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. 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 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). 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), 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).

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...
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-
Minority 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
Evaluation of critical importance in documenting and assessing the reduction of racial/ethnic health disparities. 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