

# RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH (REACH 2010): AN OVERVIEW

Wayne H. Giles, MD, MS; Pattie Tucker, DrPH;  
Levator Brown, BA; Cyntia Crocker, BA; Nkenge Jack, MPH;  
Annie Latimer, MSA; Youlian Liao MD; Thijuanie Lockhart;  
Sara McNary, MPH; Michael Sells, MS; Virginia Bales Harris, MPH

During the last 400 years, substantial disparities in health among US racial and ethnic groups have been well documented. While numerous efforts have been made to document and address these disparities, the first large-scale Department of Health and Human Services (DHHS) effort toward this end was the *Secretary's Task Force Report on Black and Minority Health*, which was released in January 1986.<sup>1</sup> The objectives of that report were:

1. To study the current health status of Blacks, Hispanics, Native Americans, and Asians/Pacific Islanders;
2. To review each racial and ethnic group's ability to gain access to, and utilize, the healthcare system;
3. To assess factors contributing to the long-term disparities in health status between minority and non-minority populations;
4. To review existing DHHS research and service programs relative to minority health;
5. To recommend strategies to redirect Federal resources and programs to narrow the health differences between minority and non-minorities; and
6. To suggest strategies by which the

---

From the Division of Adult and Community Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, Atlanta, Georgia.

Address correspondence and reprint requests to Wayne H. Giles, MD, MS; 4770 Buford Hwy; MS K-30; Atlanta, GA 30341; 770-488-5514; 770-488-5974 (fax); hwg0@cdc.gov

public and private sectors can cooperate to bring about improvements in minority health.

After an initial review of national data, the Task Force adopted a study approach based on the statistical technique of "excess deaths" to define the differences in health between minority and non-minority populations. The Task Force's analysis revealed that 6 specific health areas accounted for more than 80% of the difference in death rates between minority and non-minority populations. Those 6 areas were: 1) cardiovascular diseases; 2) cancer; 3) chemical dependency; 4) diabetes; 5) homicide and suicide and unintentional injury; and 6) infant mortality and low birth weight.

Despite several efforts to address racial/ethnic disparities in health since the 1986 Task Force Report, large disparities persist. For example, the heart disease mortality rate is substantially higher among African-American women (278/100,000 population), compared to their White counterparts (205/100,000 population).<sup>2</sup> The prevalence rate of HIV among Hispanic women is almost twice as high as that among White women (14.3/100,000 population vs 8.8/100,000, respectively),<sup>2</sup> and the prevalence rate of cervical cancer among Vietnamese women is 5 times higher than that among White women (43/100,000 population vs 8.7/100,000 population, respectively).<sup>3</sup>

Because of these sobering statistics, one of the overarching goals of Healthy People 2010 is the elimination of racial/ethnic disparities in health, especially in the following 6 priority areas: screening

**Table 1. Central coordinating organizations in the REACH 2010 demonstration programs**

Central Coordinating Organization	State	Health Priorities						Target Minority Groups			
		CVD	DM	HIV/AIDS	INFM	Cancer*	IMMU	Black	Hispanic	Asian	AI/AN
Access Community Health Network	IL					•		•	•		
African-American Health Coalition	OR	•						•			
Albuquerque Area Indian Health Board, Inc (CC)	NM					•					•
Association of American Indian Physicians (CC)	OK			•							•
Boston Public Health Commission (Elderly)	MA	•	•					•			
Boston Public Health Commission	MA					•		•			
California Black Health Network	CA	•	•					•			
Charlotte Mecklenburg Hospital System	NC	•	•					•			
Center for Community Health Education and Research	MA			•				•			
Chicago Department of Health	IL	•	•					•	•		
Choctaw Nation of Oklahoma (CC)	OK	•									•
Chugachmiut, Inc (CC)	AK	•									•
Community Health Councils of Los Angeles	CA	•	•					•			
Community Health and Social Services	MI		•					•	•		
Eastern Band of Cherokee Indians	NC		•								•
Florida International University	FL			•				•	•		
Fulton County Department of Health and Wellness	GA	•						•			
Genesee County Health Department	MI				•			•			
Greater Lawrence Family Health Center	MA	•	•						•		
Harbor-UCLA Research and Education Institute	CA						•	•	•		
Hidalgo Medical Services	NM		•						•		
Institute for Urban Family Health	NY	•	•					•	•		
Latino Education Project (Elderly)	TX	•	•						•		
Lowell Community Health Center	MA	•	•							•	
Matthew Walker Comprehensive Health	TN	•	•					•			
Medical University of South Carolina	SC		•					•			
Migrant Health Promotion	TX		•						•		
Missouri Coalition for Primary Care	MO	•	•					•	•		
National Black Women's Health Project	LA		•					•			
National Indian Council on Aging (Elderly)	NM		•								•
New Hampshire Minority Health Coalition	NH		•					•	•		
Oklahoma State Department of Health	OK	•	•								•
San Francisco Department of Health	CA				•			•			
Seattle-King County Department of Public Health	WA		•					•	•	•	
Special Services for Groups	CA					•				•	
Special Services for Groups (Elderly)	CA	•	•							•	
Trustees of Columbia University	NY						•	•	•		
United South and Eastern Tribes, Inc (CC)	TN				•		•				•
University of Alabama, Birmingham	AL					•		•			
University of California, San Francisco	CA					•				•	
University of Illinois, Chicago	IL		•					•	•		
University of Nevada, Reno	NV	•						•			

CVD=cardiovascular disease; DM=diabetes mellitus; INFM=infant mortality; IMMU=immunization; AI/AN=American Indian/Alaska Native; CC=AI/AN Core Capacity Building Grants; Elderly=focusing on elderly population.  
 \* Breast and cervical cancer.

for breast and cervical cancer, cardiovascular diseases, childhood and adult immunizations, diabetes, infant mortality, and HIV/AIDS. One of the components of this initiative is a community-based intervention program funded by the Centers for Disease Control and

Prevention (CDC). This program, Racial and Ethnic Approaches to Community Health (REACH 2010) targets the 6 health priority areas outlined in Healthy People 2010. The funded communities must target at least one of the following 6 racial/ethnic groups: African

Americans, Alaska Natives, American Indians, Asian Americans, Hispanic Americans, or Pacific Islanders.

A number of groups have played important roles in helping CDC implement and evaluate the REACH 2010 program, including the Office of Mi-

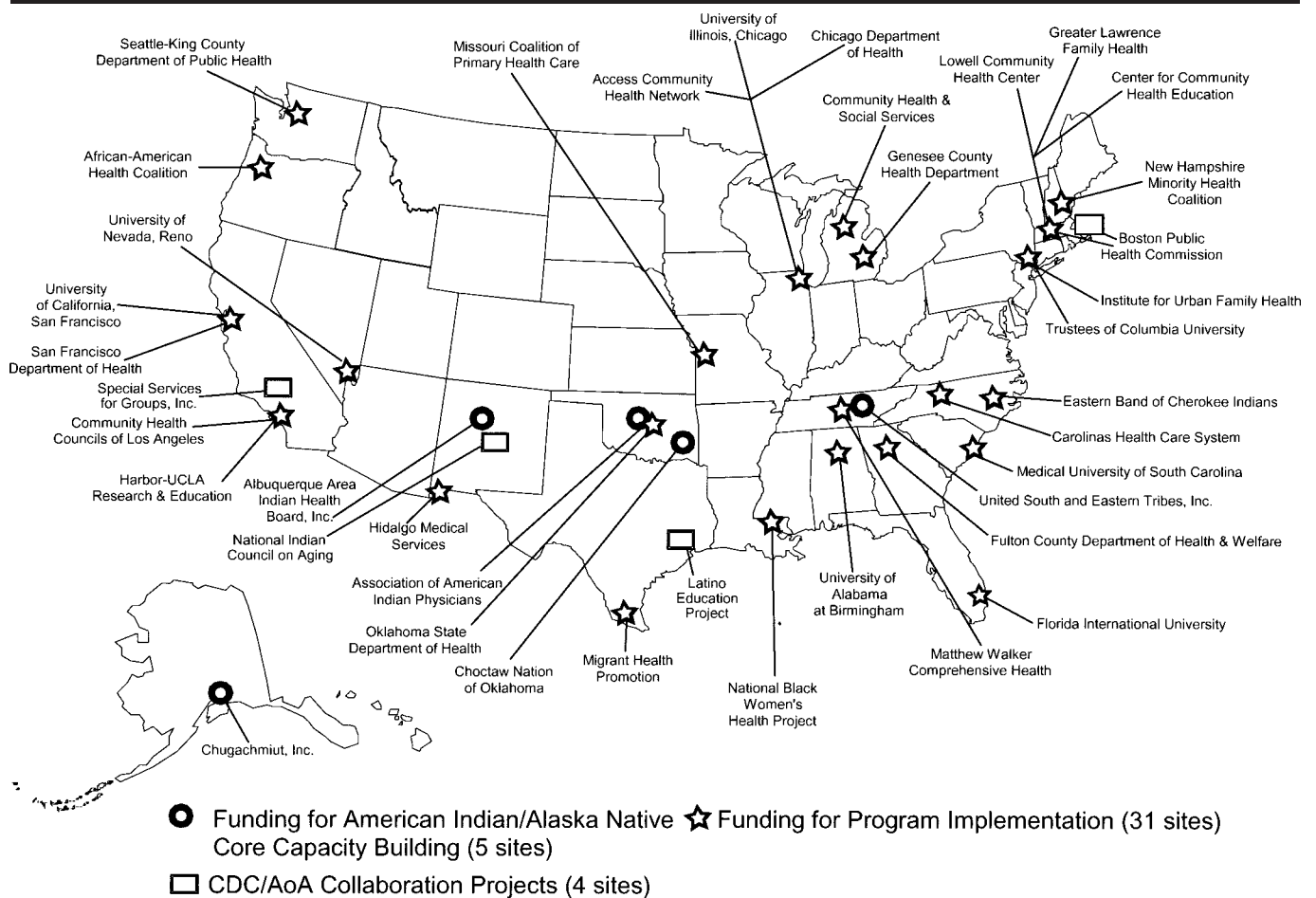


Fig 1. Central coordinating organizations in the REACH 2010 demonstration program

nity Health, the Office of Public Health Science, and the Office of the Assistant Secretary for Program Planning and Evaluation within the Department of Health and Human Services, as well as the National Institutes of Health, the Administration on Aging, the California Endowment, and the RAND Corporation. The Office of Minority Health, Office of Public Health Science, the Office of the Assistant Secretary for Program Planning and Evaluation, and the RAND Corporation, helped in the initial design of the program, and in developing the evaluation model. The National Institutes of Health and the California Endowment provided additional resources that have enabled the program to increase the number of communities funded. In addition, the Administration

on Aging provided technical assistance to communities focusing on health disparities among elderly persons.

The initial funding for the REACH 2010 program was for a planning year, during which each community developed a community action plan for their local intervention and evaluation activities. Subsequent funding was for intervention activities, and most of the communities are now in their fourth year of conducting intervention activities. Each community decided which racial/ethnic group or groups, and which health priority areas, should be targeted (Table 1 and Figure 1). Of the 42 currently funded REACH 2010 communities, 26 target African Americans, 15 target Hispanics, 5 target Asians and Pacific Islanders, and 8 target American Indians

(11 communities target multiple racial/ethnic groups). Eighteen of these communities target cardiovascular disease, 23 target diabetes mellitus, 3 target HIV/AIDS, 3 target infant mortality, 6 target breast or cervical cancer, and 4 target immunization (14 communities target multiple health priority areas). Finally, 5 communities focus on capacity building activity among American Indians/Alaska Natives.

Each community developed a community coalition that had to include a community-based organization, a state or local health department, and a university or research organization. Within each community coalition, one organization was designated as the Central Coordinating Organization (CCOs). The funded CCOs include community

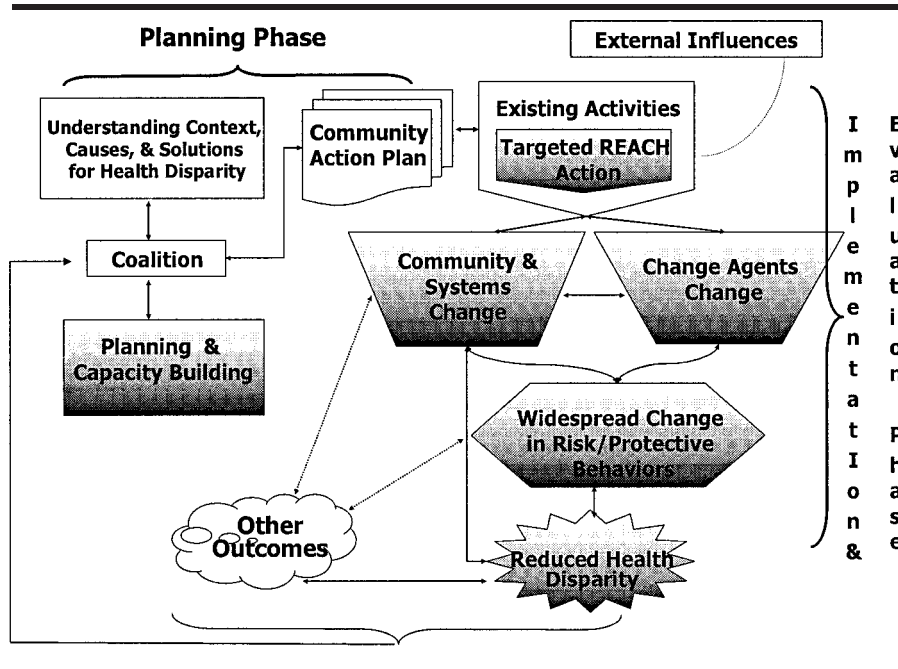


Fig 2. REACH 2010 evaluation logic model

based organizations, universities, health departments, hospitals or community health centers, national regional minority organizations, and American Indian tribes.

Evaluation is of critical importance in documenting and assessing the reduction of racial/ethnic health dispari-

ties. To assess progress in reducing these disparities, a logic model was developed (Figure 2). This model includes 5 stages:

1. Capacity building.
2. Targeted actions.
3. Change among change agents and systems change.

4. Risk and protective behavior change.
5. The elimination of disparities in health.

During the early years of the program, it was anticipated that most progress will be made in stages 1–3, and that progress in the final two stages will occur during the program’s later years.

The program evaluation has enabled the REACH 2010 communities to assess their sociodemographic and risk factor characteristics at baseline, and to process information regarding the effectiveness of strategies to eliminate disparities. The lessons learned from the REACH 2010 communities will be instrumental in helping additional communities develop intervention strategies to eliminate racial and ethnic disparities in health.

REFERENCES

1. US Department of Health and Human Services. *Report of the Secretary’s Task Force on Black and Minority Health*. Washington, DC: US Dept of Health and Human Services; 1985.
2. Centers for Disease Control and Prevention, National Center for Health Statistics. *Health, United States, 2003*. Hyattsville, Md: National Center for Health Statistics; 2003.
3. Miller BA, Kolonel LN, Berstein L, et al. *Racial/Ethnic Patterns of Cancer in the United States, 1988–1992*. Bethesda, Md: National Cancer Institute; 1996. National Cancer Institute Publication NIH 96-4104.