

# Racial and Ethnic Approaches to Community Health

BY LARK GALLOWAY-GILLIAM

Despite improvements in morbidity and mortality rates for some of the leading causes of death in the United States, the health status of racial and ethnic populations lags seriously behind and is often comparable to that of low- and underresourced nations. African Americans have higher rates of diabetes, hypertension, and heart disease than any other group, and black children are far more likely than white children to visit an emergency department. They have a higher death rate from asthma. Fourteen percent of Hispanics have been diagnosed with diabetes compared to 8 percent of whites; they are 50 percent more likely to die from diabetes as non-Hispanic whites. Hispanic women are diagnosed with cervical cancer at twice the rate of white women. Asian Americans suffer higher rates of certain types of cancer, tuberculosis, and hepatitis B: Cervical cancer rates for Vietnamese American women, for example, are five times those of white women. From 2003 to 2006, the direct and indirect costs of health disparities totaled \$1.24 trillion. This breaks down to a \$309.3 billion loss each year on the local and national economy. Many of these illnesses and diseases are preventable and attributed to the conditions in which people live and work. Despite a decline in segregation over the last fifty years, housing patterns reveal significant and persistent segregation by race. Racial segregation is often compounded by a divestment of public and private resources, a higher concentration of hazardous sites and incompatible uses, fewer health care resources, a lack of access to health-promoting nutrition and physical activity infrastructure, and poverty.

The Racial and Ethnic Approaches to Community Health (REACH) program was designed to develop community-driven interventions and solutions to the disproportionate rates of cardiovascular disease, diabetes mellitus, HIV/AIDS, infant mortality, breast or cervical cancer, and immunization within one or more of these racial and ethnic groups: African American, Hispanic/Latino, Asian Pacific Islander, and Native American/Alaska Natives. It began as a research and demonstration project in 1999

in forty-two communities across twenty-three states and continues today with subawards to ninety communities through six national-level grants. The initial funding supported a partnership with three core partners (a community-based organization, university, and local department of public health) and a multisector coalition to develop a community action plan delineating their local interventions and evaluation activities. Consistent with the healthy cities model, the REACH program addresses inequality in health and urban poverty; the needs of vulnerable groups; participatory governance; and the social, economic, and environmental determinants of health.

Each community determined which racial/ethnic group or groups and which health priority areas should be targeted. Subsequent funding provided support for the implementation and evaluation of the intervention activities around three core areas designed to reduce racial and ethnic health disparities: health education and promotion, clinical and preventive services, and policy and systems change. REACH interventions focus on the root causes and social determinants of health and are by design accountable to, responsive, and reflective of the specific needs of each geographically specific racial/ethnic community. The REACH program has empowered residents to seek better health and actively engage the health, public health, and non-health sector to implement innovative evidence- and practice-based strategies that promote healthier communities.

REACH communities across the country have demonstrated that health disparities are not intractable. They have worked with school districts, city agencies, health care providers, and community members to achieve concrete change in the systems and policies that have contributed to health disparities. In South Carolina's Charleston and Georgetown counties, improvements in the health care education delivery system for self-management of diabetes resulted in a 44 percent reduction in

amputations for African Americans. These improvements were designed and implemented by the South Eastern African American Center of Excellence in the Elimination of Disparities in Diabetes program at the Medical University of South Carolina College of Nursing, a REACH grantee. Similar impacts were achieved through culturally tailored and competent interventions in other communities. In New England, working with community groups and local health care providers, the Greater Lawrence Family Health Center reduced total cholesterol to under 200mg/dL in 71.9 percent of Latino patients with diabetes. Absences were reduced in Boston's schools, there was a 68 percent decrease in asthma-related emergency department visits, and an 84 percent decrease in hospitalizations as a result of the work of the Community Asthma Initiative REACH program.

The REACH program goes beyond health care and seeks to fully integrate health considerations in economic regeneration, community development, and environmental efforts. The Cherokee Choices Program of the Eastern Band of Cherokee Indians works to reduce the risk for type 2 diabetes and cardiovascular disease in rural western North Carolina. They secured an agreement to ban fast food from schools and require approved healthy foods at school events, and they collaborated with the regional food bank to provide supplemental fruits and vegetables for low-income children in the Cherokee school system.

In an effort to reduce disproportionately high rates of nutrition-related chronic diseases such as cardiovascular disease and diabetes, Community Health Councils (CHC) in Los Angeles worked with city planning to introduce land use standards to reduce the proliferation and overconcentration of fast food restaurants. CHC also collaborated with local grocers, community developers, and a charitable foundation to establish California's \$230 million Fresh Food Financing Fund to eliminate food deserts and fight childhood obesity.

The Bronx REACH program brought city, public health, and school officials together to establish a citywide low-fat/skim milk-only policy in New York City public schools, affecting 1.1 million students. The Public Health Institute—Regional

Asthma Management and Prevention program focused on addressing asthma disparities among African American/black and Hispanic/Latino populations in nine counties in the San Francisco Bay Area of California. Working with land use and transportation planners, they were able to secure the passage of new diesel regulations by the California Air Resource Board.

The REACH program goes beyond health care and seeks to fully integrate health considerations in economic regeneration, community development, and environmental efforts.

These are a few of the many success stories in communities facing difficult health challenges. The REACH programs across the country are closing inequities in health. A national behavioral risk factor survey conducted in 2001 and again in 2009 highlights the success of REACH. In the eleven communities that were examined, meaningful improvement occurred in thirty-four of the forty-eight benchmark measurements.

- From 2009 to 2011, cholesterol screening increased among African Americans 74 to 78 percent, Hispanics 58 to 71 percent, and Asians 53 to 72 percent in REACH communities while screening decreased or remained constant among the same population groups nationwide.
- From 2001 to 2009, the percentage of Hispanics who reported having hypertension and were taking medication for it increased from less than half to more than two-thirds.
- During the same period, pneumonia vaccination rates increased from 50.5 to 60.5 percent in black communities, from 46.0 to 58.5 percent in Hispanic communities, from 37.5 to 59.7 percent in Alaskan/Pacific Islander communities, and from 67.3 to 78.7 percent in Native American communities.

The REACH program has been on the cutting edge of innovative policy and systems change to reduce health disparities. At its foundation is the engagement of those who share and are bound together by a geographic area and a set of conditions that impact

how they work, live, and govern. The REACH program stands as a model of the Healthy Cities organizing methodology that engages both policy makers and community stakeholders in a visioning process leading to collective action that reflects their values and a strong sense of ownership. These efforts have resulted in unprecedented partnerships and collaboration across a broad range of sectors and systems. Implementation is based on principles and values related to equity, empowerment, partnership, solidar-

ity, social justice, and sustainable development. Only through a community-driven and led process such as the REACH program can the United States truly develop “healthy cities.”

---

*Lark Galloway-Gilliam is executive director of Community Health Councils, a Los Angeles-based health promotion, advocacy, and policy organization dedicated to building healthy communities.*

---