Society for Public Health Education's

18TH ANNUAL ADVOCACY SUMMIT

RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH (REACH) PROGRAM

REQUEST: Funding to build on the body of knowledge established in the Racial and Ethnic Approaches to Community Health (REACH) program. Since 1999, REACH awardees have used community-based approaches to reduce racial and ethnic health disparities by addressing the root causes of health disparities in their communities. $50 million per year is needed to continue to implement evidence-based practices and public health programs that fit the unique social, economic, and cultural needs of populations that suffer from health disparities.

Since 1999, the Centers for Disease Control and Prevention (CDC) has continuously funded the Racial and Ethnic Approaches to Community Health (REACH) program, a national program to reduce racial and ethnic health disparities. Through REACH, awardees plan and carry out local, culturally appropriate programs to address a wide range of health issues among African Americans, American Indians, Hispanics/Latinos, Asian Americans, Alaska Natives, and Pacific Islanders.

Addressing Health Disparities through REACH

Health gaps remain widespread among racial and ethnic minority groups. For example:

- Non-Hispanic blacks have the highest rates of obesity (48%) followed by Mexican Americans (43%).
- Compared to non-Hispanic whites, the risk of diagnosed diabetes is 77% higher among non-Hispanic blacks, 66% higher among Hispanics/Latinos, and 18% higher among Asian Americans.

The REACH US model was originally designed to build capacity in communities long neglected by our health care system and to improve the health and wellbeing of racial and ethnic communities with the greatest burden of disease.

What Makes REACH Unique?

REACH addresses barriers to health caused by education, income, location, or other social factors. REACH awardees use tailored community-based and participatory approaches to identify, develop, and disseminate effective strategies for addressing racial and ethnic health disparities. Health priority areas include breast and cervical cancer, cardiovascular disease, diabetes mellitus, adult immunization, Hepatitis B, tuberculosis, asthma, and infant mortality.

How are REACH projects funded?

REACH 2014, a 3-year CDC initiative, funds 49 governmental and nongovernmental agencies, including state and local health departments, tribes, universities, and community-based organizations in urban and rural communities. Along with funding, CDC provides expert support to REACH awardees. Individual grantees received $803,040 on average.

Continued funding is needed to launch a new funding opportunity in 2017 to build on the program successful models and to fund a national evaluation of REACH.

Proven Impact of REACH

The latest REACH U.S. Risk Factor Survey gathered health - and behavior related information from 28 REACH U.S. communities about chronic disease prevalence, fruit and vegetable consumption, physical activity levels, preventive services usage, and adult immunization rates. Following are some findings:

- Over the 3-year intervention period, smoking prevalence decreased on average 7.5% (or an average of 2.5% per year) among African Americans and 4.5% among Hispanics.
- In REACH communities that focused on cardiovascular disease or diabetes during this time, the percentage of adults who reported eating five or more fruits and vegetables daily increased 3.9% among African Americans and 9.3% among Hispanics.

- The percentage of adults aged 65 years or older who had an influenza shot in the past year increased on average 11.1% across the 3-year intervention period.

REACH communities are empowering and mobilizing community members to seek better health.

How Does REACH Work?

REACH's approaches cut across a number of evidence- and practice-based interventions by:

- Supporting community coalitions that design, implement, evaluate, and disseminate community-driven strategies to eliminate health disparities in chronic disease.
- Providing the infrastructure to implement, coordinate, refine, disseminate, and evaluate successful evidence
- 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.
- Increasing the evidence around effective strategies to reduce obesity and hypertension in racial and ethnic communities.
- Funding community-based organizations to reduce health disparities.

EXAMPLES OF REACH AT WORK

Boston's Community Asthma Initiative addresses health disparities in neighborhoods and schools most affected by asthma. There has been a 68 percent decrease in asthma-related emergency-department visits and an 84 percent decrease in hospitalizations. For every dollar spent on program costs, there was a return on investment of $1.46.

The REACH Charleston and Georgetown Diabetes Coalition, South Carolina has seen a reduction of amputations among African Americans decreased from 38.7 in 1999 to 21.7 in 2008, a decrease of 44% per 1000 diabetes hospitalizations. The Coalition estimates they save between $1.6 to $2 million a year in prevented amputations.

The rate of cigarette smoking among Asian American men in REACH communities decreased from 42 percent in 2002 to 20 percent in 2006.

Cholesterol screening increased among African Americans 74 to 78 percent, Hispanics 58 to 71 percent, and Asians 53 to 72 percent in REACH communities from 2009 to 2011.