ethnic Approaches to Community Health (REACH)

REACH is a critical cornerstone of CDC's leadership and efforts in eliminating health disparities.

For years, public health officials, program managers, and policy makers have been frustrated by the seemingly insurmountable phenomenon of health disparities. Officials at all levels have been at a loss for solutions to address a national imperative of improving health in the communities most severely affected.

In response, the Centers for Disease Control and Prevention (CDC) embarked on a bold approach to confront health disparities by establishing REACH (formerly REACH 2010). This program is showing that we *can* reduce health disparities and we *can* improve the health status of groups that traditionally are most affected by health inequities.

REACH supports CDC's strategic goals by addressing health disparities in the critical life stages of infancy, childhood, adolescence, adulthood, and older adulthood and by developing approaches to improve health in communities, health care settings, schools, work sites, and after-school programs.

CDC's REACH program funds communities throughout the United States that work toward eliminating health disparities in key health areas among African Americans, Alaska Natives, American Indians, Asian Americans, Hispanic Americans, and Pacific Islanders.

Health Disparities Can Be Overcome

REACH communities create innovative solutions that reduce health disparities.

CDC provides training, technical assistance, and support to REACH communities. CDC also helps communities to develop, implement, and sustain effective interventions, deepen their understanding of social determinants of health, evaluate program results, disseminate findings, and publish reports in scientific journals.

CDC's REACH program is producing significant improvements in communities across our nation. REACH communities have begun to disseminate best practices and lessons learned to other communities so they can be adopted widely. These effective strategies will help inform health improvement efforts across our nation and increase the impact of health and social programs in reducing health disparities.

REACH communities are

- Empowering and mobilizing community members to seek better health.
- Bridging gaps between the health care system and community members by encouraging people to seek appropriate care and by changing health care practices.
- Changing the social and physical environments of communities to overcome barriers to good health.
- Implementing evidence-based strategies and public health programs that fit their unique social, economic, and cultural circumstances.
- Moving beyond interventions that address individual behavior to the systematic study of community and systems change.

"Over the last couple of years, I have lost over 40 pounds. I feel more energized. This has been a great program for Native people. We are proud that our community has this program."

—Participant, Oklahoma Native American REACH 2010 Project

"I came to the Village because my family suffers with a high rate of diabetes and heart disease, and I want to break the cycle by being here to see my daughter graduate from high school and get married. I do everything I can to watch what goes into my mouth and my baby's mouth, and we stay very active to keep healthy. I was tested today for diabetes and I plan to monitor my health closely."

—Ellecia Williams, participant, mother to 1-year-old daughter, 8th Annual Wellness Village Day, African American Health Coalition

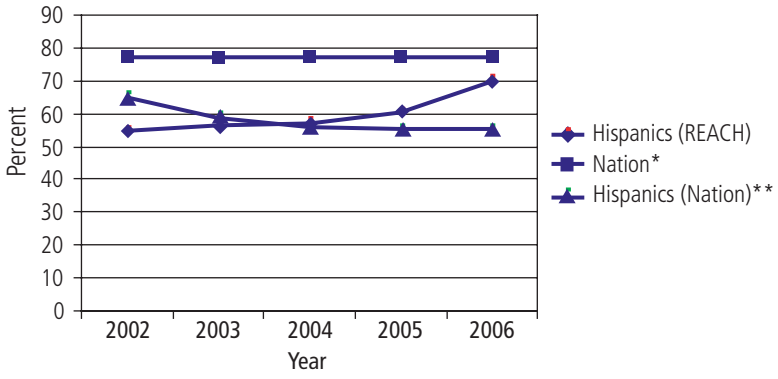
Nationally Demonstrated Results

REACH outcomes prove that health disparities are not *inevitable and* can *be overcome.*

Data from the REACH Risk Factor Survey show that the program is having a significant impact in key areas of risk reduction and management of chronic disease. The survey assesses improvements in health-related behaviors and reductions in health disparities in the 27 REACH communities that focus on prevention of breast and cervical cancer, cardiovascular health, and diabetes management.

Positive behavior changes that reduced health risks in REACH communities include the following:

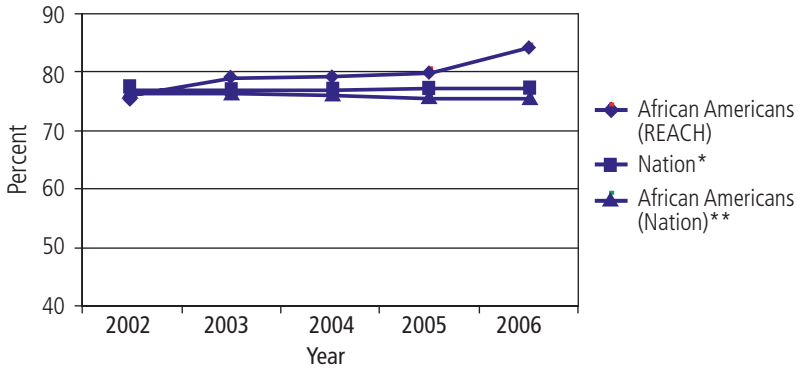
Figure 1. Cholesterol Screening Rates Among Hispanics: REACH Risk Factor Survey+, 2002–2006



+Data from REACH communities that focus on cardiovascular disease/diabetes.
*Behavioral Risk Factor Surveillance System, indicating national data.
**Behavioral Risk Factor Surveillance System, indicating data from Hispanic sample population.

- In 2002, Hispanics from REACH communities were less likely to be screened for high blood cholesterol levels than were those in the national Hispanic population. The gap was even wider when comparing Hispanics from REACH communities with the overall national population. By 2006, the cholesterol screening rate for Hispanics from REACH communities surpassed that for the national Hispanic population, and the gap between the rate for Hispanics from REACH communities and the overall national average was closing and continues to improve. (See Figure 1.)

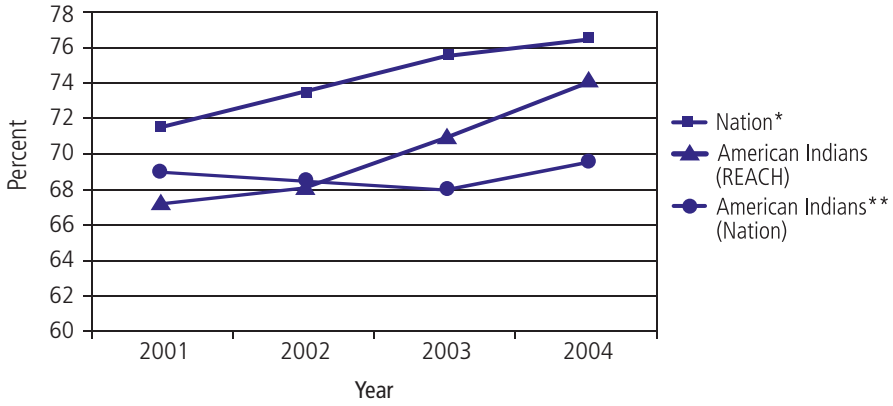
Figure 2. Cholesterol Screening Rates Among African Americans: REACH Risk Factor Survey+, 2002–2006



+Data from REACH communities that focus on cardiovascular disease/diabetes.
*Behavioral Risk Factor Surveillance System, indicating national data.
**Behavioral Risk Factor Surveillance System, indicating data from African American sample population.

- Although the proportion of African Americans from REACH communities who participated in screening for high blood cholesterol levels was below the overall national average in 2002, the cholesterol screening rate for this group exceeded the national level by 2006 and continues to improve. (See Figure 2.)

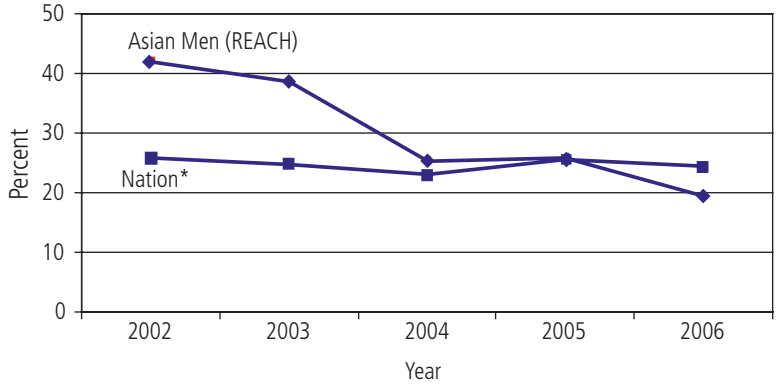
Figure 3. American Indians Currently on Medication for High Blood Pressure: REACH Risk Factor Survey+, 2001–2004



+Data from REACH communities that focus on cardiovascular disease/diabetes.
*Behavioral Risk Factor Surveillance System, indicating national data.
**Behavioral Risk Factor Surveillance System, indicating data from American Indian sample population.

- The proportion of American Indians from REACH communities who began to take medication to manage high blood pressure increased from 67% in 2001 to 74% in 2004, surpassing the national rate for the American Indian population. (See Figure 3.)

Figure 4. Asian Men Who Smoke Cigarettes: REACH Risk Factor Survey+, 2002–2006



+Data from REACH communities that focus on cardiovascular disease/diabetes.
*Behavioral Risk Factor Surveillance System, indicating national data.

- In 2002, the rate of cigarette smoking among Asian men from REACH communities was much greater than that of the overall national population. Since 2002, cigarette smoking among Asian men from REACH communities drastically decreased, from 42% to 20% in 2006, and is now below the national average for the general population. (See Figure 4.)

"If I had known about this earlier, maybe I would have not lost my sister, who died from cervical cancer. She was just busy working, taking care of her kids and her husband. She had to get a hysterectomy but she died last year. I now know as a result of VHRI [Vietnamese Health REACH Initiative] that we can prevent and treat the disease if it is detected early. Now when I meet women in the street, at school, or in the market I encourage them to get a Pap test. I even tell my friends and family in Vietnam."

—Lay health worker and participant, Vietnamese REACH for Health Initiative, Santa Clara County, CA

Impressive Community Outcomes

REACH communities are reporting striking health improvements to CDC.*

- In the span of 3 years, blood sugar levels for program participants in the REACH 2010 Latino Health project in Massachusetts improved by nearly 9%. The percentage of Latinos with systolic blood pressure below 130 mm Hg increased almost 18%; the percentage with diastolic blood pressure below 80 mm Hg increased 14%. The proportion of patients with diabetes referred for eye examinations also increased by 25% (from 51% to 64%).
- In South Carolina, the REACH 2010: Charleston and Georgetown Diabetes Coalition implemented strategies that virtually eliminated a 21% disparity in blood sugar testing between African Americans and whites. Amputations of lower extremities for African American men with diabetes living in Charleston and Georgetown counties also decreased dramatically, by 36% and 44%, respectively, over a 3-year period.
- Participants in a project of the REACH Detroit Partnership demonstrated significant improvements. The proportion of participants with diabetes who had uncontrolled blood sugar levels decreased by 17% (from 71% at the start of the program to 54% after 6 months) as measured by A1c values greater than 7. In addition, the proportion of persons with high blood pressure decreased by nearly 12% (from 56% to 44%).
- In Macon County, the Alabama REACH 2010 Breast and Cervical Cancer Coalition reduced disparity in use of mammography screening between African American and white women from 15% to 8% over a 5-year period. In Dallas County, disparity decreased from 20% to 14% during the same period. According to Medicare data for these counties, the disparity decreased from 16% in 1998 to 10% in 2003, nearly a 38% proportional reduction.
- The Vietnamese REACH for Health Initiative Coalition implemented activities, including an outreach program for lay health workers, to improve rates for cervical cancer screening among Vietnamese American women in Santa Clara County, California. As a result, 48% of Vietnamese American women who had never had a Papanicolaou's (Pap) test received the test after meeting with lay health workers. The overall percentage of these women who received Pap tests increased 15% in 2 years.
- The REACH for Wellness program in Fulton County, Georgia, designed REACH OUT, a campaign to promote cardiovascular disease education. In 2 years, this successful program led to an increase in the percentage of regular adult participants in moderate-to-vigorous physical activity from 25% to 29%. During this period, the percentage of adults who reported checking total blood cholesterol levels increased from 69% to 80%, and the percentage of adults who smoked decreased from 26% to 21%.
- Prior to its inception, immunization rates for children aged 19 to 35 months who were enrolled in the Northern Manhattan Start Right program were 10% below the national average. One year later, rates for the same age group from the program surpassed the national average for all racial and ethnic groups by 13% and were almost 10% above the New York City average.

*A profile of each REACH community is available on the REACH Web site at www.cdc.gov/reach.

"The greatness about REACH is that we have trained and empowered everyday people in the community—the 'moms and pops,' the ushers, the missionaries—these are folks we've trained who now know how to take blood pressures, who now understand what the side effects are of different medicines, who now understand about health education.... These are folks who are [going to] sustain it long after we leave, and these are the true champions of REACH."

—Program manager, REACH for Wellness, Fulton County, GA

Why REACH Works: Keys to Success

REACH has identified principles that can unlock the unique causes of health disparities in racial and ethnic communities across the country.

Community involvement is essential to successfully change policies, systems, and environments at the local level. Each REACH community brings together a diverse group of people from a variety of sectors to develop, implement, and evaluate unique disease prevention and health promotion strategies. However, developing effective, sustainable, community-based strategies and interventions requires recognizing the importance of key elements that respond to the specific needs of each community and its members:

- **TRUST:** Building a culture of collaboration with communities that is based on trust.
- **EMPOWERMENT:** Giving 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:** Designing health initiatives that acknowledge and are based in the unique historical and cultural context of racial and ethnic minority communities in the United States.
- **FOCUS on CAUSES:** Assessing and focusing on the underlying causes of poor community health and implementing solutions designed to remain embedded in the community's infrastructure.
- **COMMUNITY INVESTMENT and EXPERTISE:** Recognizing and investing in community expertise and working to motivate communities to mobilize and organize existing resources.
- **TRUSTED ORGANIZATIONS:** Embracing and enlisting community organizations valued by community members, including groups with a primary mission unrelated to health.
- **COMMUNITY LEADERS:** Helping community leaders and key organizations to act as catalysts for change in the community, including forging unique partnerships.
- **OWNERSHIP:** Developing a collective outlook to promote shared interest in a healthy future through widespread community engagement and leadership.
- **SUSTAINABILITY:** Making 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:** Fostering optimism, pride, and a promising vision for a healthier future.

The following cases presented from selected REACH communities illustrate how embedding these elements into the foundation for efforts designed to reduce health disparities has pushed forward the communities' momentum and makes powerful statements that attest to the program's success.

TRUST

Building a culture of collaboration with communities that is based on trust

A major challenge to public health efforts designed to reduce racial and ethnic health disparities is overcoming historical legacies of mistrust. Historical events, on both a national scale and through local experiences, have spawned legacies of mistrust over generations in many racial and ethnic minority communities. Public health approaches that do not treat communities as equal or do not give them license to direct the health agenda further erode trust and can jeopardize the success of public health efforts.

Innovative approaches from REACH acknowledge these historical legacies and begin to address them. They establish and communicate principles of respect for the community members, the value of community perspectives, and the goal of long-term community ownership of health initiatives.

Partners in Tribal Community Capacity Building (REACH 2010) Project

Albuquerque Area Indian Health Board, Inc.
Albuquerque, New Mexico

Establishing trust through small decisions that have a large impact

Partnerships with Native American tribes have been affected by historical and political realities that complicate the building of relationships. Public health efforts can help to overcome legacies of mistrust by investing time in building mutual communication, respect, and reciprocity and by basing public health approaches in the cultural fabric of the community. Programs that successfully build trust also communicate the principle that building community resources and skills is important in empowering the community to manage its future.

This principle is the basis of the Albuquerque Area Indian Health Board's REACH initiative to increase participation rates in screening to detect breast and cervical cancer among Native American women. From its inception, the board communicated the following aims:

- Create an atmosphere of inclusion and trust.
- Build skills for tribal members within the tribal health system.
- Strengthen relationships among tribal programs and between tribal and outside programs.
- Promote sustainability so tribes could better manage challenging health issues into the future.

Establishing these principles was an important decision for the board and immediately following through was even more critical. The board's first initiative in a local tribal community increased the community's scientific skills for public health planning and sought input and recommendations across the community. Priorities and a strategic plan were developed by community members and leaders.

Smaller steps were important, too. From the outset of the REACH initiative, the board sent a critical message to community members by basing all activities, including the format, orientation agenda, and planning meetings, in the community's cultural traditions. The respect communicated by this ongoing message went a long way in establishing trust.

In order to work together effectively, partners must first acknowledge, understand, and respect each other's differences. The example presented demonstrates that approaches designed to address historical legacies of mistrust are vital in order to build bridges of trust and grow capacity in the community, which are elements that are critical if community health is to thrive.

EMPOWERMENT

Giving individuals and communities the knowledge and tools needed to create change by seeking and demanding better health and building on local resources

An important step in undoing health disparities is to change the pattern of relationships between people and the organizations and social structures affecting their health. Equipped with key information, both individuals and communities can change their relationships with health care systems, community organizations, schools, businesses and other economic institutions, and policy makers. This process of empowerment engages individuals and communities in understanding and exercising control over their future health.

Although every experience with community change is different, all REACH communities have followed the same basic steps to effectively reduce health disparities:

- Equip affected communities with the knowledge that a disparity exists.
- Work with the community to assess the reason for the disparity.
- Address the priority concerns of the community.
- Provide tools to begin the long-term process of undoing the factors that have led to or perpetuated the condition.

Bronx Health REACH Coalition

The Institute for Urban Family Health
New York City, New York

Promoting changes in health care practices

Bronx Health REACH equipped New York City communities with information about serious health disparities and some common practices contributing to them. Community analysis of these factors led residents to ask important questions about health care delivery in the city. As a result, community members not only asked questions but also took action. In 2004, 500 people traveled to the state capitol to support delivery of equal health care to all. Community activism led to thoughtful analysis of policy factors that contribute to disparities in health care and potential solutions, such as innovations in the state Medicaid system and in the system for allocating funds for care of indigent persons.

African Americans Building a Legacy of Health

Community Health Councils
Los Angeles, California

Triggering policy solutions to change the food environment of low-income communities

Heart disease and risk factors for the disease (e.g., poor nutrition, lack of physical activity, and obesity) are serious problems in south Los Angeles, California; percentages of residents with these problems are among the highest in the nation. The local REACH coalition is documenting lack of access to healthy foods, assessing causes, and promoting solutions. Consequently, a series of policies was adopted by the Los Angeles City Council, the Los Angeles County Board of Supervisors, and the California legislature to achieve two goals: improve the quality of food in publicly sponsored programs and provide incentives to attract retailers of healthy foods to socioeconomically disadvantaged communities. These long-term policy solutions can change the food environment of the community, giving residents new options to the "food desert" (lack of healthy options) in many low-income urban and rural areas.

Northern Manhattan Start Right Coalition

Mailman School of Public Health, Columbia University
Harlem and Washington Heights, New York City, New York

Mobilizing families to seek improved child immunization coverage

Individuals equipped with key information can change their relationship with the health care system, just as empowered communities have sought and achieved important policy changes. The Northern Manhattan Start Right Coalition's REACH initiative took this approach. The coalition's driving principle was that parents are more likely to adhere to an immunization schedule if they are fully informed about diseases

that are prevented by vaccines, how vaccines work, and when their children are due to receive them. Through this initiative, parents received a bilingual information package developed by coalition members, were taught to read immunization cards, participated in a series of educational sessions, and received consistent reminders. Feedback indicates that training in card reading empowered parents to talk about immunizations with the children's health care providers and to ask which vaccinations were needed and when. Before the REACH initiative was implemented, children aged 19 to 35 months who were enrolled in the program had immunization rates 10% below the national average. Just 1 year later, children in the same age group surpassed the national average for all racial and ethnic groups by 13% and were almost 10% above the New York City average.

Seattle & King County REACH 2010 Coalition

Public Health – Seattle & King County
Seattle, Washington

Empowering people to engage with their health care providers in a partnership for improved diabetes outcomes

The REACH 2010 Seattle & King County Coalition is reaching out across local communities to engage community members in analyzing opportunities to change their relationship with the health care system and improve outcomes in diabetes control. Through lay health workers and outreach in beauty salons, faith-based organizations, and community organizations, the REACH coalition is equipping individuals with skills to better control diabetes and to take specific steps toward full engagement in their medical care.

Through the activities shown here, it can be seen that a program that is successful in one minority community often does not, and many times will not, work in another minority community. Many times, different racial and ethnic groups have different priorities when it comes to eliminating health disparities. If we are to progress toward health equity in our nation, groups that are affected by health disparities must be empowered and strengthened so that they can tailor prevention and intervention strategies to meet their specific needs.

"I learned how to inquire about the immunizations my baby should get. Now I know what shots the baby needs.…It helped me by giving me information on places to go for immunizations and also handing out lots of materials on immunizations.…Some people are not aware of how important it is to keep your child's immunizations up to date."

—Participant
Northern Manhattan Start Right Coalition

"I've learned to be ready for the doctor.… [W]hen I go to the doctor's office and I go into the examination room, I take off my shoes and socks. I don't wait for him to tell me.…On the counter I lay my monitor book with all my blood pressures and all my sugars. So it is there so he [doesn't] have to walk out and come back. I'm getting every bit of the minutes he's supposed to be giving me."

—Participant, Seattle & King County REACH 2010 Coalition, WA

CULTURE and HISTORY

Designing health initiatives that acknowledge and are based in the unique historical and cultural context of racial and ethnic minority communities in the United States

Risk factors that influence health status are shaped over time and reflect the social, economic, political, and cultural experiences of communities. The collective history of racial and ethnic groups in the United States is marked by struggle; multiple forms of inequality; and social, political, economic, and cultural divides. REACH initiatives base public health responses to health problems in the cultural and historical experiences of the communities in which they work.

REACH Detroit Partnership

Community Health & Social Services Center, Inc.
Detroit, Michigan

Basing diabetes curriculum in the strengths of African American and Latino communities

Among other activities aimed at making important community-wide changes, the REACH Detroit Partnership developed a family-based intervention to address diabetes that builds on the cultural perspectives and strengths of African American and Latino communities in Detroit. Family health advocates deliver five curriculum meetings to help participants and their families make critical changes in nutrition and physical activity, as well as diabetes self-care. Participants demonstrated significant improvements. At the start of the program, 71% of participants had uncontrolled blood sugar levels (as measured by A1c values greater than 7). At the 6-month follow-up after the intervention, 54% had uncontrolled blood sugar levels, a 17% decrease. In addition, 56% had high blood pressure at the start. After 6 months, 44% had high blood pressure, a decrease of nearly 12%.

Genesee County REACH 2010 Team

Genesee County Health Department
Flint, Michigan

Tackling difficult factors related to infant mortality at individual and societal levels

In Flint, Michigan, the Genesee County REACH coalition is tackling tough issues contributing to severe disparity in infant mortality. Nationally, African American infants are 2.5 times more likely than white infants to die before their first birthday. REACH in Flint is combining approaches, including partnering with "Birth Sisters," a program through which an expectant African American mother identifies a "birth sister" who will undergo a series of trainings in order to provide social and emotional support to the expectant mother during pregnancy and the first year of the child's life. Another approach is the assistance from mother-and-infant health advocates with strategies addressing the broad societal influence of racism. REACH in Flint developed and institutionalized an innovative course at the University of Michigan for students and professionals preparing for careers in health. The course aims to improve the ability of the health care system to reduce health disparities by preparing future practitioners with an understanding of how society-wide racism can influence health care practice and health care systems. In response to a mailed survey 6 months after the end of a sample course, most students indicated that they had better understanding of the negative role of racism in health outcomes and were able to directly apply their learning in patient–provider interactions.

These two strategies illustrate how focusing on cultural and historical experiences becomes the door through which REACH engages communities to tackle difficult and serious health problems. Recognizing that individuals and communities live, work, and play under unique circumstances, success becomes possible only when health-related interventions focus on the communities' specific cultural influences and historical roots that jointly affect health-related behaviors, access to health care services, and health status over the life course.

FOCUS on CAUSES

Assessing and focusing on underlying causes of poor community health and implementing solutions designed to remain embedded in the community's infrastructure

Eliminating health disparities requires a sustained, coordinated, and focused strategy that systematically addresses root causes of health disparities and consequences of these underlying factors, such as limited access to quality health care, lack of adherence to medical care plans, poor nutrition, poor stress management, and other unhealthy behaviors.

REACH encourages local coalitions to examine the elements contributing to poor health in their communities. Coalitions have recognized that many important factors fall outside the traditional realms of the physician's office and educational efforts to encourage healthy choices.

REACH 2010 Charleston and Georgetown Diabetes Coalition

Medical University of South Carolina
Charleston, South Carolina

Using a community needs assessment that led to a library initiative to assist the community in diabetes self-management

Although the Internet is widely used as a health information tool by health care professionals and consumers, unequal access to information technology continues to affect minority populations. Unequal access to information on diabetes care and the resulting poor outcomes in diabetes are documented in the scientific literature. The REACH 2010 Charleston and Georgetown Diabetes Coalition discovered that people with diabetes in the community had high interest in using the Internet to seek important information about how to manage their condition. However, 50% of older community members and 40% of people with less than 12 years of formal education needed help in learning how to use the Internet, so the coalition built a library partnership to support and sustain diabetes education across the community. This library partnership promotes use of online health information in the context of support systems for the African American community. Overall, the coalition demonstrated tremendous success with its multipronged REACH initiative; the library initiative is one of an array of approaches the coalition has used. The coalition's experience of including a library partnership in a health initiative can deepen public health's understanding of the role libraries and networked information technology can play in reducing and eliminating health disparities.

A crucial lesson learned from REACH is the importance of allowing communities to directly address those factors not traditionally viewed as health related through their health improvement initiatives. Having a clear view of the variables for change and the infrastructure to support the efforts needed to achieve these changes is key in the campaign to eliminate health disparities.

COMMUNITY INVESTMENT and EXPERTISE

Recognizing and investing in community expertise and working to motivate communities to mobilize and organize existing resources

Critical for the long-term success of initiatives designed to eliminate health disparities is the establishment of principles ensuring that an initiative will invest in a community and recognize and value community members with expertise that does not come from formal training. These principles can accelerate the building of trust and help to overcome suspicion associated with collective memory of historical events that may have drained local resources and created legacies of dependence on expertise from outside the community that may not remain engaged over the long term.

From the outset, CDC's REACH program required that local REACH coalitions demonstrate active community participation. Communities responded with active engagement that mobilized and organized local resources to focus on health improvement.

Choctaw Nation Core Capacity Building Program

Choctaw Nation of Oklahoma
McAlester, Oklahoma

Investing in issues of high priority to the community

The Choctaw Nation of Oklahoma established new community health coalitions and partnered with existing coalitions to deliver interventions to members of the Choctaw Nation. Most coalitions identified substance abuse education related to methamphetamine use as the greatest need in many of their rural communities. As a result, a program was created to incorporate substance abuse education into the project's program for cardiovascular disease prevention. Partnerships were established with an epidemiology center, a university, and an independent evaluation team for data interpretation. The project was joined by the State Bureau of Investigation and a local recovery center to promote the message to communities and schools that use of harmful substances can be detrimental to cardiovascular health. Various educational classes, train-the-trainer sessions, and printed educational materials were created and shared at many local and national events. In addition, the project was featured in numerous newsprint articles and staff made presentations at local and national conferences.

REACH African American Health Coalition

African American Health Coalition, Inc.
Portland, Oregon

"Creating a movement" for health through local investments

In Portland, Oregon, the REACH coalition tackled the complex issue of changing the community's collective norms about physical activity. In assessing local opportunities for physical activity, the coalition identified a lack of certified African American experts on physical activity to teach exercise classes. Community input indicated that this deficiency was a factor important to community members and that having African American teachers and motivators for physical activity classes, community walks, and other opportunities for physical activity could be important in changing community norms. The coalition identified African American community members who were engaged in the area of physical activity and had a rapport and a reputation of trust in the community but were not certified to teach. The coalition recruited a certified fitness expert to train 15 instructors, who now hold specific teaching certifications, as well as certifications in cardiopulmonary resuscitation (CPR) and first aid. These instructors provide innovative opportunities for community members to "try out" a physical activity routine through community-based classes. In an early 10-month assessment among

approximately 900 participants, 58% reported exercising more as a result of the program. The coalition estimates that 3,000 community members participate in the overall Wellness Within REACH physical activity initiative. Importantly, community members report that REACH is creating a "movement" that is inspiring and shifting the local African American community's norm toward incorporating physical activity into people's daily lives.

Promoting physical activity is one approach the REACH coalition in Portland is using to confront and reverse risk factors for heart disease and stroke. The coalition also trained beauty and barbershop operators as lay community health educators, and these educators regularly deliver "health chats" about risk factors for heart disease and stroke. In addition, youth advocates were trained and are making presentations to their peers and families.

To sustain these community innovations, Wellness Within REACH holds an annual Wellness Village Day health fair, which celebrates the community's health, and includes a fund-raising community walk. The health fair offers free health screenings and information to residents in a way that reflects their local culture. When the events were evaluated, 50% of respondents said the Wellness Village is the only place they get health screenings. The walk attracts more than 500 participants of all ages, and grand marshals typically include policy makers such as the mayor and state and local legislators. Funds raised through the walk help to sustain health promotion activities throughout the year.

Investment decisions made by REACH coalitions build on community strengths. As shown through the activities carried out by the REACH communities presented, the principle of community engagement communicated clearly that REACH would value the expertise of community members. This acknowledgment creates a fabric of stronger, resilient communities capable of sustaining health improvement efforts.

"I heard about the walk on television and couldn't wait to sign up. When I found out our church was walking in the event, I got even more excited. I live in a retirement home…. I believe we all need to do our part to be healthy and strong, and I support this effort all the way."

—Annie Cavil, participant
1st Annual Wellness Within Reach Walk

TRUSTED ORGANIZATIONS

Embracing and enlisting community organizations valued by community members, including groups with a primary mission unrelated to health

REACH coalition partners include a rich mix of community-based organizations, state and local health departments, universities and other research institutions, faith-based organizations, tribal organizations, groups focused on older adults, local chapters of national voluntary health organizations, and national and regional minority organizations. REACH recognizes that achieving widespread community change to improve health requires engaging organizations beyond those focused on health.

In recent years, faith-based approaches to racial and ethnic disparities in health have received increased national attention. Faith-based organizations are key participants in many local REACH coalitions and community programs and have created new bridges between community members and health resources. Many faith-based groups have institutionalized efforts such as nutrition and physical activity programs within their organizations, thus helping to change the environment of communities to give community members access to opportunities for making healthier lifestyle choices.

Bronx Health REACH Coalition

The Institute for Urban Family Health
New York City, New York

Promoting health through changes embraced by faith-based organizations

Bronx Health REACH seeks to reduce illness and death rates attributable to diabetes and cardiovascular disease in a largely minority community in the Bronx. The strategies include a faith-based initiative. Participating churches appoint a member to engage in the REACH initiative and coordinate church activities. Coordinators use existing organizational structures and communication systems within the churches to deliver individual and community outreach and education. They recruit volunteers to monitor the health of church members. Volunteers identify, for example, members with diabetes who rarely leave home because of their condition, and coordinators reach out with house calls to provide nutritional counseling, social support, and referrals. Participating churches have also made significant changes to their policies and practices. Several churches quickly realized that the food provided by their pantry was unhealthy, and they made improvements. Many now serve traditional recipes modified for better health at church events. Innovations such as "gospel aerobics" are occurring in participating churches. Pastors now routinely incorporate health messages into their weekly sermons, and weekly church bulletins include health information and messages.

The Bronx Health REACH Coalition's collaboration with local churches indicates that involving community institutions, such as faith-based organizations, often prompts these institutions to move beyond organizational changes and engage in efforts to improve health that reach across the community and mobilize widespread community action. It has become clear that change requires working with organizations trusted by community members to provide a collective voice and leadership to community mobilization.

COMMUNITY LEADERS

Helping community leaders and key organizations to act as catalysts for change in the community, including forging unique partnerships

Community-based health efforts have long recognized the important role of key community leaders in mobilizing community interest and focusing community energy. In all communities, individuals and organizations emerge as a source of leadership for solving community concerns. Those that are effective in listening and achieving solutions become established as trusted leaders supported by the community. Often, communities decide whether to participate in health improvement efforts based on judgment and guidance from these leaders.

Vietnamese REACH for Health Initiative Coalition

The University of California, San Francisco
Santa Clara County, California

Engaging new leaders who can bridge cultural divides

In Santa Clara County, California, the Vietnamese REACH for Health Initiative tackled severe disparities in cervical cancer incidence and cervical cancer screening. (The incidence rate of cervical cancer for Vietnamese American women is 5 times that for non-Hispanic white women and higher than that for women in any other ethnic group in the United States.) The coalition fostered community health workers who open communication between health systems and community members and provide critical health information to their communities. These community health workers gained personal confidence and community respect as they grew in their outreach roles. They are now emerging as leaders sought out by community members for information, advice, and solutions to health problems.

The coalition reports the following lessons learned:

- Successful community health workers were people with well-established ties and a good reputation in the community. Formal education or training was not necessary, but motivation and willingness to learn were essential.
- These health workers brought their community's cultural traditions to their outreach efforts as they formed relationships in the community.
- The workers had a deep passion for helping their neighbors and worked well beyond the scope of tasks originally planned. They responded to the needs of community members and helped women, particularly new immigrants, to access health information and preventive services.

The efforts of community health workers in Santa Clara County paid off. Almost 48% of the women who never had a Pap test had one after meeting with community health workers, and the percentage of Vietnamese American women in the community who received Pap tests increased by 15% over a period of 2 years.

Local REACH coalitions have engaged community leaders who can be catalysts for change in their communities, and they have also cultivated new and emerging leaders. In doing so, REACH also strengthens the ability of communities to respond to continuing and new health challenges. By supporting and developing emerging leaders trusted by community members, REACH creates bridges for communication between community members and organizations such as health care systems.

"Before coming to the United States, I didn't know anything about cancer. Then, with the help of women like Mai [lay health worker], I began going to the doctor and getting treatment for my cancer. It helped me save my life."

—Participant, cancer survivor, and lay health worker
Vietnamese REACH for Health Initiative

OWNERSHIP

Developing a collective outlook to promote shared interest in a healthy future through widespread community engagement and leadership

Guided by community coalitions, REACH initiatives engage members of the communities they serve to be active participants in their own health. REACH also bases initiatives in the priority concerns of local communities, and communities are fully involved in defining those priorities. This approach ensures widespread community engagement and creates community-wide investment in the success of REACH initiatives well into the future.

Metropolitan Boston Haitian REACH 2010 HIV Coalition

Center for Community Health, Education & Research, Inc.
Boston, Massachusetts

Thoughtful planning to ensure community ownership at every stage of an initiative, including data collection and analysis

The Metropolitan Boston Haitian HIV Prevention coalition is using a range of strategies for HIV prevention, including a media campaign, community-based education, training for health professionals, and mobilization of leaders in the Haitian community. The coalition discovered the importance of community ownership at every stage of health initiatives.

With careful planning, the coalition ensured community ownership of the coalition's evaluation efforts. The community was fully engaged in an evaluation survey and all aspects of the evaluation process.

- A broad array of community stakeholders was involved in defining measures for the coalition's success. This strategy gave legitimacy to the evaluation process in the community.
- The coalition took time to build understanding within the community of the evaluation process and how it could benefit the community. This approach helped community members to overcome fears of being judged, a critical issue in evaluating interventions by health professionals.
- The coalition administered a community survey as part of evaluating its efforts. Information about the survey and its importance was presented on local radio stations. Listeners were invited to contact the coalition's lead agency to discuss the survey in more detail and were encouraged to inform neighbors, friends, and family about it. Survey information was also distributed to churches and businesses in the Haitian community. As a result of this concentrated outreach, more than 2,700 residents participated, allowing measurement of community-wide changes in attitudes, beliefs, and behaviors.
- Feedback indicates that the community took great pride in its role in the community survey and was eager to learn from the survey results.

The coalition reported that when a community participates fully in all aspects of an evaluation process, the community takes ownership of the evaluation and responsibility for using and implementing results. Full engagement by community members gives legitimacy to evaluation results and increases the likelihood that findings will be used to implement change.

Through these initiatives, it is seen that REACH engages members of the communities they serve to be active participants in their own health. The program requires that each REACH community be guided by a community coalition. This ensures widespread community engagement and creates community-wide investment in the success of REACH health initiatives over the long term.

SUSTAINABILITY

Making changes to organizations, community environments, and policies to help ensure that health improvements are long-lasting and community activities and programs are self-sustaining

REACH and other federal and private initiatives designed to improve health outcomes demonstrate that good health and longevity are desired by even the most disadvantaged communities. To ensure continuous success in achieving health outcomes, communities must establish mechanisms to maintain advances and continue efforts to improve health when start-up funding ends. In communities with relatively few resources, sustaining initiatives to address health disparities requires creativity and ingenuity from community members, businesses, and community institutions. Achieving and supporting changes in systems and in behavior is a long-term commitment and investment.

REACH Out

Access Community Health Network and the University of Illinois at Chicago
Chicago, Illinois

Using local coalitions as a catalyst for long-term investment in health innovations

REACH Out in Chicago, Illinois, began as a community-based effort in nine largely African American churches and two Hispanic church organizations to mobilize African American and Hispanic women to seek screening tests for early detection of breast cancer and cervical cancer. Energy and focus on aggressively addressing cancer quickly spread, and communities from the lowest-income areas of Chicago began to work across racial, ethnic, and neighborhood boundaries to build a far-reaching, faith-based education and mobilization effort. Recognizing that health disparities could not be adequately addressed until low-income uninsured and underinsured women had access to hospital-based diagnosis and treatment services, REACH Out began a more concentrated effort to secure funds for these services. The coalition's efforts resulted in a statewide comprehensive program, Stand Against Cancer, which provides faith-based outreach and health education in low-income neighborhoods across the state as well as case management and treatment. The state of Illinois continues to commit significant funds to this effort.

Charlotte REACH 2010 Coalition

Carolinas HealthCare System
Charlotte, North Carolina

Sparking innovative changes with the potential for long-term sustainability in communities

Community members in the northwest corridor of Charlotte, North Carolina, face serious problems from heart disease and diabetes. The Charlotte REACH 2010 Coalition examined data showing that the average mortality rate for heart disease among residents of the northwest corridor was almost 40% higher than that among those in the rest of the county. The coalition identified potential causes of these local health problems. One contributing factor identified was lack of access to fresh fruits and vegetables. The coalition worked with the community to establish a neighborhood farmers' market that provides community residents with better access to fresh fruits and vegetables once a week. The market offers space for local vendors to sell produce and averages about 350 customers each week. Since the market opened, 73% of residents said they are eating more fresh fruits and vegetables each day. The coalition has now been able to withdraw, and the community has taken full responsibility for sustaining the farmers' market.

Vietnamese REACH for Health Initiative Coalition

The University of California, San Francisco
Santa Clara County, California

Making changes in the health care system that reduce health disparities and lead to replication by providers in other areas of the nation

The Vietnamese REACH for Health Initiative Coalition in Santa Clara County, California, is addressing the factors contributing to severe disparity in the incidence of cervical cancer among Vietnamese American women. Studies

showed that most Vietnamese women in the United States receive medical care from Vietnamese physicians.[11] However, Vietnamese women who regularly see Vietnamese physicians are less likely than white women to have screening to detect cervical cancer.[12–14] Many of these physicians are men who receive limited training in preventive medicine, focus on treating present illness rather than practicing preventive care, and have busy work schedules. All these factors may work against the likelihood of recommendations for such testing. To increase referrals for cervical cancer screening, the Vietnamese Community Health Promotion Project at the University of California, San Francisco, collaborated with the Vietnamese Physician Association of Northern California to develop three continuing medical education (CME) seminars on cervical cancer. The seminars were designed to train physicians to identify risk factors, to recommend Pap tests, and to evaluate and conduct follow-up of abnormal Pap test results. In just 2 years, 159 Vietnamese American physicians were educated about cervical cancer. At the end of the first CME seminar, 97% of participants knew of the risk of cervical cancer among Vietnamese American women. After the second CME class, nearly 90% knew the appropriate management for abnormalities found with Pap testing, and 87% knew that early-stage cervical cancer is 100% curable. This REACH coalition identified a specific factor contributing to a severe health disparity. The solution was an adjustment in the medical care system at the critical link of Vietnamese doctors, and this solution can be replicated in other parts of the country.

The examples presented illustrate that mobilizing communities that bear a disproportionate burden of disease to implement evidence-based public health programs that fit their unique circumstances is critical to ensure that strategies and programs remain embedded in the communities' infrastructure.

"In our clinic, the first year [2000] we had 2% Vietnamese clients. Four years later, 20% clients! The increase has a lot to do with the [lay health workers] and this coalition."

—Clinic staff
Vietnamese REACH for Health Initiative

HOPE

Fostering optimism, pride, and a promising vision for a healthier future

Many lessons are learned through observation. Hopelessness and learned defeat quickly derail the promise and effectiveness of evidence-based interventions. However, when people see others overcome health problems and live a full life, they are inspired to believe that the same possibility exists for them. Successful community interventions to eliminate health disparities build a sense of hope in the community that the future will be brighter than the past.

REACH 2010 Charleston and Georgetown Diabetes Coalition

Medical University of South Carolina
Charleston, South Carolina

Supporting healthy changes among African Americans by promoting positive relationships

In 1999, African Americans living in South Carolina's Charleston and Georgetown counties engaged in less physical activity, ate poorer diets, and had higher obesity rates than whites. In addition, African Americans with diabetes had poorer quality of diabetes care and higher rates of heart disease, amputation, and kidney disease than whites did. The REACH 2010 Charleston and Georgetown Diabetes Coalition focuses on diabetes care and control for more than 12,000 African Americans who have diabetes. The Diabetes Initiative of South Carolina and more than 40 partner organizations are supporting the coalition as it implements a community action plan to reach out to African Americans where they live,

How Does Phyllis Manage Diabetes? One Dress Size at a Time.

In early 2005, Phyllis* was admitted to the intensive care unit because of a high blood sugar level. She did not know she had diabetes before she was admitted and did not know how to take care of her diabetes. In addition, she had no income and could no longer afford the care of a private physician.

Phyllis contacted staff of the REACH 2010 Charleston and Georgetown Diabetes Coalition and started to attend the diabetes class offered through the program. She has made great progress since she was admitted to the intensive care unit, including significant lifestyle changes, such as exercising at least 3 days a week for 30 minutes a day and cutting her meal portions in half when dining out. These efforts helped her to drop from a size 26 to a size 18—a whopping 8 sizes!

These changes enabled Phyllis to maintain a blood sugar level within normal range, and her vision has improved. After learning that diabetes has a genetic component, she encouraged her children to have tests to detect diabetes and to watch what they eat. Phyllis describes how the program has helped her get on the path to better health: "REACH 2010 and the Medical University of South Carolina got me back on my feet again. I am working again and enjoying life with friends and family. Don't ever end this program; we need more support groups like this one."

* Participant's name has been changed.

worship, work, play, and seek health care. The plan aims to decrease the burden of diabetes and link people to needed services. Strategies include the following:

- Creating walk-and-talk groups.
- Providing diabetes medicines and supplies.
- Creating learning environments where health professionals and persons with diabetes learn together.
- Establishing library learning and resources.
- Offering advice on how to buy and prepare healthier foods.
- Improving the quality of diabetes care.

Just 2 years after the program started, African Americans in Charleston and Georgetown counties were more physically active and were offered healthier foods at group activities. Some disparities in access to diabetes care and control are greatly reduced for African Americans with diagnosed diabetes. More African Americans now have the recommended annual blood tests for hemoglobin A1c (glycosylated hemoglobin A) to measure this indicator of average blood sugar levels, lipid profile, and kidney function, as well as annual eye examinations with dilation and measurement of blood pressure. A 21% gap in hemoglobin A1c testing between African Americans and whites has been virtually closed. Amputation of lower extremities in African American men with diabetes also decreased dramatically. In Charleston and Georgetown counties, amputations fell by 36% and 44%, respectively.

Eliminating health disparities invokes a sense of power over one's destiny and gives hope that something can be done to ensure a healthier and vital future. Therefore, when planning community interventions to eliminate health disparities, it is essential to build a sense of hope in the community that the future will be brighter than the past. By sharing and using these principles, we will become a nation that will help people—regardless of race or ethnicity—obtain and maintain optimal health.

"The REACH 2010 Project has meant a great deal to me. I have not only learned to care for myself, but for others as well. REACH has taught me how to buy and prepare foods that are healthy and tasty. Since I recently learned that I am a diabetic, being able to prepare healthy meals is very important. The REACH 2010 Project has shown me how to treat myself better. I take my medicine on time, buy healthy foods, and stay away from foods that are high in cholesterol and fat. REACH 2010 is truly a blessing. Because of what I have learned I can now help others live healthier lives."

—Lay health advisor and participant, Charlotte REACH 2010 project, NC

Spreading the Word: Sharing Principles That Work

Improving the nation's health depends on implementing and expanding proven REACH strategies.

REACH communities are reporting measurable outcomes that show reductions in health disparities and significant improvements in health. As the program continues to help its communities analyze local data and evaluate prevention activities, REACH has begun to disseminate effective strategies, lessons learned, and keys to success in order to have broader impact on public health efforts to overcome disparities. As REACH spreads findings from REACH communities through diverse channels, additional communities and public health programs across the nation will be provided with vital tools to address this area.

CDC's REACH program will begin a new phase of increased emphasis on disseminating effective strategies to reduce health disparities. In the wake of a major strategic planning initiative, CDC is now positioning REACH to have greater national impact by disseminating and building on the body of knowledge established by the initial REACH communities. By sharing best practices and lessons learned, REACH Across the U.S.—the new phase of the program—will expand the reach of promising interventions nationwide by giving more communities and public health programs tools they need to eliminate health disparities among racial and ethnic minority populations.

Future REACH priorities include the following:

- Disseminating lessons learned, effective strategies, and keys to success to strengthen public health and community efforts designed to eliminate racial and ethnic health disparities across the country.
- Documenting the impact of cultural competency in creating behavioral change among racially and ethnically disadvantaged communities.
- Continuing to support community-based participatory approaches.
- Establishing Centers of Excellence in Eliminating Disparities that will serve as mentoring institutions.
- Providing programs with the tools to engage in research on the social determinants of health.
- Expanding policy initiatives designed to create environmental change.
- Broadening the program's impact by cultivating partnerships with national, state, and local organizations that focus on minority health, have ties to local communities, and share the mission of REACH to eliminate health disparities and build healthy communities.

The REACH program has generated striking improvements in health. REACH continues to show that eliminating health disparities for and among racial and ethnic minority groups is achievable. We now know enough to urge the spread of these efforts nationwide. The time has come to actively disseminate the lessons learned in REACH communities and to provide additional communities with the tools to implement effective strategies and interventions. The nation's health depends on it!

For more information on REACH, visit the program's Web site at www.cdc.gov/reach.

REACH Communities 1999–2007

A network of innovative communities working to eliminate health disparities

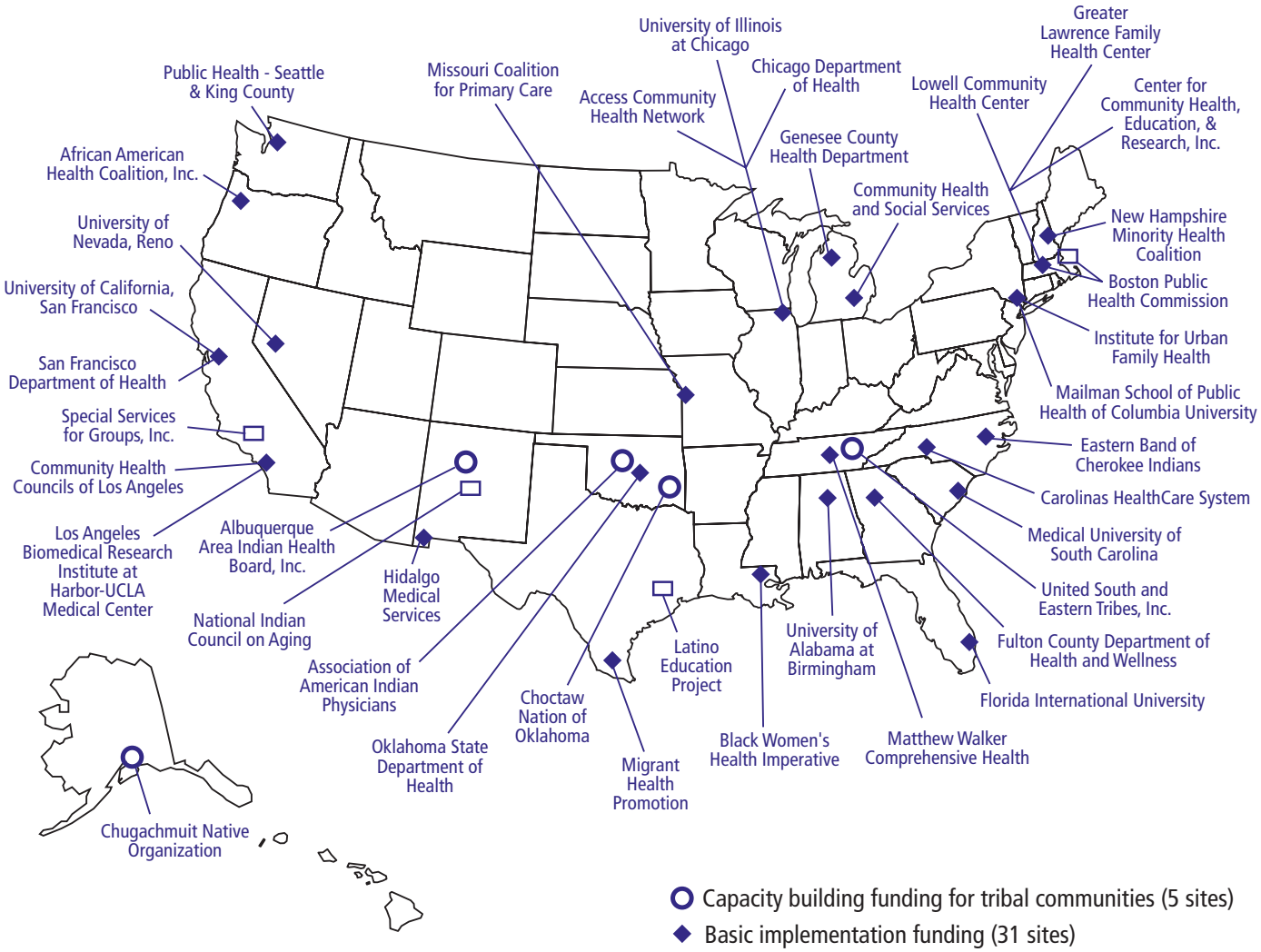
State	REACH Project (Central Coordinating Organization)	Health Priority Area(s)						Minority Group(s) Served						
		Cancer*	CVD	DM	HIV/AIDS	IMMU	INFM	AA	AI	AN	Asian	H/L	OA	PI
AK	Alaska Native CVD Prevention/Core Capacity Building Project (Chugachmiut Native Organization)		●						●	●				
AL	Alabama REACH 2010 Breast and Cervical Cancer Coalition (University of Alabama at Birmingham)	●						●						
CA	African Americans Building a Legacy of Health (Community Health Councils of Los Angeles)		●	●				●						
CA	Immunize LA Kids Coalition (Los Angeles Biomedical Research Institute at Harbor-UCLA Medical Center)					●		●				●		
CA	REACH 2010/Health Access for Pacific Asian Seniors (HAPAS) (Special Service for Groups, Inc.)		●	●		●					●		●	●
CA	SevenPrinciples Project (San Francisco Department of Public Health)						●	●						
CA	Vietnamese REACH for Health Initiative Coalition (University of California, San Francisco)	●									●			
FL	Coalition to Reduce HIV in Broward's Minority Communities (Florida International University)				●			●				●		
GA	REACH for Wellness (Fulton County Department of Health and Wellness)		●					●						
IL	Chicago Southeast Diabetes Community Action Coalition (University of Illinois at Chicago)			●				●				●		
IL	REACH 2010/Lawndale Health Promotion Project (Chicago Department of Health)		●	●				●				●		
IL	REACH Out (Access Community Health Network and Univ. of Illinois at Chicago)	●						●				●		
LA	REACH 2010: At the Heart of New Orleans Coalition (Black Women's Health Imperative)		●					●						
MA	Cambodian Community Health 2010 Program (CCH 2010) (Lowell Community Health Center)		●	●							●			
MA	Metropolitan Boston Haitian REACH 2010 HIV Coalition (Center for Community Health, Education & Research, Inc. [CCHER])				●			●						
MA	Boston REACH 2010 Breast and Cervical Cancer Coalition (Boston Public Health Commission)	●						●						
MA	REACH Boston Elders 2010 (Boston Public Health Commission)		●	●				●					●	
MA	REACH 2010 Latino Health Project (Greater Lawrence Family Health Center)		●	●								●		
MI	Genesee County REACH 2010 Team (Genesee County Health Department)						●	●						
MI	REACH Detroit Partnership (Community Health & Social Services Center, Inc.)			●				●				●		

State	REACH Project (Central Coordinating Organization)	Health Priority Area(s)						Minority Group(s) Served						
		Cancer*	CVD	DM	HIV/AIDS	IMMU	INFM	AA	AI	AN	Asian	H/L	OA	PI
MO	Kansas City - Chronic Disease Coalition (KC-CDC) (Missouri Coalition for Primary Care)		●	●				●				●		
NC	Charlotte REACH 2010 Coalition (Carolinas HealthCare System)		●	●				●						
NC	Cherokee Choices/REACH 2010 Diabetes Prevention Program (Eastern Band of Cherokee Indians)			●					●					
NH	New Hampshire REACH 2010 Initiative (New Hampshire Minority Health Coalition)			●				●				●		
NM	Partners in Tribal Community Capacity Building (REACH 2010) Project (Albuquerque Area Indian Health Board, Inc.)	●							●	●				
NM	Diabetes Educational Outreach Strategies (DEOS) Project (National Indian Council on Aging)			●					●	●			●	
NM	La Vida Program (Hidalgo Medical Services)			●								●		
NV	Healthy Hearts Project (University of Nevada, Reno)		●					●						
NY	Bronx Health REACH Coalition (Institute for Urban Family Health)		●	●				●				●		
NY	Northern Manhattan Start Right Coalition (Mailman School of Public Health of Columbia University)					●		●				●		
OK	Choctaw Nation Core Capacity Building Program (Choctaw Nation of Oklahoma)		●						●	●				
OK	Oklahoma REACH HIV/AIDS American Indian Capacity Building (OKRAICB) program (Association of American Indian Physicians)				●				●	●				
OK	Oklahoma Native American REACH 2010 Project (Oklahoma State Department of Health)		●	●					●					
OR	REACH African American Health Coalition (African American Health Coalition, Inc.)		●					●						
SC	REACH 2010 Charleston and Georgetown Diabetes Coalition (Medical University of South Carolina)			●				●						
TN	Nashville Health Disparities Coalition REACH 2010 Project (Matthew Walker Comprehensive Health Center)		●	●				●						
TN	REACH 2010 Immunization and Infant Mortality Project (United South and Eastern Tribes, Inc.)					●	●		●	●				
TX	REACH Latino Education Project (Latino Education Project)		●	●								●	●	
TX	REACH Promotora Community Coalition (Migrant Health Promotion)			●								●		
WA	Seattle & King County REACH 2010 Coalition (Public Health - Seattle & King County)			●				●			●	●		●

*Cancer = breast and cervical cancer
CVD = cardiovascular disease
DM = diabetes mellitus
IMMU = immunization
INFM = infant mortality
AA = African American
AI = American Indian
AN = Alaska Native
H/L = Hispanic/Latino
OA = older adult
PI = Pacific Islander

REACH Communities, 1999–2007

A network of pioneering communities working for better health



Selected Publications and Presentations

Alabama

Alabama REACH 2010 Breast and Cervical Cancer Coalition (ABCCC) University of Alabama at Birmingham

- "Addressing Disparities Through Coalition Building: Alabama REACH 2010 Lessons Learned." *Journal of Health Care for the Poor and Underserved* 2006;17(2, suppl): S55-S77.
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Washington

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REACH

RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH

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